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Achieving Alignment in an Academic Health Science System: Creating WVU Healthcare

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Overview

The ongoing success of academic health science systems (AHSS) requires new approaches to better align key AHSS participants around the design and execution of a unified vision and strategies. The alignment approaches and organizational models developed over the past 20 years are increasingly inadequate for many academic health science systems in a period of rapid change and increasingly constrained resources. At West Virginia University, academic leadership worked in concert with the leaders of the faculty practice plan and an affiliated not-for-profit hospital system to achieve alignment of mission, governance, strategy, and management across the AHSS’s distributed ownership and governance structure. This alignment has resulted in substantial improvements in clinical service and related financial results and increased financial support of the School of Medicine. This paper demonstrates how to achieve alignment in an environment where structure could not easily be changed. The approaches described in this paper can be used by those academic health science systems which participate in regional health systems separate from their university, as well as those which are under unified ownership and management, to improve coordination and alignment among the key operating units.

West Virginia University (WVU) was a pioneer in the development of a distributed model of governance and management in academic healthcare in the 1980s. A publicly-owned university hospital was divested from state control to a not-for-profit hospital corporation, West Virginia University Hospitals, Inc. (WVUH). A faculty-governed not-for-profit corporation, West Virginia University Medical Corporation, doing business as University Health Associates (UHA), managed the faculty’s practices. The Schools of Medicine, Nursing, Pharmacy, and Dentistry remained within the Robert C. Byrd Health Science Center (HSC) of West Virginia University. The practice plan and hospital services continued to mature, and in 1996, the original legislative authorization that created WVUH was amended by the state legislature to create a health system, West Virginia United Health System (WVUHS), which enabled linkages with several community hospitals. The distributed system functioned successfully throughout the latter part of the 20th century, with steady growth and financial success across all entities.
Stresses began to develop early in the 21st century as the various components of the AHSS responded—sometimes in concert, and sometimes independently—to proposals for healthcare cost control and reform, regionalization of healthcare systems, and flat state support for the HSC and its academic programs.

Early in the 2000s, the leaders of the University and the AHSS component organizations began discussing structural changes to enable more coordinated approaches to strategic planning and growth and a unified response to changes in the healthcare environment. Several unsuccessful attempts were made to change the governance of the AHSS entities, including the relationship between UHA and WVUH. The initial effort failed due to differences of opinion on the right model.

A 2009 effort to create an integrated clinical enterprise would have made UHA a subsidiary corporation within WVUHS. This approach required two-thirds of UHA’s members (clinical faculty in the School of Medicine) to approve changes to UHA’s bylaws. The proposal was endorsed by approximately 60% of UHA’s members, just short of the two-thirds required. It failed, in part, due to uncertainty over key leadership roles and concerns about loss of faculty autonomy. A number of key HSC positions, including the Chancellor, School of Medicine Dean, and UHA President, were filled by interim leaders at this time.

**Agreement on a Contractual Model**

By the end of 2009, WVU had appointed a new Chancellor for Health Sciences who re-engaged the planning process. The new Chancellor, with the support of WVUH and UHA leadership, made a key strategic decision to approach alignment through strong contractual agreements without forcing integration of UHA into WVUHS. The leaders agreed that governance changes could be examined at some point in the future if a record of operational success could be established within a contractual framework.

By the summer of 2010, the various components of the AHSS agreed upon a unique joint operating agreement (JOA) that has aligned the organizations to function as an integrated healthcare delivery system. The clinical entities participating in the Joint Operating Agreement, UHA and WVUH, operate under a common brand, WVU Healthcare.

These approaches have contributed to significant performance improvements which have enabled investments to strengthen the academic and clinical enterprises and position them for sustained success. The alignment strategies utilized by WVU are best described using The Chartis Group Academic Health Center Alignment Framework pictured in Figure 1. This framework suggests that overall alignment is best achieved by trying to optimize on several interdependent dimensions: governance, management, strategic, and economic. This framework was also used by Reece, Chrencik, and Miller to describe approaches to achieving alignment in Johns Hopkins Medicine and University of Maryland Medicine.
Using this framework, the key areas of focus at WVU included:

**Governance Alignment:** The governing bodies of WVUH and UHA remained in place and have the ultimate fiduciary responsibility for the individual corporations. However, major WVUH and UHA Board committees meet together to review the performance of the combined clinical enterprise. Key actions continue to require approval of each Board.

