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Building a Community Physician Network for Your AMC: 5 Things to Consider

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Academic medical centers' survival increasingly depends on strong relations with community physicians. More AMCs are developing their own community physician enterprises with the goal of supporting the tripartite mission of academic medicine. Even as AMC-led health systems consider new relationships with large independent physician practices and emerging practice aggregators, they must have a sound model for their employed community physicians.

But for AMC leaders, establishing an effective community physician enterprise necessitates new cultural sensitivities, clinical approaches, and reporting expectations between faculty and community physicians. Further, AMC leaders must establish expectations around quality, develop payer priorities that make sense for the institution, and create the culture and infrastructure needed to support long-term success.

The potential for rewards in building an AMC community physician enterprise is substantial, but it requires careful planning and skill to execute. Here are five questions AMC leaders should consider as they embark on this journey.

No. 1: What are the AMC's physician needs over the next three to five years?

Leaders must consider not just which physicians and groups might be available in a region, but also a concrete view as to how many physicians are needed to connect the AMC's specialists with patients. From there, leaders need to evaluate: "Who are these physicians? How willing would they be to partner with the AMC—and what would a functional partnership look like?" They must also take a hard look at who their competitors are, from community hospitals and regional health systems to physician aggregator entities (e.g., Optum) and size up their ability to compete for talent. This is not easy work, as AMC leaders may not be used to thinking about interdependencies in this way.

No. 2: What are the governance and organizational structures an AMC can implement to effectively meet its strategic goals?

AMCs must have a clear structure for organizing and managing community network physicians with reporting relationships that ensure all physicians have the direction, support, and even respect needed to succeed. Otherwise, these physicians can become lost within a faculty culture and feel as if they are second-class citizens among the institution's medical staff. By the way, the need to consider the impact on culture extends beyond the physician members of the team.

Thus, assigning the right leadership can be tricky. While the natural inclination may be to have an academic chair oversee these new physicians, academic chairs may struggle to build relationships with community physicians simply because that isn't their expertise. Leaders who are sensitive to the unique needs of both community and academic medicine will be critical to the successes of these integration initiatives. At the same time, leaders must manage performance and quality that does not meet expectations.

Establishing clear clinical and administrative authorities is essential. So is developing the right supports for managing regional relationships with community enterprise physicians. In everything they do, it should be clear to all physicians that these practices are part of an inter-connected, patient-centered team.

No. 3: How will your organization create a feeling of "systemness"?

Academics need community physicians to be brand ambassadors for highly specialized services, and academics need to reinforce that community care is often better for the system as well as the patient. However, all clinicians in a health system need a consistent concept of quality as a common thread throughout the patient experience. The community physicians as well as AMC faculty must, in partnership, develop clinical approaches, communications, and patient support to convey a feeling of "systemness" for patients as well as practitioners.

No. 4: To what extent do existing funds flow methodologies need to evolve?

As academic health systems expand and evolve, the range of opportunities for faculty and community physicians also expands. (This is also the case for systems that do not have an AMC entity.) Community clinicians may be tapped to provide some limited teaching, or faculty may be asked to offer services in a community hospital setting. Or, core AMC functions (like IT) may be tapped to expand services outside of the traditional campus.

The mix of entities and scenarios for professional or administrative services can be, at a granular level, ongoing and raise complex questions of, "Who and how do we pay for that?" An effective funds-flow methodology provides a framework for establishing inter-departmental (or entity) fees as well as expectations for the process of doing so—importantly, without triggering a series of C-suite meetings. This facilitates payments for

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ongoing services as well as establishes a process for new initiatives among entities. This can greatly facilitate new program opportunities for AMC faculty and community practitioners alike by setting terms for sometimes sticky questions in advance (such as payments for windshield time, community physicians with teaching time, and sub-specialty faculty time at community facilities).

No. 5: What enterprise financial incentives, especially compensation, are needed to drive organizational growth?

Issues around compensation can be an impediment to any health system as it tries to integrate legacy practice groups, especially faculty and community practitioners. Traditional academic faculty and full-time clinicians have different expectations of compensation and benefits. Yet they are often asked to work together. It is important to establish consistent design across compensation components yet recognize that different jobs have different compensation opportunities. Establishing these distinctions helps to maintain expectations and reduce the impediments to growth and professional development.

By taking a comprehensive, proactive approach to community physician enterprise planning, AMCs can ensure they receive the intended value from their investment while setting both faculty and community physicians up for success.

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