MAYO CLINIC

Community and Academic Physicians Working Together in Integrated Health Care Systems

Chris D. Stamy, MHA, MPH; Christine C. Schwartz, MD; Lin Po Han, MD, MBA; and Debra A. Schwinn, MD

Abstract

Objective: To examine best practices and policies for effectively merging community and academic physicians in integrated health care systems.

Methods: Deans of US allopathic medical schools were systematically interviewed between February and June 2017 regarding growth in their faculty practice plan (FPP), including logistics and best practices for integration of community physicians.

Results: The survey was completed by 107 of 143 (74.8) of US medical school deans approached. Of these institutions, 73 met criteria for final analysis (research-based medical schools with FPPs of >300 physicians). Most academic medical center–based FPPs have increased in size over the last 5 years, with further growth anticipated via adding community physicians (85%). Because of disparate practice locations, integration of community and academic physicians has been slow. When fully integrated, community physicians predominantly have a clinical role with productivity incentives. Deans report that cultural issues must be addressed to avoid conflict. Consensus exists that transparent clinical work requirements for all FPP members, clearly defined productivity incentives, additional promotion tracks, and early involvement of department chairs and other leaders enhances trust and creates better synergy among all physician providers.

Conclusion: Findings from this study should help guide FPPs, academic medical center leaders, chief medical officers, and professional and trade organizations in working toward positive physician synergy in consolidated health care organizations. Work and cultural considerations must be addressed to honor distinct talents of each physician group, facilitating smooth transition from disparate groups to healthy synergy.

 ■ Mayo Clin Proc Inn Qual Out 2021;5(5):951-960

Integrated regional networks are being established to provide comprehensive health care for populations.[1] Concurrently, many community physicians are transitioning from solo, independent practice to group practice or various employment models (eg, hospital/health system employment).[2-5] Full-spectrum health care systems, spanning from primary to quaternary care, often include an academic medical center (AMC) and their faculty practice plan (FPP). This occurs through financial integration of an AMC hospital with a private health care organization, or more often results from AMCs expanding to include community physicians and regional health systems. Thus, community and academic physicians increasingly work together.

Community and academic physicians bring distinct expertise. Community physicians are generally characterized as hard working, business oriented, and providing patient-centered, efficient medical care within communities.[6] Academic physicians are characterized as hard-working teachers, creators of new clinical methodologies, research oriented, providing clinical safety net coverage for the poor and 24/7 emergency and intensive care for entire regions.[7,8] These characterizations have blurred recently, with community physicians becoming more involved in clinical teaching and academic

From the Departments of Anesthesia (D.A.S.), Pharmacology (D.A.S.), and Biochemistry (D.A.S.) Roy J. & Lucille A. Carver College of Medicine, University of Iowa, Iowa City, IA, USA; Roy J. & Lucille A. Carver College of Medicine, University of Iowa, Iowa City, IA, USA (C.D.S., C.C.S., L.P.H., D.A.S); and University of Iowa Healthcare, Iowa City, IA, USA (D.A.S.).

clinical practice groups becoming more business savvy and efficient.

What is the best way to integrate these culturally distinct groups of physicians to synergize their strengths? This question is being asked by health care leaders across the country. Because AMC-based regional health care systems have the highest density of academic and community physicians working together in the same organization, we interviewed US medical school deans to determine logistics and best practices for how AMC FPPs are integrating community physicians. Our purpose is to provide an overview of current practice as well as elucidate best practices for integration from practical, cultural, and systems perspectives.

METHODS

In February 2017, deans from all US-based allopathic medical schools accredited by the Liaison Committee of Medical Education were invited to participate. Between March and July 2017, structured phone interviews were conducted one-on-one with each dean (or in seven cases, a dean-designated delegate) by the senior author (DAS). Deans who had not responded were contacted a second time. Interviews were halted at the end of July, and unresponsive schools were excluded from analysis.

