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Creating a Successful Physician Enterprise in Academic Health Systems

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Many academic medical centers (AMCs) have evolved into academic health systems (AHSs) by building or joining large delivery systems to ensure their continued access to patients, teaching settings and a leadership role in their market. Many of these AHSs now employ growing numbers of full-time clinicians alongside their traditional faculty physicians, most of whom are part-time clinicians. While some of these full-time clinicians have faculty appointments, the vast majority have limited involvement in education or research and no expectation for meaningful scholarly contributions.

Most of these AHSs aspire to organize the practices of the academic faculty and the employed full-time clinicians into a unified physician enterprise that enables the organization's overall strategy and provides patients with a consistent care experience across the system. Realizing this aspiration can be challenging as organizational dynamics, history and structural constraints often impede the integration of the AHS's clinical workforce into a unified practice. **This paper explores the approaches and lessons learned from assisting numerous organizations in building physician enterprises that support the journey from AMC to market-leading AHS.**

The goal of building an integrated physician practice and the set of challenges that must be overcome are not fully unique to academic health systems. Many non-academic integrated delivery networks (IDNs) are also struggling with how to integrate their clinical workforce into a unified physician enterprise that operates in a coordinated and consistent manner across the IDN's broad service areas and multiple inpatient and outpatient facilities. Unlike their AMC counterparts, these IDNs are seeking to integrate physician groups that at their core are fundamentally similar, in that they are primarily clinically focused, have similar compensation expectations, and often share a common understanding of their relationship to and role within the broader health system. This paper discusses the specific challenges that AHSs face in creating an integrated physician enterprise comprised of both academic faculty and full-time clinicians.

Background

Academic medical center organizational dynamics have historically been defined through the interaction between the executive vice president (EVP), dean, chairs, faculty practice leader and university hospital leader. These relationships in and of themselves can be complex and require a well-designed operating and economic model to foster alignment across the enterprise. The addition of full-time clinicians into this environment, while often necessary to support the overall system's strategy and goals, changes the dynamics between these traditional players. When structured well, AHSs have the opportunity to create powerful physician enterprises that help them successfully fulfill their missions and strategic vision. A variety of cultural differences between the academic faculty and the full-time clinicians can lead to competition, distrust and misunderstanding which contribute to costly turnover, suboptimal care coordination and lost referrals.

When structured well, AHSs have the opportunity to create powerful physician enterprises that help them successfully fulfill their missions and strategic vision.

Successful physician enterprises are characterized by mutual respect and collaboration between the academic faculty and the non-academic full-time clinicians. However, building respect and collaboration is often challenged by several factors which impede health system leadership's ability to provide patients with a consistent experience and superior outcomes for populations and episodes of care. These impediments typically include:

Different compensation levels contributing to jealousy and distrust

Concern about quality and dilution of the AMC brand

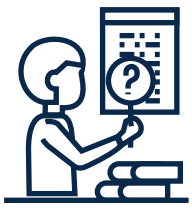
Unclear, fragmented management structures resulting in limited professional collaboration and confusion about chair and chief roles

Funds flow mechanisms that discourage key leaders from focusing on optimizing overall enterprise performance

Different Models Used Across the Country

With these challenges in mind, an academic health system client recently asked Chartis to help determine how they should organize their growing complement of employed, non-faculty clinicians. As part of this effort, Chartis investigated how 14 peer academic health systems addressed this issue. The peer group was comprised of research-intensive organizations with a variety of ownership and governance structures. The resulting case studies revealed that the organizations were in various stages of building their network of full-time clinicians and believed their own approaches would continue to evolve as the scale of their physician networks expanded and the physicians gained experience working together. We observed three organizational approaches in the case study AHSs, as described on the following page.

CASE STUDIES



Six of the academic health systems employ full-time clinicians through a community group practice that is a subsidiary of the health system.
In these AHSs, the community group practice is separate from the faculty practice group which is part of the medical school. Figure 1 provides a picture of this model. Some health systems believe they can be successful building the full-time clinician group, separate from the faculty group, because they can make decisions more quickly, provide more attractive physician compensation and have better access to the financial resources needed to rapidly grow the physician enterprise. However, this approach perpetuates the separation between the academic practice and the practices of the full-time clinicians, making it difficult or impossible to create a single strategy and deliver uniform patient outcomes and experience. A few academic health systems are bringing these physician groups together by creating a third practice entity to serve as the integration vehicle for the physicians employed by the health system and the faculty physicians employed by the medical school.

