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Academic Health Focus

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 impediments often hinders integration of the AHS's clinical workforce into a unified practice. This article explores the approaches and lessons learned from assisting numerous organizations in building physician enterprises that support the journey from AMC to market-leading AHS.

Key Board Takeaways

- Make sure that your leadership team is considering alternative approaches (role, organization, compensation models) for hiring physicians whose primary role is to serve patients; resistance to change and organizational inertia can often limit leadership's ability to consider different approaches.
- Understand the expected long-term scale, scope, and timing for development of the physician enterprise as this can help determine the optimal model and approach.
- Learn from other academic health systems that have experience with different approaches.
- Plan for the approaches to evolve and try to avoid creating barriers to that evolution; approaches that might be unacceptable today could become the preferred approach in a few years when situations and people in key leadership roles change. Therefore, try to think about the long-term model and avoid creating impediments to evolving toward that model.
- At the same time, recognize that the long-term model might not be achievable today due to market and people constraints; be willing to accept other approaches as long as the model can evolve.

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 AHSs addressed this issue. The peer group was comprised of research-intensive organizations with a variety of ownership and governance structures. The resulting learning 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.

Key Takeaways for Board Members

The key takeaways below are based on our experience assisting numerous AHSs to design their approach to a physician enterprise organization, which were

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supplemented by the 14 case studies referenced above:

- **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 physician practice models 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 clinical departments as relationships between the academic clinicians and the full-time clinicians 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 AHSs 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. One AHS made this mistake and premature integration efforts led to significant conflict, requiring management of the academic practices and the full-time clinicians to be separated, creating a setback that will 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 that can be deployed for different specialties, such as varying approaches for primary care and specialty care physicians or for different geographies (e.g., 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, office-based primary care clinicians, integration is often not as critical as it is within other specialties where there is more significant overlap in roles.
- **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 AHSs 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.
- **Avoid infrastructure barriers to future integration:** Having all physicians on the same infrastructure (EHR, revenue cycle, and 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 they need to be clearer about this role in the selection and hiring process.

- **Compensation should reflect each person's expected role:** Significant differences in compensation between faculty clinicians and full-time clinicians often creates 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 they ultimately land. 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.

The Governance Institute thanks Steve Levin, Director with The Chartis Group and leader of the firm's Academic Medical Center Practice, and Michael Tsia and Michael Shenk, both Principals with The Chartis Group, for contributing this article. They can be reached at slevin@chartis.com, mtsia@chartis.com, and mshenk@chartis.com.