We initially asked, "Do you have an FPP as part of your Medical School?" Faculty practice plans provide services such as billing, collections, scheduling, compliance, legal, revenue distribution, and financial services to physician faculty for clinical components of their work.[9] For AMCs without a FPP, we concluded the interview. For deans who affirmed, further information was obtained about hospital ownership, hiring practices, FPP size, compensation, benefits, funds flow, responsibilities, faculty titles and promotion criteria, results of integration, and any concerns. Community-based medical schools (identified by deans and confirmed via Association of American Medical Colleges [AAMC] Organizational Characteristics Database[10]) were excluded as these schools generally use community hospitals and regional private physicians to achieve their educational mission, thus making potential integration of community and more research-oriented academic physicians infrequent. Academic medical center FPPs with less than 300 members were also excluded from analysis as these practice plans tend not to have integrated significant numbers of community physicians to assess interactions. Faculty practice plan size was elucidated from each dean and confirmed using the 2017 AAMC US Faculty Report.[11]

Faculty promotion tracks were identified during the interview and verified on respective AMC websites. Because individual promotion track names vary considerably across institutions, promotion tracks were grouped into five general pathways based on dean and website descriptions. Cultural issues resulting from integration were ascertained through specific, open-ended questions asked of each dean (Supplemental Appendix 1, available online at http://www.mcpiqojournal.org).

RESULTS

Institutions Surveyed

A total of 143 US Medical Schools were invited to participate. Deans from 107 responded for an overall survey response rate of 74.8%. Figure 1 shows a flow diagram of AMC enrollment in the study. Thirty-four schools were excluded from analysis either because they were community-based (n=24), have no FPP (eg, all faculty are hospital employees or private practice community members; n=3) or FPPs were less than 300 faculty (n=7). This resulted in 73 AMCs available for final analysis (see Supplemental Appendix 2 for AMCs included in final analysis, available online at http://www.mcpiqojournal.org).

Organization Characteristics

Health Systems. To compare across AMCs, we first examined general characteristics of the health systems in which each AMC FPP is embedded. Regarding hospital ownership, 19 (26.0%) of the 73 AMCs stated they owned all hospital(s) in their health system, 24 (32.9%) own some health system hospitals, and 30 (41.0%) do not own any hospitals. In terms of clinical growth, most (n=52, 71.2%) AMCs have already grown their regional networks by adding community physicians and the vast majority of AMCs see this trend continuing.

Membership in Faculty Practice Plans. Another defining characteristic of these health systems is whether community physicians

Mayo Clin Proc Inn Qual Out ■ XXX 2021;5(5):951-960 ■ https://doi.org/10.1016/j.mayocpiqo.2021.06.008
www.mcpiqojournal.org

formally join the FPP or are organized in groups distinct from academic faculty. Fifty-six of 73 (76.7%) AMCs stated that they are currently adding community physicians to their FPP, particularly those who work at the main, or closely affiliated, academic hospital/clinic sites. In some cases, these represent a minority of overall community physicians joining the AMC network. The number joining FPPs is projected to increase going forward for 62 organizations (84.9%), whereas 5 (6.8%) who have already added community physicians did not anticipate further growth. In a few health networks, community physicians have their own, distinct community practice plan run by the AMC. There was no correlation between whether an AMC owns their hospital and whether community physicians joined the FPP.

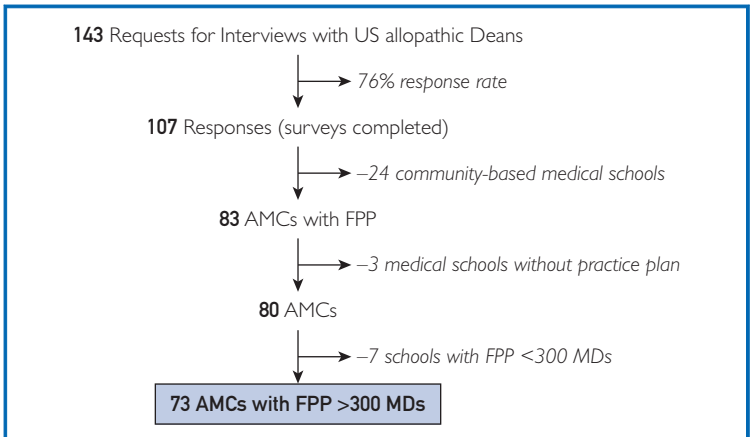

FIGURE 1. Flow diagram of enrollment of academic medical centers (AMCs) in the study. FPP, faculty practice plan.

Practical Features of Incorporating Community Physicians Into AMC Networks

Once an AMC decides to grow physician provider capacity by adding community physicians, whether or not they are ultimately included in the FPP, key questions arise as to how to practically manage this integration. Deans stated that optimal integration is transparent and as equitable as possible to empower both groups, with the long-term goal of synergy. Many deans noted that young physicians appear more open to integration than some of their older community/academic colleagues, so cultural integration will likely take time. Several major practical considerations arise including effort allocation (clinical practice expectations), education expectations (training medical students, residents and/or other clinical providers), academic status (promotion track), remuneration, and contracting. Each is described in more detail below.