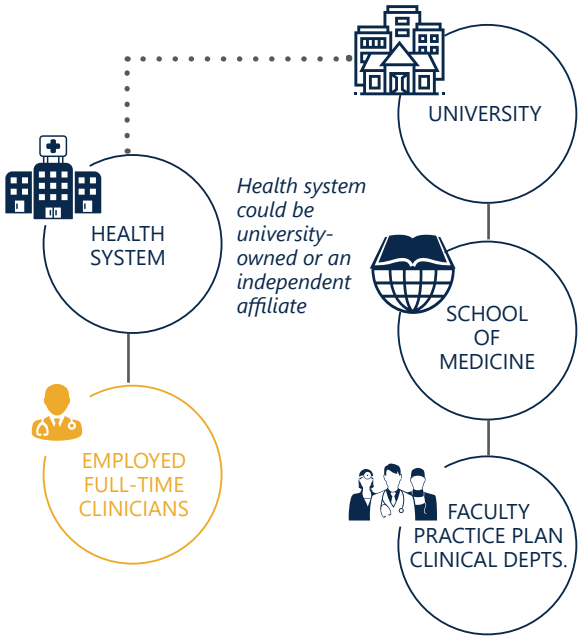


FIGURE 1. ORGANIZED THROUGH THE HOSPITAL/HEALTH SYSTEM *(ILLUSTRATIVE EXAMPLE)*

Another six of the AHSs Chartis studied started with separate structures but have since integrated the faculty and community practices under a unified physician enterprise structure. While the physicians within the academic and community groups may continue to function separately from each other, there is a single physician enterprise leader in these organizations who can work to bring the different groups of physicians together over time and mediate disputes as needed. Figure 2 provides a picture of this model. Creation of a physician enterprise structure that includes separate practices for the academic physicians and the full-time clinicians should be viewed as a stepping stone toward a single physician enterprise in which the physicians in each specialty or programmatic area function as a single group. This model may only be feasible in academic health systems which are fully integrated or have a clinical enterprise structure with the physicians and hospitals in a single organization separate from the medical school.

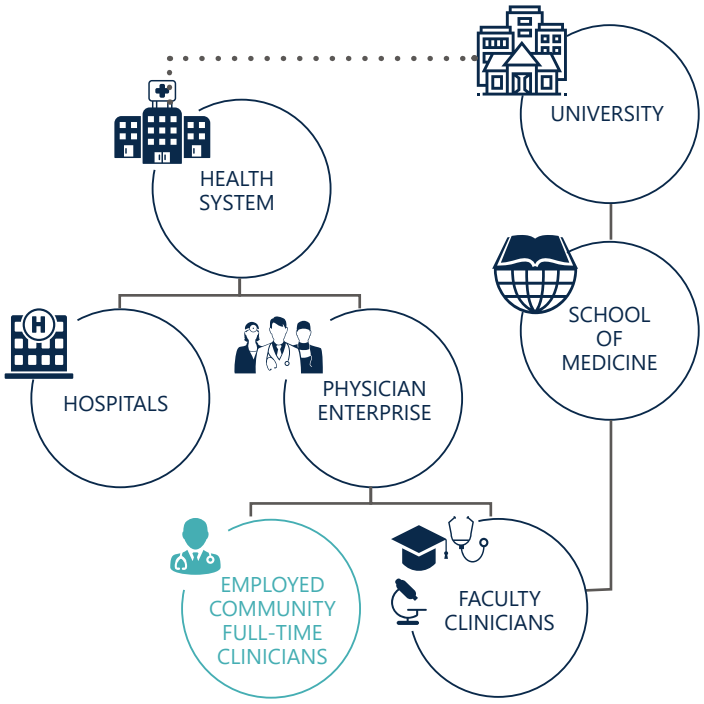


FIGURE 2. ORGANIZED AS A UNIT OF THE PHYSICIAN ENTERPRISE WITHIN THE HEALTH SYSTEM *(ILLUSTRATIVE EXAMPLE)*

Two of the case study AHSs organize the community physicians through the medical school and its faculty practice group.

