BUILDING A TRANSCONTINENTAL AFFILIATION: A NEW MODEL FOR ACADEMIC HEALTH CENTERS

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INTRODUCTION

The affiliation between The Methodist Hospital, Weill Medical College of Cornell University and New York-Presbyterian Hospital is, to our knowledge, the first transcontinental affiliation between major nonprofit academic health centers (AHCs) in the United States. The rationale for the affiliation was clear to those involved in the discussions. The institutions share the same mission of fostering progress in clinical care, education and research; and because of their geographic separation, Methodist, Weill Cornell and New York-Presbyterian do not compete with each other in providing clinical care to their regional populations. While academic "competition" and potential competition for international referrals do exist, it was judged that these potential areas of competition could easily transform into collaborations. Most importantly, this situation ottered an opportunity to explore new models for AHCs, which many feel must change to better meet society's needs.1 Also, it seemed that this could have importance beyond the collective interests of the three institutions. A spirit of optimism and possibility, respect and trust between the key individuals, the support of senior board leadership, and recognition of the need to conclude the negotiations promptly served as the key enablers of agreement.

The affiliation agreement's straightforward basic terms facilitate collaboration in patient care, teaching, research and operational performance. The affiliation is primary and reciprocally exclusive in New York and Texas (e.g., Methodist is Weill Cornell's only affiliate in Texas, and Weill Cornell is both The Methodist Hospital's primary academic affiliate and its only affiliate in New York, but both may have other affiliations). Members of Methodist's medical staff are eligible for faculty appointments at Weill Cornell, but appointments are neither automatic nor required. The primary academic appointment for chairs will be at Weill Cornell. Mutual efforts to improve clinical care include coordination between department chairs and sharing best practices, quality methods and clinical databases. The affiliates intend to collaborate extensively in education - including graduate medical education (GME), medical student education and research training at the graduate and postgraduate levels - and foster joint research, particularly clinical and translational research. Finally, administrative staff explore opportunities for sharing processes and progress in operational performance.

PROGRESS TO DATE

Progress during the inicial nine months has confirmed and reinforced our decision co enter into chis innovacive affiliation. Methodist has successfully secured its clinical and financial base, started co rebuild cramming programs, established a research infrastructure, implemented The Methodisc Hospital Research lnscicuce and recruiced new department chairs, most recently Dr. Barbara Bass as chair of surgery.

In addition, Methodist and Weill Cornell have started collaborating on a number of activities. Faculcy from both sites auchored an academic paper regarding the innovative architecture and pocenrial of che relacionship. Large-scale site visits to each instirucion have been held on a number of occasions. A highly successful joint research symposium was conducted in Houston, as was the first of a series of collaborative leadership forums regarding clinical quality improvement. A joint piloc grants program has been launched and research collaboracions have begun. Many Mechodisc physicians have applied for and received Weill Cornell faculcy appointments, and many more are anticipated.

Our academic departments are beginning to collaborate in GME programs wich the scrong support of New York-Presbyterian, and resident rocacions are planned in both directions. Methodist has decided co establish a Department of Public Health jointly with Weill Cornell. Several specific areas for collaboration were identified, including standardization of mecrics, eleccronic medical record data mining and reporting, daca warehouse development, standardization of patienc satisfaccion cools, exchanging specific qualicy prococols and establishing cross-inscicucional teams for ongoing collaborations.

Mose recently, Weill Cornell's executive vice dean, Dr. H. Dirk Sostman, accepted an offer co become Methodisc's chief academic officer,

as well as chief medical officer of The Merhodist Hospirnl System while remaining a Weill Cornell executive vice dean. In these capacities, he brings rhe affiliates together on all academic fronts.

OPPORTUNITIES AND CHALLENGES

In the short term, Weill Comell and New York-Presbyterian needed co assist Methodist in amending lost functions and programs - such as G M E and faculty appointments - that had been furnished by its former primary medical school affiliate. As chis phase nears completion, the three institutions are exploring opporruniries in education, research, quality improvement and international program development.