Clinical Practice Characteristics. It is no surprise that community physicians generally remain predominantly clinical once they align with an AMC health care system. Indeed, 46 of 73 (63.0%) of AMCs provide community physicians with no nonclinical time. Several deans indicated that such individuals are able to participate in research activities if they choose (although this was reported as a rare occurrence). In many cases, particularly for community physicians practicing far from the main AMC campus, these clinicians may continue to earn their own salary and work essentially as private practitioners. Deans stated that such individuals may benefit from decreased cost of malpractice insurance available through the larger organization and perhaps a new electronic medical record provided by the AMC to connect their practice while still employing their own staff and (in some cases) continuing to rent/own clinic space. A subset of these AMC-affiliated community physicians opt to use the AMC FPP for purposes of billing clinical activities, whereas others continue to provide this service themselves. More geographically distant network-affiliated physicians tend not to be primary faculty and have affiliate titles (see academic section below) to recognize their joining the AMC health care system, tend to earn somewhat higher salaries than their academic physician partners, and provide their own benefits.

When formally joining the faculty, community and academic physicians in the same promotion track generally have identical work and nonclinical time expectations as well as discipline-calibrated salaries and benefits, although several deans indicated that it may take 2 to 3 years for private practice salaries to ultimately equilibrate with academic salaries. Salary equilibration already existed in 24 of 73 (32.9%) of AMCs at the time of

TABLE 1. Promotion Tracks Available to Faculty at AMCs in Survey[a]

General promotion category	Tenure	Clinician scientist	Clinician educator	Research	Clinician
n (%) [b]	71 (97.3) T	33 (45.2) T/NT	66 (90.4) T/NT	62 (84.9) NT	64 (87.7) NT
Specific track names at various AMCs	Tenure	Academic Academic clinician Academic investigator Clinical investigator Clinical research Clinician scientist Investigator Investigator/ educator Physician investigator Physician scientist Physician-scientist pathway Scientist Scientist educator	Basic science educator Clinical educator Clinical practitioner- educator Clinical scholar Clinician and/or educator track Educational Educator track Investigator educator Medical educator & service track Professor in residence Scholarly activity Teaching scholar Teaching track	Basic science nontenure Basic scientist track Integrated basic investigator (PhD) Integrated basic science Research Research faculty track Research professor Research scholar Research scientist Research track/PhD or MD Researcher Science track Team scientist track	Auxiliary track Clinical track Clinical faculty track Clinical practice track Clinician track Clinician clinician Clinician expert Faculty physician Field service track Fixed term Health clinical science Health science series Health system clinical track Health system clinician (institution name) medicine clinician Practice track Practitioner track Professional practice track Regular series Term track

[a]AMC, academic medical center; NT, nontenure; T, tenure (determination of T versus NT for a given promotion category depends on institution).

[b]Number of AMCs with this category of faculty promotion track (% of total AMCs [n=73] who offer this track). Because many schools have more than one promotion track, total percentages add up >100% (see Methods section for details). Track names were obtained from the survey and respective AMC websites. See Supplemental Appendix 2 for list of participating AMCs.

the survey, whereas 41 (56.2%) of AMCs still had some salary discrepancy (community physicians earning somewhat higher salaries); 8 deans chose not to answer this question. In institutions with clinical work incentives, deans noted that faculty and community physicians have equal access to such bonuses and this sometimes alters (increases) clinical work hours and resultant salaries for individual practitioners in transparent ways, with details depending upon the specific institution. In a few AMCs where community physicians have a distinct parallel practice plan of their own, benefits tend to be less extensive compared with regular faculty, although salaries sometimes remain higher.

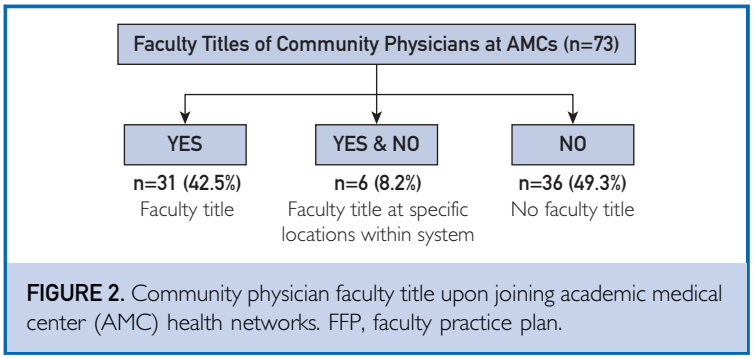

FIGURE 2. Community physician faculty title upon joining academic medical center (AMC) health networks. FFP, faculty practice plan.