**Management Alignment:** A number of changes were made to align key leadership roles, including establishment of a unified clinical enterprise leadership team which operates under a single identity, “WVU Healthcare.” This leadership team has significant overlap with the AHSS leadership. The overall WVU academic and clinical enterprises now function through a unified leadership structure even though ownership of the key assets remains unchanged. Numerous other leadership roles have been integrated as will be described more fully below.

**Economic Alignment:** Funding mechanisms were restructured to better align incentives between the clinical entities (WVUH and UHA) and with the School of Medicine. Improved alignment has helped enhance performance and expand the resources available to the clinical enterprise and for investment in the academic enterprise. The flow of funds between the entities was simplified and the budgets became more transparent.

**Strategic Alignment:** Creation of WVU Healthcare enabled the leadership team and faculty to quickly design a unified strategic plan for the first time in many years. The strategic plan encompasses the entire clinical enterprise. Implementation is being managed aggressively, including development of new facilities to serve the significant growth in patient activity resulting from a more coordinated approach to serving the local and statewide communities. The strategic plan is closely linked to the Health Sciences Center strategic plan and WVU’s strategic plan.
Creating enterprise-wide management, economic, strategic, and governance alignment has allowed the AHSS to make coordinated and strategic investments in facilities and program development that will foster improvement in all four missions of the AHSS. Initial results of the Joint Operating Agreement (JOA) have been positive both operationally and financially, with measured improvement in healthcare quality and outcomes, rapid action toward implementation of a unified strategic plan, and significant increases in faculty recruiting, patient volume, research funding, and other outcomes.

The sections below describe the approaches used to gain alignment in greater detail.

**Governance Alignment**

**Four entities were signatories to the JOA:** WVU-HSC (on behalf of WVU), WVUH, UHA, and WVUHS. Each had a separate governing board and committee structures as outlined in Figure 2.

**FIG. 2 Governance Structures of the Three WVU Healthcare Organizations**

**WVU Board of Governors**

- President, West Virginia University
- Chancellor, Health Sciences Center

**WVUHS Board**

- WVU President, Chair
- Chancellor & SOM Dean
- Ex-officio members
- With vote

**WVUH Board**

- WVU President, Chair
- Chancellor & SOM Dean
- are members
- With vote

**WVU Medical Corp. Board of Directors**

- SOM Dean is member (with vote)
- Chair of Board is elected
- Chancellor is ex-officio member (without vote)

**Challenges to Governance Integration:** The existence of the four separate organizations and governing boards (WVU, WVUHS, WVUH, and WVU Medical Corp.), each with overlapping memberships and interdependent responsibilities, was recognized as a potential barrier to strategic alignment. After the failed 2009 faculty vote to have UHA become a subsidiary corporation of WVUHS, the new Chancellor and leadership of the four organizations conducted a systematic review of why the proposal failed. A survey of faculty members revealed several reasons for the reluctance of some of the voting members of UHA to approve the change:

- Although not everyone supported the bylaw change, there was near-unanimous agreement on the inadequacy of the status quo. Dissatisfaction with the existing structures and relationships was widespread; the need for a single clinical enterprise with a common management structure, closely aligned with the academic enterprise, was recognized.
• A number of faculty members were uncomfortable with the proposed absorption of the faculty-led practice plan board into a regional system whose board would likely include substantially more non-physicians than physicians.

• A substantial number of faculty members expressed concern that a merger of governance systems – rather than just a management agreement – would be difficult or impossible to unwind if it proved unworkable or if the healthcare environment changed to make such an arrangement less desirable.

• There was a strongly expressed sentiment that faculty members had not been adequately consulted during the discussion process.

• And last, a key factor identified by many faculty members after the vote was the level of uncertainty they felt related to turnover in key leadership positions across the organizations.

**Approach to Governance through the Joint Operating Agreement (JOA):**

Early in 2010, the new Chancellor re-started the effort to establish a single clinical enterprise by establishing an HSC Steering Committee, including the Dean of the School of Medicine, the CEOs of WVUH and WVUHS, the President of UHA, and himself. The new chancellor also convened a series of town-hall meetings to solicit faculty input. The meetings were well attended and faculty members – both clinical and non-clinical – were vocal about their concerns. What emerged from these conversations with faculty was the clear message that to justify changing the status quo, the academic mission had to be front and center. Among the comments that supported this emphasis were:

“Many concerns were expressed about the lack of support of non-clinical missions. It was in the model, but it got lost in the discussions…there was all this talk about who is in what board. There needs to be an academic component.”

“There was a lack of academic support from the WVUH/UHA side; or if it was there it was not well stated.”

