Integrating a Community Practice into

The Academic Medical Center: Practical Considerations

As new affiliations strengthen existing healthcare systems and create new ones, there is an increasing need for academic medical centers (AMCs) to be competitive healthcare systems that minimize unnecessary costs and provide the full range of clinical care to patients. While many AMCs offer tertiary and quaternary care, AMCs may not be prepared to provide sufficient primary and secondary care without affiliating with and/or integrating established community practices. Faculty practice plans may find these sufficient reasons to consider integrating individual community practitioners or physician groups. This paper discusses some of the practical considerations related to integration and identifies issues that likely will need to be addressed both during the integration and following the integration.

1. Why is the Community Physician Interested?

Understanding the motivation of the community practitioner to join the faculty practice plan may help integrate the community physicians and help to structure the arrangement in a way that is more likely to be successful. Following are some potential reasons that community physicians may be interested in joining the AMC:

- If the physician’s community hospital joins the AMC, this change may threaten or shift referrals from the community physician. Even when the physician is employed by the affiliated community hospital, to the extent
that the affiliation between that community hospital and the AMC disturbs referrals patterns with other community practitioners, the community physician’s practice may suffer. Joining the faculty practice plan or another AMC entity assures the community physician a place in the AMC health system.

- Employment in a multispecialty faculty practice plan offers the physician the security of an established practice and, as payers seek to bundle payments and pay for quality, the opportunity to contract as part of a system.

- For individual practitioners, independent practice offers a high degree of flexibility and autonomy, as well as the potential financial rewards. At the same time, the practitioner is responsible for all financial risks. When the risk to autonomy/financial benefits shifts, the stability of a faculty practice plan or other AMC component may be an attractive alternative.

2. **Why is the AMC Interested?**

- Independent community physicians have a business focus that may not be present in the AMC setting with its competing research and teaching activities. Community physicians who have operated successful practices
have developed efficient business models and clinical workflows that
maximize revenues and reduce or eliminate waste.

- AMCs need to assure that they are able to offer patients primary and
  secondary care, as well as ready access to tertiary and quaternary services.
  Establishing strong ties to primary and secondary care providers in the
  community helps to assure a steady flow of patients for the tertiary and
  quaternary services, as well as sufficient populations for teaching and
  research.

3. **What Does Integration Look Like?**

Integration of a community practice may be as simple as employment by the affiliated
community hospital or as complicated as transitioning the physician to a faculty
appointment and employment and membership in the faculty practice plan. Below are
some potential models for integrating community physicians into the AMC:

- **Model One**: Integrate community physicians into the faculty practice plan
  within the school of medicine departments by individual negotiation
  between the chair and physician or physician group. This model offers an
  opportunity for negotiated variation to meet particular demands and
  preserves the sole authority of the chair over the department. However,
  negotiations may be resource intensive to the department and other AMC
  component entities. To the extent that arrangements for particular
  physicians or groups vary or are not transparent, the arrangements may be
  perceived as showing favor to the community physicians or otherwise
unfair. Also, this model may align the physicians with the department at the expense of existing and valuable relationships among community physicians recruited into different departments.

- **Model Two:** Create a new division or department within the faculty practice plan, comprised solely of community physicians of differing specialties. As a practical matter, this model offers standardized processes that may bring economies of scale to the negotiations and enhanced transparency and perceptions of fairness among the community physicians. This model also preserves existing relationships among the community practitioners. However, this model may encourage a culture of “us vs. them” between the community physicians and the regular faculty. To the extent that the community physician department has a funds flow that differs from that of the regular faculty departments (i.e., reduced “dean’s tax” or “department taxes”), this model may invite regular faculty or departments to seek reduced contributions. Also, the role of the chair may need to be defined. Certainly, the chair would remain responsible for appointment and faculty matters, but issues of compensation, day-to-day supervision, and deployment likely would need to be shared or otherwise clarified between the chair and any department leader for the community physicians.
• **Model Three**: The affiliated community hospital employs the community physicians. While this model may advance the AMC toward the likelihood of ACO status, it does not fully integrate the physician practices and alone may not provide inherent economies of scale. However, if the community hospital purchases professional support services like coding, billing and compliance services from the faculty practice plan, economies of scale and appropriate use of professional billing resources within the AMC can be achieved. This option may be a helpful stopgap for the AMC with community physicians who are not yet ready to be integrated fully. It provides a view to the benefits of the AMC professional billing infrastructure. However, without complete integration into the faculty practice plan, it may be difficult for both the community physicians and the faculty physicians to feel completely aligned. To the extent that there are overlapping specialties, competition may impair the ability to adopt integrated clinical pathways.