Teaching. One benefit of a widening network of physicians affiliated with an AMC is more sites for teaching. Increasing medical school class size, including increased requirement for outpatient rotations for some residents/fellows, and a proliferation of midlevel provider trainees who require clinical experience have created pressure on clinical education sites across the country. By requiring that affiliated community physicians be willing to teach (and prioritize AMC learners) as part of their affiliation agreement, teaching capacity is greatly enhanced. Indeed, 39 of 73 (53.4%) of AMCs currently require affiliated community physicians to be willing to teach at least medical trainees (medical students, residents, and fellows) and find this increased capacity has been beneficial for medical education.

A thorny issue in medical education is direct payment for teaching. Historically, faculty at AMCs were not directly paid to teach because that was considered part of faculty duties in supervising trainee clinical teams and/or expected use of nonclinical time for more formalized education venues; thus, faculty have been historically paid indirectly for teaching. Dean response in this survey suggests the method for tracking and crediting teaching has changed at some AMCs in recent years, including more transparent tracking of education relative value units (RVUs) and research RVUs in addition to more classical clinical work RVUs to more fairly credit faculty effort (and distribute funds where appropriate). Also, historically, because private practitioners were not required to teach, direct payment per student rotation was used by some institutions (MD and DO) as enticement; this too is changing. At the time of our survey, 18 of 73 (24.7%) of AMCs provided compensation to community physicians for teaching, whereas 49 (67.1%) did not provide compensation (instead requiring a willingness to teach as one of the conditions of joining the health care system); 6 (8.2%) deans preferred not to answer this question.

Academic Status. In parallel with AMC clinical network growth over the last 10 years, clinical faculty spend an increasing portion of their time in direct patient care activities, seeing larger patient volumes each day. As a result, deans in our survey confirmed there has been an increase in promotion track options as new kinds of scholarship are valued within the academy beyond traditional National Institutes of Health–funded research.

To get a sense of the landscape for faculty promotion tracks at AMCs across the country, we asked deans what promotion pathways exist at their institution. Table 1 summarizes five general promotion track categories identified as follows: 1) tenure, 2) clinician scientist, 3) clinician educator, 4) research, and 5) clinician. The wide variety of other names given to these tracks at specific institutions is listed below each of these general categories. Specific characteristics of promotion track options include the following: 3 (4.1%) of the 73 AMCs have a single faculty promotion track, 11 (15.1%) have two promotion tracks (tenure and nontenure), and 59 (80.8%) have three or more promotion tracks available. Overall, 71 (97.3%) AMCs have a tenure track, 33 (45.2%) have a clinician scientist

track (tenure or nontenure), 66 (90.4%) have a clinician educator track (tenure or nontenure), 64 (87.7%) have a clinician track (nontenure), and 62 (84.9%) also have a research track (nontenure, rarely used by clinicians).

We next assessed what faculty titles were given to community physicians. Here, deans used various approaches. As shown in Figure 2, 31 of 73 (42.5%) of the AMCs provide community physicians with full faculty titles, 36 (49.3%) do not provide faculty titles, and 6 (8.2%) AMCs stated they offer community physicians full faculty titles only at specific locations within their system. When added to FPPs, community physicians most frequently join either the clinical track 44 of 73 (60.3%), clinical educator track 10 of 73 (13.7%), or are given a nonfaculty title within the FPP (adjunct/affiliate, 15 of 73 [20.5%]; nonfaculty employee, 4 of 73 [5.5%]).

Overall System Benefit. A majority 58 of 73 (79.5%) of AMC deans stated that overall integration of community physicians into their system has thus far gone smoothly, whereas a minority 6 of 73 (8.2%) of AMCs has experienced significant problems. Drilling down further, one-third of the AMCs documented having encountered at least some initial difficulties with community and faculty physicians working side-by-side providing patient care, although deans stated this ultimately diminished over time. Tensions have primarily been cultural (eg, business versus teaching/research focus; administrative authority). There has been competition for various resources/assets (eg, clinical space, support personnel, access to residents, insured patients), uncertainty about contracting and remuneration, control over and/or influence on clinical protocols, and (in a few instances) contention between physicians who view themselves as superior either because of their academic prowess or, conversely, their business acumen. Table 2 provides a comprehensive summary of integration issues gleaned from our survey; these include a myriad of issues ranging from clinical productivity to communication, governance, resources, and salary.

