Physician Executive Council

How AMCs are achieving scale and systemness

Seven insights from the 2020 AMC Physician Executive Retreat

To address the unique challenges academic medical centers face, we gathered 15 academic physician group leaders together for a day of candid discussion. This brief captures insights from the day.

1 A common problem

All three pillars of an AMC's tripartite mission—research, education, and clinical care—are under financial threat.

Research: The margins on research are declining. While grant funding from the National Institutes of Health decreases, it increasingly costs more money to maintain a grant than the grant itself. At the same time, technology giants with vastly more capital—like Amazon and Google—increasingly compete with AMCs on medical innovations and research.

> "Research is often no longer spending money to make money, it's **spending money to lose money**."
>
> Physician leader
> AMC in the Midwest

Education: Reimbursement for training the next generation of physicians, educators, and scientists has not kept up with the costs to do so.

Clinical: While the margins on clinical care are comparatively higher than both research and education, payer reimbursement and patient preferences increasingly reward the low-cost, convenient provider organization. AMCs want to produce enough clinical revenue to support their other missions, but often find themselves constrained by their legacy high-cost, subspecialized business model.

2 Academic physician group leaders agree—systemness is the next step

Most AMCs realize that to succeed in this new economy, they must evolve from an academic medical center into an academic health system. Instead of the legacy AMC strategy centered on being the hub for subspecialty referrals, academic health systems require greater scale, a diversified footprint, and systemness—getting both academic and community physicians to coordinate efforts across quality, cost, and the patient experience. They balance the needs of the entire organization without losing the advantages brought by the academic missions. AMCs have two main options for increasing their scale:

"Do it yourself"

Acquire or merge with non-academic hospitals or physician groups

"Find a partner"

Affiliate with non-academic institutions in the community

Source: Advisory Board interviews and analysis.

3 Proceed with caution when it comes to affiliations

Several academic physician executives voiced concerns over the value proposition of increased community affiliations. Academic leaders worry the "affiliatee" gets more than the academic does as the "affiliator". They noted that it's very possible the non-academic affiliate develops into a potential competitor over the length of the affiliation. AMCs pursuing growth through affiliation should look to include guardrails in their affiliation agreements:

Standard quality expectations so patient receive the same level of care at all sites

Longer non-compete timelines so affiliates can't poach talent

4 Overinvest in proactively addressing cultural differences during acquisitions

Clinical enterprise leaders in AMCs feel they see greater success when they expand their footprint through acquisition of community medical groups or facilities instead of affiliation. But, acquisitions and mergers come with significant cultural challenges. Non-academic institutions have significantly different cultures than most AMCs because they typically only focus on clinical care. Leaders also must address physician infighting when there are two physician phenotypes within the same organization. Even in the same organization, faculty and community physicians often see one another as competitors. Academic physician group leaders should proactively and regularly address this cultural divide. Two areas to prioritize:

Quality

Many academic physician group leaders say they are building in-house quality dashboards to gain visibility into and be better able to manage tensions between physicians about their quality of care.

Physician Recruitment

Leaders must regularly evaluate physician workforce needs across both faculty and non-faculty, especially before and after acquisitions. Groups should consider having physician recruitment living outside the direct control of both the faculty practice plan and the community physician group so neither dominates the recruitment process.

Advisory Board Research Report

The Unified Academic Medical Group

Three steps AMCs can take to bridge the divide between their employed academic and non-academic physicians and unite them in pursuing common clinical and business goals.

Source: Advisory Board interviews and analysis.

5 Need for more investment in Chair leadership development

As AMCs become larger, the role of the department Chair also expands. The legacy Chair role entails significant departmental control and autonomy, accountable only to the Dean of the school of medicine. The "new" Chair role in an academic health system is more holistic and less academic in nature—putting a premium on business acumen and leadership skills. Leaders at the Executive Retreat reported a need to invest in leadership development for all Chairs and even to recruit new talent where appropriate.

FOR RESOURCES ON physician leadership development, visit **advisory.com**

Strengthening Your Physician Leadership Development Program

Five must-answer questions for chief medical officers

Leadership Potential Diagnostic from *The Physician Executive's Guide to Succession Management*

6 Align physician compensation to organizational goals and contribution

The evergreen challenge of aligned physician compensation is even harder in an academic health system. Faculty physician compensation can vary by numerous factors, such as department, career track, and mission. When an AMC employs both faculty and non-faculty, another tension emerges because faculty often want to be compensated equally to non-faculty physicians for their clinical effort. Clinical enterprise leaders can foster alignment between an individual physician's compensation and the academic health system by:

- **Establish expectations** that faculty pay and benefits aligns to the faculty's work and contribution to the organization just as non-faculty pay and benefits align to community physicians' work and contribution to the organization.
- **Communicate clearly and in advance** about any changes to physician compensation. Leaders should embody the evergreen physician change management principle of "we may have ugly truth but we don't have dirty little secrets."
- Give physicians **significant input** into compensation redesign within reasonable bounds.
- **Convene all stakeholder groups**—especially physician leadership, finance, and legal—for conversations about physician compensation both in developing and enforcing a model.
- Create and apply a **single physician compensation philosophy** across departments, missions, and physician phenotypes.

Advisory Board Research Report

Engaging Physicians in Compensation Redesign

Nine ways to build physician support for compensation redesign.

Source: Advisory Board interviews and analysis.

7 Leading from the hot seat

The pressure is on physician group leaders to keep a strong margin and lead a diverse physician workforce on this uncertain journey to become academic health systems. Clinical enterprise leaders report relying on three main change management strategies:

Overcommunicate changes

Especially the potentially contentious ones, like compensation and organizational structure redesign, and do so as early as possible before decisions so you can solicit actionable input.

Focus on "the why"

If chairs and physicians understand "the why" behind the organization's actions, leaders have a strong foundation no matter the misstep. Leaders should articulate the reasoning well in advance and consistently throughout new initiatives.

Don't be afraid to change models

The evolution from AMC to academic health system will come with missteps. Leaders on this journey report that plans may shift unexpectedly, but to understand that iteration is critical to getting this new model right.

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15-Minute Physician Leadership Essentials

Your Data-Driven Road Map for Physician Engagement

The Physician Communication Toolkit

Source: Advisory Board interviews and analysis.

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