THE GOVERNANCE INSTITUTE
A SERVICE OF nrc HEALTH
FEBRUARY 2023
Academic Health Focus

Governance Considerations for Bringing Faculty and Community Physicians Together in Academic Health Systems

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Academic medicine has undergone significant change in recent years:

- Faculty practice plans, which were once primarily independent entities, are now largely affiliates of a medical school, academic medical center (AMC), or both, and operate under an employed or retained model.
- AMCs have transformed into academic health systems (AHSs). In some cases, this growth has been the product of community hospital acquisitions made by an AMC. In other cases, a community health system has acquired an AMC as an asset.
- As a result, many AHSs now employ a mix of physicians, some strongly aligned with the AHS's teaching and research missions and others strongly aligned with delivering care in the community.

Faculty practice plans are complex entities; the addition of a community physician group adds to that complexity. The question for the AHS board and executive leadership is whether and when to combine the faculty and community physicians into a single entity.

For a small AHS—an AMC that has added one or two community hospitals—the academic focus of the enterprise likely remains dominant, and physicians at the community hospitals might be integrated into the faculty practice plan. For a larger AHS—an AMC within a network of six to 12 community hospitals—managing the clinical enterprise would consume the academic leadership's time, to the detriment of teaching and research interests. At this point, it often makes sense that the physician enterprise reports up through the system's Chief Medical Officer or Chief Physician Executive, with the faculty practice plan operating as a subset of that physician enterprise or aligned with an academic sub-entity under the system.

It is in the middle of the AHS continuum—an AHS with more than two or three hospitals, but fewer than 10 or 12—where the question is most acute. The primary orientation of the AHS—toward its academic mission or community health mission—may be unresolved. If a growing number of community physicians are added to a faculty practice plan, cultural differences between physician groups are likely to intensify. If the groups are kept separate, opportunities for collaboration—for example, expansion of residency programs into community hospitals or participation in value-based care models—may be jeopardized.

Governance Considerations

When discussing governance of faculty and community practice plans, it can be helpful to distinguish between "Big G" and "small g" governance. Big G governance relates to the governing body that has an official fiduciary duty, for example, the board of an AHS that employs both faculty and community physicians or the board of a university that oversees a school of medicine with an affiliated faculty practice plan. Big G governance is a fiduciary board with oversight of the mission, strategic direction, and overall performance of the organization and its owned or affiliated entities.

Small g governance is equally important and often involves an advisory body, as it sets the guidelines that allow leadership of, in this case, owned or affiliated practice plans to address and resolve issues that arise on a daily basis. Big G governance will want to know that small g governance issues have been thought through and that processes have been put in place to manage issues when—or ideally, before—they arise.

As faculty and community physicians are brought together within a growing AHS, key governance considerations include the following:

- **How did the system develop, and what will be its primary cultural orientation?** If growth of the AHS was led by an AMC, it is more likely that the academic focus of the AHS will be stronger and that faculty will exert a stronger voice in governance decisions. If an AMC was acquired as an asset by a larger community-based system, that system orientation is more likely to prevail, with the academic component viewed as a complement or enhancement to the system's capabilities (for example, providing improved access to tertiary and quaternary services or improving the talent pipeline for new physicians and other health professionals). Having clarity on this point will help all physicians

understand the balance between academic and community health missions within the AHS and their individual role within the organization.

- **What will be the impact on funds flow?** Is the AHS looking for increased clinical revenues from the community-based hospitals to support the academic enterprise? How will that impact funds flow between the practice plan, the AHS, and the medical school? How much input and visibility will faculty practice plan physicians have into how much different departments are contributing to those funds and how those funds are being deployed?
- **To what extent will community physicians be participating in academic functions?** If, for example, the AHS is hoping to expand teaching or residency programs into its community hospitals, community physicians will likely be asked to take on teaching roles. Will their time spent teaching be compensated, and how will that compensation compare to their clinical activities? Will the practice plan develop recognition and payment mechanisms for community physicians who participate in academic activities?
- **How will differences in compensation be addressed?** Community physicians often have higher salaries than their academic counterparts but fewer benefits.

➜ Key Questions for Board Members

When deliberating whether and when to combine a faculty practice plan and community physician group, board members should consider:

- Is our strategic vision to create an academic institution with a community-based health component or a community-based health system with an academic component?
- To what extent does achievement of our strategic goals depend upon effective collaboration between our faculty and community physicians?
- What does physician management see as the primary challenges in combining our faculty and community practice plans?
- What would be the impact of keeping faculty and community practice plans separate?
- How will various physician perspectives be represented in governance (i.e., decision-making) that affects physician practice plans?
- Are our physician leaders, faculty, and community at the table and engaged to help answer these questions and design solutions?

Does the practice plan intend to equalize compensation between community physicians and faculty, and what will be its pathway for doing so? How will teaching and research commitments be weighted vis-à-vis clinical care?To what extent will faculty and community physicians be involved in making these decisions?

These issues will play out on both the Big G and small g governance levels. Big G governance—the board of the AHS—will want to know that these issues have been addressed and that processes are in place to manage them. Small g governance—the leaders of the practice plan—will need to ensure that processes are being administered equitably across the practice plan and are producing the desired outcomes (including both academic and clinical outcomes and physician satisfaction).

It will take time for these issues to be resolved and an AHS may prefer to keep the faculty practice plan and community physician group separate for some time (which raises its own issues, including the question of whether two management structures will be required). But as the AHS grows or matures, the need to address and reconcile differences between the faculty and community physicians will likely intensify if the AHS wishes to take full advantage of the opportunities for collaboration between these groups. Governance—both Big G and small g—will play a significant role in ensuring that the combination of physicians is a success.

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