One final issue explored was whether growing clinical networks offer opportunities to generate additional revenue to support the academic mission. Roughly half of deans surveyed stated they have used various revenue transfers from new clinicians joining FPPs to support academic missions (predominantly in the range of 1% to 5%, with some up to ≈10% of total new revenues). Deans were quick to note that such transfers result from multiple sources such as enhanced clinical profits due to economies of scale, better patient outcomes in value-based contracting with resultant enhanced payment from insurers, having patients cared for in the most appropriate local setting which tend to be less expensive than the AMC, as well as from an overall increase in clinical volume. In many cases, with better contracting and other benefits realized upon joining a large AMC, community physicians may not see a net decrease in overall remuneration even with academic transfers.

DISCUSSION

To our knowledge, this is the first comprehensive study examining integration of community and academic physicians into FPPs. Specifically, we evaluated current practice across the United States. Although our survey examines the topic through one specific lens, that of relatively large AMC-based FPPs that have recently grown by adding community physicians, we predict these results have broad applicability. The results also present several emerging policy considerations in this changing and unchartered AMC landscape.

A majority of the AMC deans state their health system has added community physicians over the last 3 to 5 years to provide integrated clinical care across the region, with added benefit of increasing clinical teaching capacity. Deans see this trend continuing for several more years, a finding supported in the literature.[2,5,12] Two main scenarios appear to be occurring today. The first occurs when community physicians are added geographically far from the AMC, and the second when regionally local private practice physicians join AMCs. Over time, AMC health networks tend to become a mixture of these two models. Each is described below.

When community physicians are located at distance from the AMC main campus, integration tends to be minimal and interaction of community and academic physicians can be described as complementary. In this situation,

Mayo Clin Proc Inn Qual Out ■ XXX 2021;5(5):951-960 ■ https://doi.org/10.1016/j.mayocpiqo.2021.06.008
www.mcpiqojournal.org

TABLE 2. Practical Integration Issues Identified by School of Medicine Deans When Community Physicians Affiliate With Academic Medical Centers[a]

Categories	Responses
Clinical productivity	Different electronic medical record usage across sites creates barriers Equipment, supply standardization across system takes time Standardization of clinical protocols/procedures important (community and academic faculty should work together to create system-wide protocols) Who resolves quality/productivity differences between groups (community/faculty)? (Chair vs CMO vs practice plan vs hospital)
Communication issues	Inadequate communication about hospital/clinical expectations Transparency with contracting important What are best ways to communicate to all physicians across the system?
Culture	Academic faculty concerned education/research missions may be lost with increasing emphasis on clinical productivity Community physicians can be frustrated initially by slower AMC "system," not as responsive to their demands Crucial to embrace strengths of each group (so not 2 classes of physicians) Cultures (community/academic) different; Chairs/leaders need to be welcoming to community physicians Slow process to integrate 2 cultures (easier for new graduates, may take a decade for senior physician integration) Research trial payment should be identical across system (all paid, or not paid, equally) Teaching should be an expectation in contracts for everyone when students, residents/fellows available "Us vs them" mentality can develop if not careful Academic physicians may "look down upon" community physicians as clinical workers only Community physicians may "look down upon" academics as not as efficient nor patient-centric
Governance issues	Are department chairs, CMOs, hospitals, or practice plan responsible for quality issues in their specialty? (many chairs want to have new practitioners report through them to ensure same clinical quality) Contracting needs to be transparent Need to clarify oversight/governance structure throughout health system (problem cited by several deans) Noncompetition clauses (if exist) should be in place for all clinicians in system (ultimately), or clarified based on location of practice in transparent way Who is responsible for credentialing/recredentialing new providers? Who do new community physicians report to? Practice plan? Chair? Who has authority hire/fire new providers? Does it matter if they were hired by hospital vs AMC department? Who is involved in initial, and continued, contracting?
Resources	Competition for trainees (who gets to work with residents, fellows?) How can limited clinical space be shared most equitably? Who gets support personnel (nurses, MA, NP, PA)?
Salary issues	All physicians should have equal opportunity to earn clinical incentive payment for extra work Concern private community physicians earn more than academic physicians in same system (equal pay may take several years to achieve Fear of special deals for community physicians joining (some deans state there needs to be a glide path toward target of equality over a few years) How does overnight and weekend call affect pay? Who takes call? Opportunity vs shared burden? How to continue honoring social contract of caring for poor and most vulnerable patients? How does this affect salary? Internal competition for better payer mix can occur (how to resolve while maximizing insured patients?) Should salary/pay be location dependent?