One of the AHSs described the community physicians as the "19th department," separate and distinct from the 18 academic clinical departments. They also had some legacy non-faculty "staff physicians" practicing through and managed by the clinical departments, but no new non-faculty physicians were being hired into this model. The other medical school created two subsidiary corporations (one for primary care and one for specialists) to employ the non-faculty physicians; the separate corporations provide greater employment flexibility and lower benefit costs for the staff in these practices. Figure 3 provides a picture of these models. The benefit of these approaches is the ability to align the academic physicians with the full-time clinicians from the outset, enabling a single strategy and uniform approaches to care and service. The downside is that implementing this strategy is likely to require investment and ongoing financial support which typically comes from the health system. Health system leadership may resist this approach if they are asked to provide financial support to implement a strategy for which they have little control and may lack transparency into the actual economics.

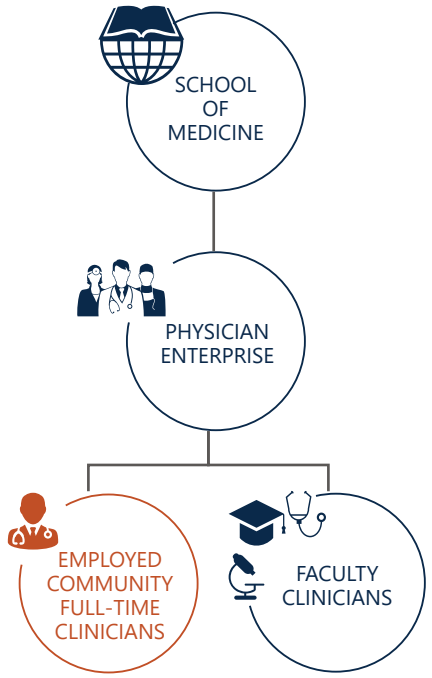


FIGURE 3. ORGANIZED AS A SEPARATE UNIT/DEPARTMENT IN THE FACULTY PRACTICE *(ILLUSTRATIVE EXAMPLE)*

Key Lessons Learned

Define the Desired Objectives Before Selecting a Model

Leadership needs to determine what it is trying to achieve by hiring non-academic, full-time clinicians into the AHS, including the expected scale of its future clinical enterprise and the numbers and types of physicians required for future success, before determining what model to utilize. For example, hiring full-time clinicians into traditional departments and faculty tracks might work if small numbers of physicians are anticipated. However, this approach may impede the organization's ability to reach the desired scale if a large number of full-time clinicians are needed.

Plan for the Model to Evolve and Change Over Time

While AHSs generally evolve slowly, there has been significant fluidity in the models described above as market and organizational dynamics evolve. For instance, one AHS began with a separate community physician practice organization for newly hired physicians primarily working at its owned community hospitals. However, after a few years, the specialists in this model migrated into the departments as relationships between the physicians were strengthened and the need for a unified approach to patient care and to the market in each specialty became apparent. Still, the community primary care practices in this health system remain separate from the faculty general medicine practices, due to significant differences in their roles and economics.

Minimize Barriers to Change while Managing the Pace of Change

Given that the physician enterprise organization in most academic health systems is evolving toward greater integration of the academic clinicians and the full-time clinicians in most specialties, the AHS should try to minimize barriers to future integration. At the same time, integrating these different groups of physicians shouldn't be attempted too quickly; at one AHS, premature integration efforts led to significant conflict, requiring management of the academic practices and the full-time clinicians to be separated, creating a setback from moving too quickly which is likely to take many years to repair.