The relationship becween institutions represents a new kind of collaboration, a step forward in che globalization of health care. A simplifying factor is that the three parties do not compete for a single geographic patient base; however, all are active in international outreach, including international referrals, education and development. Further, their primary global catchment areas have little existing overlap. While potential comperirion has always existed for intemarional ventures, rhe affiliarion opens the opportunity for developing a joinr presence in the international marker. Developing further affiliations could enhance this model with the aim ofcreating rhe first global nonprofit health care enterprise.

One clear opportunity is to develop clinical trials, investigacor-initiated, patienr-orienred research and heath services research on a national scale. Large and diverse patient populations have become essential in all types of clinical research, as emphasized in the National Institutes of Health Roadmap.[2] The collaborative faculcy, common information systems and shared Department of Public Healrh should help us rapidly develop chis area.

Educational opportunities include medical students, G M E, continuing medical education and scientific training {graduate students and poscdoctoral trainees). Elective opportunities for entry-level trainees will be an attractive part of educarional programs, and upper-level trainees such as clinical fellows could benefit significantly from direct exposure co the broadesr range of faculty and parients. Disrance learning and electronic media are increasingly used in medical education and could provide obvious benefits co boch sites.3· Weill Cornell's campus in Qatar has given it considerable experience with distance learning, and the three affiliates have accelerated their investments in chis infrastructure to foster its creative use in education.

The potential role of shared or joint clinical programs, including inremational projects, is being discussed. Quality improvement eforrs are high priorities clinically, operationally and academically in both New York and Houston.5 Benchmarking, best practice sharing and integrated quality research are already under way. Alrhough collaboration and familiariry enable appropriate referrals, clinical medicine remains in most instances a personal and geographically localized service. Thus, the development of joint clinical programs will be pursued only if physicians at both sites propose chem. Futurisric programs such as virtual reality consultations and robotic telesurgery are technically feasible and may be explored at a later dace. The greatest opportunity exists for quality improvement, benchmarking and sharing best practices, and we anticipate that shared qualiry acnvmies will become major efforts given the national heakh policy and payer focus on these topics.

There is immense opportunity for exploiting the capabilities provided by information technology (IT) since it is the key infrastrucmre to developing successful research and quality programs among the sires. Electronic medical records, standardized data dictionaries and mumally accessible data repositories are essential for data sharing on quali$_{ty}$ improvement and outcomes measurement, facilitaring data warehouse functions for clinical research and, ultimately, for maximizing hospital operational performance. Distance-learning and conferencing technologies will enable shared educational programs. Other possibilities include sharing incellecmal capital and implementation expertise; standardization of produces, rules, terminology and data collection practices; and strategic planning. In May 2005, an IT forum assembled leaders from Mechodisr, New York-Presbyterian and Weill Cornell co sec an agenda for clinical, operacional and research IT collaboration.

The principal challenge rhus far has been the physical distance between the panies. Although exrensive use of videoconferencing has been successful, more sophisicaced technologies such as videoscreamed seminars and Web-based educarional archives or shared Internet workspaces have nor yet been adopted. The effectiveness of electronic meetings increases wirh an individual's familiarity wirh the medium, and chis medium is particularly successful for chose who already have established a personal relationship. Since there is no substitute for personal contact when initially establishing relationships,

frequent interchange has been encouraged. Finally, external regulatory processes have created some discontinuities or anomalies (e.g., in residency programs) making it necessary to devise compensatory measures.

CONCLUSION

Academic medicine and AHCs face significant challenges as they enter the 21st cencury,[6] and many AHCs have responded to these challenges through mergers of various types. We have established a unique transcontinental affiliation between two major AHCs. The key enablers of this affiliation were a rapid process and mumal trust based on personal relationships of executive management teams, and commitment to the project by board leadership. Any novel venture involving complex academic entities faces many potential obstacles; in chis instance, most were avoided or overcome in the early phases of che projecc.

Those involved in the affiliation recognize that challenges will continue to evolve. One ongoing challenge that we are actively working co resolve is co maintain and enhance functional integration at a distance - a challenge that is notably unique to health care as numerous corporations with geographically dispersed units have overcome it successfully.[7] The prior experiences of those involved with international projects, multicenter biomedical science and networks of affiliations are major advantages in dealing with chis issue, and the challenges create great opportunities co design models for education, research and clinical collaborations. Realizing the potential of these oppormnities will require unconstrained ideas and substantial investment of time and other critical resources.

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