[a]AMC, academic medical center; CMO, chief medical officer; MA, medical assistant; NP, nurse practitioner; PA, physician assistant.

AMC-based health systems provide numerous benefits to community physicians such as potentially lower malpractice group rates, electronic medical record implementation, more efficient tracking of quality metrics, enhanced patient referral to hospital and back to community provider, options for contracting billing to the FPP, larger group bargaining power, positive public relations in the community, and enhanced security in a rapidly changing health care environment.[13,14] For the AMC-based health care system, adding

TABLE 3. Cultural Tensions Extrapolated Based on Model of Integration Used by Academic Medical Center[a]

	Side-by-side issues? (n=66)[c]		Overall integration gone smoothly? (n=63)	
Integration models[b]	Yes	No	Yes	No
Separate	0 (0.0)	11 (100.0)	10 (100.0)	0 (0.0)
Mixed	9 (31.0)	20 (69.0)	26 (92.9)	2 (7.1)
Integrated	13 (50.0)	13 (50.0)	20 (80.0)	5 (20.0)

[a]Values shown are n (%).
[b]See Discussion for description of integration models.
[c]This table accounts for any side-by-side concerns/tensions present, and therefore does not describe the overall frequency or severity of such concerns.

community physicians provides a more geographically distributed, integrated health care and referral network, options for high-quality and lower-cost care in the community, better patient follow-up after hospital discharge, ability to achieve scale (sufficient number of covered lives), provide and participate more fully in population health, more clinical education sites for students, increased sites for community research, and competitive advantage with other health care systems.[15] Distant community physicians tend to be affiliate faculty and retain many aspects of private practice including 100% clinical work. This scenario has potential for being a win-win for all parties.[16,17]

However, there are policy considerations that should be addressed including ongoing professional development and ensuring quality is maintained. Hence, AMCs with this model may also need to invest in telemedicine and mechanisms to track clinical quality.

Benefits also accrue when geographically neighboring community physicians join AMC health care networks, although the approach changes somewhat. In this situation, community physicians and the AMC may opt to have community physicians (either primary care or specialists) join the faculty, often as full FPP members. Alternatively, a few institutions have separate tracks for community providers within their FPP or a separate parallel practice plan. In general, however, deans in this survey stated that virtually all community physicians practicing at their main AMC hospital and affiliated AMC outpatient clinical sites are full faculty. In this circumstance, a clinician promotion track provides the most logical placement within the AMC, although strong teachers may opt for a distinct clinician educator track where available. Deans were clear that all members of a given promotion track are treated equally with similar clinical duty expectations, access to clinical bonus incentives, nonclinical (academic/administrative) time, teaching expectations, promotion criteria, benefits, and salary. Because most AMCs base salary targets on AAMC salary information, the AAMC and Association of Academic Health Centers should conduct future salary studies with this in mind to ensure salary equity is assured and performance incentives are based upon the type and quality of work.

Cultural issues are real according to our dean's survey and must be respected. When problems do occur, they tend to be over issues such as lack of clarity over professional and productivity expectations, competition over resources and/or (insured) patients, transparent/fair compensation, as well as standardization of procedures and clinical protocols. Table 3 extrapolates cultural issues encountered based on the model of integration used by AMCs. Although no studies directly examine integration of community and academic physicians, some of the issues listed in Table 2 have been reported when community physicians move from private practice to hospital or health system–based employment.[16,18-27]

Despite our many important findings, this study has limitations. Because we examined issues only from the dean's perspective, and not from the physician's viewpoint, there may be differences which may have implications on local and national policy issues. The literature suggests ongoing concerns about physician satisfaction, development, burnout, and depression that should be examined to see if there are differences based upon physician type or other sociodemographic factors. Hence, there is a role for leaders of individual AMC organizations (eg, deans, vice presidents [vice chancellors] for medical affairs, associate/vice deans for clinical affairs, FPP leaders, hospital chief executive officers, chief medical officers, etc), medical schools and health

Mayo Clin Proc Inn Qual Out ■ XXX 2021;5(5):951-960 ■ https://doi.org/10.1016/j.mayocpiqo.2021.06.008
www.mcpiqojournal.org

centers (eg, AAMC, American Hospital Association, Association of Academic Health Centers), quality organizations (eg, National Committee for Quality Assurance, Joint Commission on Accreditation of Healthcare Organizations), regulators (eg, Centers for Medicare and Medicaid Services), physicians locally (eg, faculty group practices, chief medical officers), and regional/national organizations (eg, professional societies, American Medical Association, etc) in examining all sides of these issues. Also important is examination of potential local and national quality issues from the patient and community's perspective, which prompts the question as to how relationships between academic and community physicians affect the patients being served. Specifically, future studies should address whether AMC health care and community partnerships improve quality of care and patient satisfaction at the individual, local, and community levels.