4. **Active Engagement in Management of the Physician Practice**

One of the outcomes of successful integration will be the ability to design and adopt system-wide clinical standards that increase quality for populations as well as individual patients, and reduce unnecessary cost. Another outcome will be the effective and efficient deployment of physicians, resources and programs to maximize convenience and service for the patient. A third outcome may be for the AMC to modify clinical workflows by taking advantage of the knowledge and experience of the community physicians. All of these outcomes will be enhanced by engaged participation of the
community physicians. This engaged participation likely must include a meaningful voice in the process. In most cases, this will be a role on the appropriate governing board or decision-making committee. If community physicians are integrated into the faculty practice plan on an individual basis within each department, the chair will need to be mindful of the need to include community physicians in key committees or other appropriate settings. If, however, the AMC creates a department for the community physicians with the faculty practice plan, there are a number of important considerations:

- If the faculty practice plan has a governing board, does the community department have membership on that board? Who is the representative for the community physicians and what authority does he/she have within the group of community physicians?
- Is the governing board/committee membership equal (i.e. voting membership) to that of a department chair? Consider whether the authority and responsibility over finances, compensation, day-to-day deployment and oversight of the community physicians’ clinical practice is equivalent to that of a chair’s to the clinical activities of regular faculty.
- The authority of the chair to appoint individuals to the faculty cannot be diluted, but the management of clinical activities by the community physicians may be the subject of negotiations. Successful integration will depend on how effectively all resources are coordinated to minimize unnecessary duplication and cost and to appropriately and strategically maximize existing resources and new investments.
If the community physicians are integrated by employment in an affiliated hospital, the entities will need to adjust existing processes to avoid focus on the local interests of each physician “group”. In other words, the parties should look for opportunities to have the two physician “groups” coordinate and adopt common standards aligned with the AMC mission.

5. **Integration of the Community Physicians into the School of Medicine Mission: Avoiding Culture Clash**

The business experience of the newly integrated community physician may be a valuable asset to the AMC, but for the physician who has been able to manage her own business and collection practices, invest resources, and hire, supervise and fire ancillary staff, the change to a more structured AMC environment may be challenging. The faculty practice plan may provide increased resources for standardized regulatory compliance, billing and collections practices as well as increased access to favorable contracting rates. The affiliated hospital also may have infrastructure to support physician practices. As a result, the community physician may have the opportunity to focus on her clinical practice and devote less attention to every detail of running a practice. However, the physician may be frustrated by the lack of control and unfamiliar with restrictions on her clinical practice and vendor relationships.

- AMCs engage in highly regulated activities and tend to be subject to public scrutiny. AMC policies and procedures related to conflicts of interest, sites of clinical practice, and outside activities may appear to be overly restrictive to the community physician.
• How and to what extent do the community physicians participate in research? Joining an AMC may provide the community physician with an opportunity to engage in research that might not otherwise have been available. If research is conducted in a community hospital setting, does the community physician or the hospital have the appropriate infrastructure to maintain regulatory compliance and avoid inadvertently misbilling or subsidizing funded research? How do regular faculty perceive this research activity?

6. Compensation Challenges

• Depending on specialty, community physicians may be compensated at a higher rate than regular faculty, with no caps or balancing among peers.

• Community physicians who have run their own practice are accustomed to “eating what they kill” and determining how to allocate receipts for their practice.

• Community physicians are not accustomed to “Dean’s Tax” and Departmental overhead. Or is it just that these overhead costs are out of their control, because every business has overhead expenses?

• When the community physicians are offered the security of a base salary, how are productivity and quality measures structured to maintain
appropriate incentives? If the base is too high, productivity may decrease. If the base is not high enough, are you providing enough security for the community physician to want to join the AMC?

- If there are disparities between community physician compensation and regular faculty compensation, the disparities will invite requests for increased compensation among regular faculty. Also, how will the compensation disparities play out for clinical faculty who are already in the system?

7. Post-Integration Issues

- One potential outcome of integrating the community practice into the faculty practice is creation of the “us vs. them” culture creating competition among physicians. This potential is increased if the funds flow between the entities is not transparent or if the funds flow differs in some way that is perceived as unfair. When incentives are based on clinical productivity, longstanding referral patterns may not adjust to incorporate physicians outside of the historical relationships among either the faculty practice or the community physicians. Anticipate how the new relationship will play out over time and take steps to develop trust.

- If the system has a patient-centered philosophy or mission, focus on that mission for alignment of incentives.
Beware of language differences: For example, although Medicare defines “provider” to be a hospital, not everyone uses this terminology consistently. “Provider-Based” may mean hospital-based clinic or it may mean physician-driven freestanding clinic, depending on the speaker and audience. Until you know, be sure that common terms really are understood by everyone.

Lack of familiarity breeds misunderstanding. It will be important to spend the time to walk through arrangements even when both parties believe they understand the details. Invest in orientation and developing strong relationships to avoid potential misunderstandings and surprises.

Listen carefully and don’t make any assumptions.

Conclusion
Successful integration of community physicians into an AMC is possible, and can enhance the ability of the AMC to remain a thriving participant in the healthcare industry. To be successful, the parties must be willing to devote time and energy to designing an integration that facilitates success for each party and values their respective strengths. They must also commit their time and energy to implementing cohesive strategic programs that allocate resources fairly among the different practices. While healthy competition among peers is a good thing,
competition between the community physicians and regular faculty physicians can impede or disrupt clinical programs. Whichever model is selected, the participants should take care to be inclusive and avoid establishing or perpetuating unnecessary and disruptive competing practices.