“A lot of people spent a lot of time on integration. But to have a good reason to integrate, it has to be based on a clear academic mission. We need a clear mission statement. If our goal is expressed as “We will get an extra $2 million” that seems trivial…it should be about a shared mission.”

Based on the above information, the Steering Committee concluded that WVU’s best opportunity for success was to move toward a JOA among the parties without governance changes. Because this proposal was constructed as a contract among the four organizations it did not require changes to either the enabling legislation for WVU, WVUH, and WVUHS, or to the bylaws of UHA. The organizations were able to execute the JOA through board votes without additional legislation or a vote of the clinical faculty.

The UHA and WVUH boards, however, determined that they would need to adjust their practices and coordinate decision making in order to provide consistent direction and oversight to the combined management team.

In addition, key committees from each board (including the strategic planning committee and the finance committee) were instructed to meet together prior to full
Board meetings so that the performance of the combined clinical enterprise and of the component organizations could be evaluated jointly and that the reports of these evaluations could be presented to each Board.

Key actions – budget approvals, strategic plan adoption, and appointment of executive leadership for WVU Healthcare – continued to require independent approval by each of the Boards.

**Economic Alignment**

The JOA development process included agreement that the historic funds flow and deal making arrangements would be revised to support all missions and new strategic initiatives. The “Commitment to Economic Integration” section in the JOA included these key components:

- Development of a common financial plan, operating budget, capital budget, and long term capital plan for WVUH and UHA by the shared management team.
- Identification of adequate funding and investment strategies to fund all missions of the School of Medicine.
- Commitment to transparency to enable better understanding of cost and revenue by mission.
- Equalization of the operating margin of the hospital and physician corporation annually.
- Transfer of funds in excess of agreed-upon amounts directly to the School of Medicine when and if enhanced financial results are achieved.

**Margin Equalization:** Two main funds flows were defined in the JOA: the margin equalization process that, in effect, aligned the operating financial performances of WVUH and UHA and the transfer of excess funds to the WVU School of Medicine.

A WVU Healthcare operating margin is calculated routinely by combining the UHA and WVUH operating results. Funds have been transferred from one corporation to the other to ensure that the operating margins of each corporation were equal to the combined operating margin. A single CFO and accounting function has been formed to support both corporations. This group oversees a single budget development process, provides common and individual entity financial performance reporting to the Executive Leadership Group (ELG) and the governing Boards, and implements and reports on funds transferred between the organizations.

The margin equalization approach replaced numerous departmental support arrangements negotiated by each chair with WVUH over many years. The myriad of support ‘deals’ contributed to mistrust across the entities and among the departments, reflecting vast differences in the level of support provided to each department. WVUH continues to pay a portion of faculty salaries for medical administrative roles where there is a clear job description and a clear time allocation for a specific individual providing the services. These medical administrative arrangements must be approved by the ELG whereas in the past they were negotiated by each department often resulting in random assignments of individual faculty and unclear accountability and expectations for the services to be provided. All of the other support arrangements...
are funded through margin equalization such as start-up packages, assistance for specialties unable to support themselves, and specialties which were previously able to demand support due to their importance.

**Excess Funds Transfers:** In the event that the combined UHA/WVUH operating margin exceeds 2.5% (raised to 3% in 2012), the JOA required 50% of excess funds over that threshold to be transferred to the School of Medicine. The JOA further required that 100% of all margin in excess of 3% (now 3.5%) be transferred to the School of Medicine. (“Prior period” items that occurred prior to the implementation of the JOA and meaningful use funding were excluded from these calculations.)

**Other Financial Arrangements:** The JOA addressed faculty compensation issues by stating a “high priority” of the financial plan was to enable the establishment of a compensation plan that better recognized contributions to all missions and market forces. The Dean retained final approval of all physician compensation. A new unified clinical faculty compensation plan was created in 2011 and implemented on January 1, 2012, which put all departments and faculty on the same methodology which defined clear base compensation benchmarks and incentive formulae. The new plan recognized and rewarded performance which exceeds expectations across all mission components of the School, not just clinical productivity. This unified plan replaced the numerous departmental plans common at WVU and in most schools of medicine.