From a practical perspective, when a community physician joins the faculty, they report to a division chief or department chair. It is important that this leader be involved in hiring the community physician (no matter the employment scenario) so that commitments for salary, clinical responsibilities, and use of shared space are clarified up front, as well as ensuring that oversight of clinical quality and privileging is uniform across the health system. Several deans remarked that focus on sharing best practice and working together to solve problems at a division/department level helps integration occur more smoothly. While acknowledging communication breakdowns do occasionally occur, a majority of AMC deans believe that overall integration of community physicians has gone well. Clearly, more data are needed and evidence-based best practices must be developed, described, and disseminated.

Although there were many important observations provided by the deans, this study prompts many policy questions as well. Specifically, how are physician salaries and other incentives aligned to address the core missions of the AMC (eg, health care quality and medical education) while at the same time providing patient-centered value-based care? Also, when considering the new diversity of the physician populations (community physician and/or academic research-oriented full-time faculty providing clinical care within AMCs), more granularity may be needed in emerging literature regarding concerns about physician wellness and attrition. Organizations representing physicians, health systems, and health care quality should commission health-policy-relevant studies of these multiple ongoing and emerging issues by an independent and respected authority such as the National Academy of Medicine[28] as has occurred in the nursing profession (eg, The Future of Nursing 2020–2030) in order to examine these issues thoroughly.

CONCLUSION

A majority of AMCs with FPPs are currently hiring community physicians and many anticipate this trend increasing. It appears that when planned and executed well, these partnerships may go beyond creating win-wins for each group of physicians — they can lead to true synergy with community and academic physicians working together in integrated health care systems. This study provides an initial roadmap and some best practices so health care organization leaders can move forward successfully in this rapidly emerging reality.

ACKNOWLEDGMENTS

The authors to thank Amber Ryan for assistance with initial data entry and Jamie Holmes for help with data entry and phone interview scheduling; and Jean Robillard, MD, Professor of Pediatrics and Molecular Physiology & Biophysics, Vice President for Medical Affairs & Dean emeritus, Roy J. & Lucille A. Carver College of Medicine, University of Iowa, and Michael M.E. Johns, MD, Professor, Schools of Medicine and Public health, Executive Vice President for Health Affairs, CEO, and Chair, Emory Healthcare emeritus, Emory University, and Emory University Chancellor emeritus, for their helpful comments. The University of Iowa Institutional Review Board determined that this survey does not qualify as human subjects research.

SUPPLEMENTAL MATERIAL

Supplemental material can be found online at http://www.mcpiqojournal.org. Supplemental material attached to journal articles has not

been edited, and the authors take responsibility for the accuracy of all data.

Abbreviations and Acronyms: **AAMC** = Association of American Medical Colleges; **AMC** = academic medical center; **FPP** = faculty practice plan

Potential Competing Interests: The authors report no potential competing interests.

Correspondence: Address to Debra A. Schwinn, MD, President's Office, Palm Beach Atlantic University, 901 S Flagler Dr, West Palm Beach, FL 33401, USA (debra_schwinn@pba.edu).