Plan for Multiple Models for the Foreseeable Future

Alignment of faculty and full-time clinicians in the same specialty is critical to creating a single approach to care and to the market, but it must be done carefully. Therefore, some organizations might want to retain multiple models which can be deployed for different specialties, such as different approaches for primary care and specialty care physicians, or for different geographies, such as different approaches for nearby affiliates or sites of care vs. those further away where alignment across geographies is not as crucial. In primary care, where the role of academic general medicine faculty is very different than that of full-time clinicians, integration is often not as critical as it is within other specialties where there is more significant overlap in role. One AHS lost well over $150,000 per faculty general internist, while the community primary care practices operated near break-even, due to the differences in their roles and operating model. That AHS now has regular meetings of the academic and community primary care physicians to discuss approaches to improve professional satisfaction and patient care while also retaining separate organizational structures for the two types of physicians. A few organizations have created "centers" for community health or for primary care to formalize the importance of aligning the different types of primary care practices without actually forcing them into a single organizational unit.

Align Economics with the Desired Model

In some cases, funds flow approaches need to be changed to enable movement toward a unified physician enterprise. For example, many academic health systems are moving away from significant reliance on dean's tax based on a percentage of the faculty's professional fee revenues; this approach is being replaced with models that provide the dean and departments funding based on overall clinical enterprise revenue, and a portion based on health system financial performance. This approach can increase support among the dean and chairs for building a significant group of full-time clinicians. However, changing one key funds flow element typically requires changes in the other department and medical school funds flow components; faculty compensation plans also may need to be modified to avoid significant economic disruption to individual parts of the organization. Nonetheless, focusing AHS leadership on optimizing overall academic health system revenue and profitability can help align incentives and contribute to improved performance across the organization.

Avoid Infrastructure Barriers to Future Integration

Having all physicians on the same infrastructure (EHR, revenue cycle, other business systems) is ideal as it can reduce the barriers to integration in the future and make it easier to understand the performance of each practice model. In addition, if the practices are under one leader, it is also easier to build bridges between the physician groups and facilitate future integration.

Be Cognizant of the Evolving Role of Chairs and Departmental Organization

Ideally, all physicians in the same specialty or interdisciplinary program will be under the same organizational structure over time. In many organizations this is likely to be the clinical departments. Achieving this integration will require chairs and division chiefs capable of leading the various clinical practices or the appointment of someone else in the department empowered and with the skills to provide this leadership. AHSs need to help chairs and division chiefs develop the skills and experience needed to lead this type of organization and to be clearer about this role in the selection and hiring process. Some organizations have created clinical service lines (analogous to departments) to manage the clinical practices across the faculty and full-time clinicians, however, this approach can lead to Chair dissatisfaction if they believe their role is being limited to leadership for education and research.

Compensation Should Reflect Each Person's Expected Role

Significant differences in compensation between faculty clinicians and full-time clinicians often create barriers to aligning these physicians as referenced above. Ideally, each physician should earn competitive remuneration for their clinical effort while recognizing that research and education effort will require lower compensation. Total compensation for academic faculty who are part-time clinicians will naturally need to be a blended average of the two different compensation rates based on each individual's role, effort allocation and expected output for that effort. Each faculty member and their department leadership can determine the appropriate allocation of their time and effort.

THE RIGHT STRUCTURE ULTIMATELY DEPENDS ON FACTORS UNIQUE TO EACH ORGANIZATION. **IN ADDITION, WHERE AN AHS STARTS IS UNLIKELY TO BE WHERE IT ULTIMATELY LANDS.**

Where possible, the AHS should move toward organizing its different physician groups under one cohesive physician enterprise to make it easier to provide patients with consistent, high-quality experiences and outcomes and to design and pursue a single market strategy focused on the overall growth needed for continued success.

AUTHORS' NOTE

In writing this paper we struggled with the right labels to describe the faculty who are generally part-time clinicians and the employed full-time clinicians since some organizations object to calling them faculty and community physicians. The terms "academic clinicians" and "full-time clinicians" have been used in this paper though there are probably terms which are better descriptors and don't trigger value judgments about each person's role and contribution.

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Steve Levin is a Director with The Chartis Group. He has over 35 years of experience as a management consultant to the healthcare industry. He is a nationally recognized expert in a number of areas pertaining to academic medicine organization, governance, funds flow and strategy. He also has significant expertise with clinical program development, merger and affiliation evaluation and implementation, and academic strategy. He has worked closely with the leadership of numerous academic medical centers to help define their strategic direction and to help the leadership team to implement that strategic direction over several years.

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