**Management Alignment**

Prior to the JOA, the separate legal entities comprising WVU’s AHSS each maintained separate management structures and decision-making processes. Each management team attempted to optimize their operating unit’s performance sometimes at the expense of overall AHSS performance. This, in turn, led to constant negotiations between the parties to gain support for existing and new programs. In addition, WVUH’s ownership by WVUHS, which includes several community hospitals, also created conflict due to the differing levels of involvement in and commitment to academic programs among the participating hospitals. More specifically:

- UHA’s CEO was selected by and reported to the UHA Board.
- The WVUH CEO reported to the WVUHS CEO as well as to the WVUH Board.
- The WVUHS CEO reported to the WVUHS Board.
- The Deans of the Schools of Medicine, Nursing, Pharmacy, and Dentistry reported to the Chancellor (the position’s title was VP for Health Sciences until 2009). The Chancellor reported to the WVU President who, in turn, reported to the WVU Board of Governors.

During the JOA negotiations, several management structures were proposed and evaluated by the Steering Committee. From earlier integration discussions, there was strong agreement that all entities needed to plan and work more closely together to establish a unified strategy and to manage growth; that financial pressures could, in part, be alleviated by achieving greater alignment and by focusing on the common missions. That being said, creating the right management structure was challenged by ambivalence and mistrust among some sectors of the AHSS.
For WVU Healthcare to succeed, the Steering Committee determined that an integrated UHA and WVUH management team was needed, supported by a new incentive model as described in the financial alignment section of this paper. The integrated team was made responsible for day-to-day operations of all clinical programs; for developing and implementing new programs; for evaluating and modifying existing programs; and for meeting the goals set by the governance bodies. Additional principles stipulated that the management structure had to have defined roles and responsibilities for executives and managers at every level within the new organization; distinct and clear reporting relationships that crossed organizational lines had to be constructed; and intra-organizational negotiation and “special deal-making” that often frustrated efficient management had to be eliminated. Out of the negotiations the following organizational structure was established.

As shown in Figure 3, at the top level of the structure for WVU Healthcare, where multiple points of responsibility for strategy and policy occur, resides the Chancellor for Health Sciences and the Chief Executive Officer of the WVUHS, which now includes five hospitals. Their explicit roles are defined as follows:

- The Chancellor’s role was defined as the point of integration for all activities that support the clinical, academic, and research missions of the Health Sciences Center and WVU Healthcare, which consists of UHA and WVUH, so that all important decisions with broad implications are effectively addressed and made in an integrated fashion.

- The role of the WVUHS Chief Executive Officer was defined as the leader for integration of the hospitals and provider networks within WVUHS and the relationship of these entities to WVU Healthcare.

- Together, the Chancellor and the WVUHS CEO are responsible for establishing overall priorities, strategy, and direction for both WVU Healthcare and WVUHS. This approach required the WVUHS CEO to share authority and responsibility for WVUH with the Chancellor; however, this sharing enabled greater alignment of UHA with WVUH such that UHA and WVUH could more effectively collaborate to achieve greater success for both organizations.

**FIG. 3  Strategic Management Alignment**

Highest level: **Statewide and Regional Clinical Strategy**
As shown in Figure 4 the next level of management created was the Executive Leadership Group (ELG) which consists of three people: the Dean of the School of Medicine (Dean), the President and CEO of WVUH (WVUH CEO), and the Chief Executive of UHA, who also serves as Chief Medical Officer of WVU Healthcare (CMO) and as Vice Dean for Clinical Affairs in the School of Medicine. The ELG functions as a single executive team responsible for achieving the goals of the JOA. In addition to maintaining existing accountabilities, the ELG reports to the Chancellor for Health Sciences to ensure that WVU Healthcare executes strategy and policy to assure achievement of all missions of the HSC. Both the Dean and the WVUH CEO also have a reporting relationship to the Chancellor. Each member of the ELG has specific assigned responsibilities.

- The Dean is responsible for setting faculty compensation, appointment of department chairs, and creating management systems within the School of Medicine to effectively manage resources. In order to assure an ongoing integration, in the event of any vacancy in this position during the term of this agreement, the Chancellor shall appoint the WVUH CEO as co-chair of the search committee for the Dean.

- The WVUH CEO provides leadership for the effective and efficient operations of WVU Healthcare. The WVUH CEO continues all existing reporting relationships to the WVUH Board and WVUHS CEO and will also report directly to the Chancellor. The WVUH CEO works in close collaboration with the Dean and other leaders across the HSC to achieve effective integration of healthcare operations, achievement of strategic initiatives, and assure the adequate support of all missions. In the event of any future vacancy in this position, the Chancellor and the WVUHS CEO will appoint a search committee to select a slate of potential nominees. In order to assure an ongoing integration, in the event of any vacancy in this position during the term of this agreement, the Dean will serve as the co-chair of the search committee for the WVUH CEO.