ORCID

Debra A. Schwinn: https://orcid.org/0000-0002-9696-5231

REFERENCES

1. VHAN. University Health Network and Vanderbilt Health Affiliated Network join to create statewide value-based healthcare alliance. https://www.vhan.com/media/uhn-ut-vhan/. Accessed October 21, 2018.
2. Carol K, Kane P. Updated data on physician practice arrangements: physician ownership drops below 50%. American Medical Association (AMA). Policy research perspectives based on the 2016 physician benchmark survey web site. 2016: https://www.ama-assn.org/sites/default/files/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf. Accessed August 9, 2021.
3. Fleishon HB, Itri JN, Boland GW, Duszak R. Academic medical centers and community hospital integration: trends and strategies. *J Am Coll Radiol*. 2017;14(1):45-51.
4. The Physicians Foundation. 2018 survey of America's physicians practice patterns & perspectives. 2018: https://www.physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf. Accessed August 9, 2021.
5. Carol K, Kane P. Updated data on physician practice arrangements: inching toward hospital ownership. American Medical Association (AMA). 2015: https://www.ama-assn.org/sites/default/files/media-browser/premium/health-policy/prp-practice-arrangement-2015.pdf. Accessed October 21, 2018.
6. Christianson JB, Carlin CS, Warrick LH. The dynamics of community healthcare consolidation: acquisition of physician practices. *Milbank Q*. 2014;92(3):542-567.
7. Rieselbach RE, Epperly T, Friedman A, et al. A new community health center/academic medicine partnership for Medicaid cost control, powered by the mega teaching health center. *Acad Med*. 2018;93(3):406-413.
8. Sabeti H, Kahn MJ, Sachs BP. The "for-benefit" academic medical center: a solution for survival. *Acad Med*. 2015;90(5):599-602.
9. Cohen JR, Fox S. Developing a new faculty practice plan with a model for funds flow between the hospital and the plan. *Acad Med*. 2003;78(2):119-124.
10. AAMC. Organizational characteristics database (OCD). https://www.aamc.org/data/ocd/60932/ocd_intro.html. Accessed February 28, 2018.
11. AAMC. U.S. medical school faculty by schools and department type, 2017. Association of American Medical Colleges. 2017: https://www.aamc.org/download/486114/data/17table2.pdf. Accessed November 4, 2018.
12. Kane CK, Emmons DW. New data on physician practice arrangements: private practice remains strong despite shifts toward hospital employment. 2013: https://www.ama-assn.org/sites/default/files/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf. Accessed October 21, 2018.
13. O'Malley AS, Bond AM, Berenson RA. Rising hospital employment of physicians: better quality, higher costs? 2011(136). 2011: http://hschange.org/CONTENT/1230/1230.pdf. Accessed October 21, 2018.
14. Mansoori B, Erhard KK, Sunshine JL. Picture archiving and communication system (PACS) implementation, integration & benefits in an integrated health system. *Acad Radiol*. 2012;19(2):229-235.
15. Hauptman PJ, Bookman RJ, Heinig S. Advancing the research mission in a time of mergers and acquisitions. *JAMA*. 2017;318(14):1321-1322.
16. Blue Ridge Academic Health Group, Emory University, Robert W Woodruff Health Sciences Center. The Academic Health Center: Delivery System Design in the Changing Healthcare Ecosystem-Sizing the Clinical Enterprise to Support the Academic Mission. Report 21. 2017: http://whsc.emory.edu/blueridge/publications/archive/blue-ridge-2017.pdf. Accessed August 9, 2021.
17. Halvorson SAC, Tanski ME, Yackel TR. Transitioning from volume to value: one academic medical center's approach to improving population health. *Acad Med*. 2017;92(5):666-670.
18. Key issues and strategies for physician integration. *Becker's Hospital Review*. 2011: https://www.beckershospitalreview.com/hospital-physician-relationships/key-issues-and-strategies-for-physician-integration.html. Accessed November 4, 2018.
19. Ovseiko PV, Melham K, Fowler J, Buchan AM. Organisational culture and post-merger integration in an academic health centre: a mixed-methods study. *BMC Health Serv Res*. 2015;15(1):25.
20. Mallon WT. The alchemists: a case study of a failed merger in academic medicine. *Acad Med*. 2003;78(11):1090-1104.
21. Dooley KJ, Zimmerman BJ. Merger as marriage: communication issues in postmerger integration. *Health Care Manage Rev*. 2003;28(1):55-67.
22. Regev A, Mahajan A. Integrating academic and private practices. *Anesthesiol Clin*. 2018;36(2):321-332.
23. Cohen MD, Jennings G. Mergers involving academic medical institutions: impact on academic radiology departments. *J Am Coll Radiol*. 2005;2(2):174-182.
24. Aston G. Hospitals wise up when adding physician practices. *Hosp Health Netw*. 2013;87:34-36.
25. Pattani R, Ginsburg S, Mascarenhas Johnson A, Moore JE, Jassemi S, Straus SE. Organizational factors contributing to incivility at an academic medical center and systems-based solutions: a qualitative study. *Acad Med*. 2018;93(10):1569-1575.
26. Thier SO, Kelley WN, Pardes H, Knight AW, Wietecha M. Success factors in merging teaching hospitals. *Acad Med*. 2014;89(2):219-223.
27. Haas S, Gawande A, Reynolds ME. The risks to patient safety from health system expansions. *JAMA*. 2018;319(17):1765-1766.
28. National Academies of Science, Engineering, and Medicine. *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*. Washington, DC: The National Academies Press; 2021.