- The UHA Board of Directors reorganized its management structure and created the Chief Medical Officer (CMO) as the UHA President and Chief Executive. In the JOA, the UHA CMO became the “CMO for WVU Healthcare,” reporting jointly to the Dean of Medicine and the CEO of WVUH. The CMO is the senior physician executive of WVU Healthcare and has management responsibilities for all ambulatory service lines, the integration for service lines that span ambulatory and inpatient settings, and all quality and safety improvement initiatives. The CMO also serves as Vice Dean for Clinical Affairs for the School of Medicine to align academic and clinical missions. In the role of Chief Executive of UHA, the CMO reports to the UHA Board. The School of Medicine department clinical chairs report to the CMO for matters related to clinical care, patient safety, and quality.

- Importantly, the JOA stipulates that the Dean, WVUH CEO, and CMO meet routinely and formally as a group with individual clinical chairs and other clinical leaders. The ELG also has the authority to appoint clinical faculty to ad hoc committees to evaluate and report on various institutional issues, including program development, new institutional initiatives, and existing programs. In practice, the ELG meets almost every week for several hours. The Chancellor attends ELG meetings on a regular basis.
The administrative reporting structure for WVU Healthcare established by the JOA is diagrammed in Figure 4.

**FIG. 4  Executive Leadership Group Management**

The creation of a unified ELG enabled integration of a number of other key leadership positions across WVUH and UHA which, in turn, helped unify operations and improve efficiency. Changes enabled by the new model include:

- A single CFO was selected to integrate and oversee key financial operations and to integrate financial reporting across UHA and WVUH.
- A single Human Resources leader was selected. Most non-physician employees of UHA became WVUH employees to enable standardization of compensation, benefits, holidays, etc.
- A single General Counsel was selected to support both UHA and WVUH.
- Facilities management was integrated to enable improved efficiency and consistent operations.
- A WVU Healthcare VP and an Associate CMO for Ambulatory Services and Access were selected to work with the faculty to improve and standardize service in the ambulatory clinics and access to all services. Clinics were previously managed by each department, with significant autonomy and high performance variation.

**Strategic Alignment**

The JOA was approved and signed by the four participating entities in August of 2010. The ELG quickly determined that WVU Healthcare needed a single strategic plan for the clinical enterprise. The strategic planning process was launched in December 2010 and the vision and key strategies for WVU Healthcare were agreed to by May 2011 and approved by each of the participating Boards (UHA, WVUH, and WVUHS) by June 2011. This is a relatively rapid process for development of a detailed strategic plan for an AHSS.
The HSC was nearing completion of its strategic plan simultaneous with the start of the WVU Healthcare strategic planning process. The contiguous timing of the academic and clinical planning processes enabled WVU Healthcare to link its strategic plan to the key themes adopted in the HSC plan and to fully align its vision and strategies with the academic plan. For example, the HSC adopted “transforming lives and eliminating health disparities” as a central tenet of its strategy. The WVU Healthcare plan added a few words such that its vision became “transforming lives and eliminating health disparities through a nationally recognized system of care.” The WVU Healthcare plan then defined five major strategies for the clinical enterprise, all of which linked to one or more objectives in the HSC’s Plan. The five key strategies included:

- Expanding WVU Healthcare’s network of patient care sites locally and statewide to improve patient access to the faculty’s services in the community and at other hospitals.
- Delivering consistent, integrated care across the continuum and achieving recognition for delivering the right care in the right place at the right time.
- Developing new models of healthcare including new team-based models of care and expanded clinical and translational research.
- Educating uniquely qualified healthcare team members by expanding educational activities across the entire network.
- Strengthening the culture of performance and excellence across the network.

These five strategies each include several specific areas of actions such that there are 21 major initiatives being pursued to realize these strategies.

The strategic plan was developed in a participatory manner to gain input and build support for rapid implementation. The Strategic Planning Steering Committee included 21 chairs, faculty, and executives from across the organization. Five work groups were established to develop more detailed plans for specific areas; an additional 30-40 chairs, faculty, and executives were engaged in this part of the planning process. The WVUH and UHA Board strategic planning committees met jointly, as described in the Governance section of this paper, to review specific elements of the environmental assessment and the plan in March and to recommend the plan’s approval in June. A retreat was held in May of 2011 to present the plan to more than 100 managers and faculty.

Implementation began immediately after adoption of the plan in June 2011. Each of the 21 major initiatives that were to be launched in the first 18 months is either on track or close to the original schedule.

Outcomes

The Joint Operating Agreement and the unified strategic plan have enabled the leadership team to move forward with rapid implementation of key initiatives and to make decisions about these initiatives relatively quickly. In addition, there is a high level of support among the faculty for the changes that are being implemented.
• The Strategic Plan called for rapid investment in new patient care capacity. A quarter-billion dollars has been committed to building a new bed tower and expansion of other facilities at WVUH. A Certificate of Need for the project is already in place and the initial construction and relocation phases of work are scheduled for late 2012.

• Increasing patient utilization across WVU Healthcare has resulted in a substantial increase in revenue, which triggered the excess funds transfer provision of the JOA. In the year ending June 30, 2012, WVU Healthcare generated $7.3 million in new funds for initiatives identified by the School of Medicine and the ELG.

• The margin equalization provisions of the JOA resulted in the transfer of $26.6 million from WVUH to UHA in the year ending June 30, 2012. This made possible the investment of $10 million to fund the initial year of the implementation of a competitive and transparent school-wide clinical faculty compensation plan through UHA.

• As a part of the new compensation model, a clinical productivity incentive plan was implemented by UHA in January, 2012. During the first six months of 2012, measured productivity increased by 10%, with 78% percent of clinical faculty members earning incentive payments.

• The entire faculty recruitment process has been revamped so that approval of new positions agreed to in the strategic plan are ‘fast tracked’ and the recruitment processes can be monitored and managed more aggressively. As a result, the pace of recruitment has increased significantly.

• Ambulatory clinics and a variety of other services formerly operated by UHA were organized as WVUH outpatient departments to optimize reimbursement and enhance quality through adherence to the more stringent regulations required of hospitals. This concept had been discussed for years but had never been implemented due to the fragmented decision-making and inability to agree on the best approach to share the expected benefits.

• Several service lines (cancer, behavioral health, cardiovascular and peri-operative services) are now being implemented, each of which has a dyad leadership structure with physician and administrative co-leaders who have joint accountability and authority for their service lines across UHA and WVUH and the same performance objectives for which they are jointly accountable.

• A unified performance improvement and incentive compensation plan was implemented in 2012 across all inpatient and outpatient units to direct efforts toward measurable common goals. Included in this plan are both resident physicians as well as clinical department chairs.

• WVU was selected in August 2012 for a $19.6 million NIH Institutional Development Award for Clinical and Translational Research (IDeA-CTR). The hospital and regional health system have committed $5 million to this project, an investment not likely to have been made before the JOA was signed.
Continuing Challenges

Much of the progress achieved in the past two years is directly attributable to the alignment developed within the JOA. However, alignment is not a panacea for all issues facing the AHSS. A number of challenges remain, not the least of which are the financial projections for academic hospitals as the Affordable Care Act moves into the implementation stage.

Some specific issues which are currently unresolved at WVU include:

- **Cost control:** We achieved little or no cost savings in our operations as a result of alignment. As a result of increasing clinical volume and planned faculty growth, we are experiencing an increase in the number of employees across the AHSS.

- **Service line organization:** We have yet to resolve some key organizational questions regarding the relative levels of accountability and authority for service line leaders and departmental leaders as we move toward a service line structure.

- **Decision making:** The ELG structure described above has improved organization’s functioning in many respects; such as transparency and accountability. However optimizing “nimbleness” of decision making is a work in progress, especially when we will be required to respond to accelerated changes in the healthcare environment.

- **Financial transparency:** WVU Healthcare financial statements and reporting have become transparent to the respective boards and faculty. Additionally, the faculty compensation plan has benchmarked physician compensation to both academic and clinical productivity measures. However, achieving a full understanding of the cross subsidies, effort reporting and mission based budgeting of the academic enterprise remain works in progress.

- **Closer alignment across and within WVUHS:** West Virginia needs additional healthcare providers across the state. The WVUHS hospital facilities and their providers could provide an excellent opportunity to educate more HSC health professional learners if there was greater alignment with WVUHS. There are opportunities to strengthen relationships among the entities such that all of the organizations grow to better serve their communities and improve the quality of care available closer to where patients live.

These last three issues are a particular concern in light of the historic issues of trust and leadership accountability that were revealed in faculty discussions and surveys leading up to the adoption of the JOA. We continue to work toward resolving them in the hopes of maintaining strong faculty and stakeholder support for the continued evolution of our AHSS.

References

