ASSOCIATION OF ACADEMIC HEALTH CENTERS

LEADERSHIP PERSPECTIVES

Optimizing Financial Health: Evolving Approaches to Faculty Practice Plans

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PERSPECTIVE

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AAHC ***Leadership Perspectives*** in 2020 will explore how academic health centers are responding to economic and competitive market pressures, and the models they are pursuing to optimize financial health. This issue features three approaches to organizing faculty practice plans leading to enhanced alignment that supports and sustains operational margins at academic health centers.

Sam Hawgood, MBBS, chancellor at the University of California, San Francisco, explains how his institution worked toward a "unified governance and management structure" among the medical school, the medical group, the medical center, and provider affiliates. This included fully integrating "previously replicated functions such as contracting, revenue cycle, and practice management" under the guiding principles of unified direction, transparency, empowerment, and accountability.

Robert Hromas, MD, FACP, dean of the Long School of Medicine and vice president for medical affairs at UT Health San Antonio, describes how his institution focused closely on improving patient access, capacity, and provider supply among the multiple clinics that are part of the practice plan. They found that the systems "engineering approach that made use of extensive data analytics" allowed leadership to determine factors directly impacting resiliency and efficiency resulting in implementation of strategies that produced increased patient access and optimized clinic performance.

At the University of Arkansas for Medical Sciences, Cam Patterson, MD, MBA, chancellor, also instituted a new model for evolving a practice plan that is part of a statewide health system. He notes that in the restructuring process, "the creative challenge is how to have enough physician bandwidth for your practice base and your referral base without sinking yourself in cost."

These three outstanding commentaries describe distinctive and transformational models of how faculty practice plans are evolving at academic health centers. Notably, they each describe a path toward a more aligned and integrated health system.

Sam Hawgood, MBBS

CHANCELLOR

University of California, San Francisco

Historically, different components of the UCSF clinical enterprise resided in our medical center, medical school, and faculty practice group. This traditional tripartite model worked but was susceptible to diffuse accountability, variability in practice management and performance, and a lack of financial transparency. In 2014, we undertook an ambitious plan to become a fully integrated academic health system, we now call UCSF Health.

UCSF Health brings all our clinical service capabilities into a unified governance and management structure, achieving strategic, operational, and financial alignment among the medical school, medical group, the medical center, and our provider affiliates. Its structure streamlines decision-making and strengthens our ability to act with one voice in the market.

We adopted four principles to guide our transformation. First, **unified direction**—or the commitment to act as one enterprise. Second, **transparency** around our operating and financial performance. Third, **empowerment** of individuals and teams at all levels of our organization. And fourth, **accountability** for delivering outstanding results to our patients and the communities we serve, and for eliminating disparities in the care we provide.

Success required substantive changes in governance, operations, and financial relationships. The previously separate governance of the medical center and medical group—our faculty practice plan—was integrated into a unified UCSF Health Leadership Council with responsibilities for all aspects of the health system – hospital, faculty practice, and affiliates. Similarly, previously replicated functions such as contracting, revenue cycle, and practice management were fully integrated. A critical and intentional goal was to empower the clinical chairs in health system leadership.

At the same time that governance and operations were integrated, funds flow between the component parts was also reformed. The opaque 'book of deals' negotiated between the individual departments and the hospital was replaced by a transparent model that aligns incentives around strategic goals, enables competitive compensation for competitive performance, and explicitly funds the academic mission recognizing this is UCSF's market differentiator.

Now six years into this new governance, operations, and funds flow model, UCSF Health has thrived with a doubling of patient visits and operating revenue. Although not perfect, there is a greater sense of clinician empowerment, accountability, and financial transparency and fairness.

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Robert Hromas, MD, FACP

DEAN, LONG SCHOOL OF MEDICINE
VICE PRESIDENT FOR MEDICAL AFFAIRS

UT Health San Antonio

Our 850 physicians represent the largest integrated multi-specialty group in south Texas, serving a population of over five million people, a high fraction of which lack insurance.

Coupled with generally poor access to integrated medical care among this population, the high incidence of diseases requiring coordinated specialty care—such as diabetes, dementia, and cancer—creates an overwhelming demand for access to UT Health clinics. Three years ago, we created an institution-wide initiative to improve access to our clinics, applying more functional and efficient appointment scheduling. However, despite these initial efforts to widen scheduling portals and expand criteria for acceptance, overall clinic access did not significantly improve, and no-shows remained high.

We decided to apply an engineering approach that made use of extensive data analytics. We generated a system-wide analytical algorithm that defined specific access issues for each clinic—whether it was clinic capacity, patient demand, or provider supply, each of which was multi-factorial in both origins and outcomes. A real-time virtual dashboard with an innovative graph provided all clinics with information they could use to resolve individual access issues. We also used the graph to correlate one clinic's accessibility with another, and identify where issues in one clinic affected another. In addition, using 22 Epic parameters—such as zip code, smoking, BMI, and marital status—we implemented predictive analytics to identify patients most likely not to show for appointments.

Assuming the wellness of any given clinic might limit their capacity to expand, we also implemented a quarterly resiliency survey and provided training to address each issue, such that improvement or deterioration trends could be immediately visualized. This survey of the resiliency of a given clinic measures the learning culture, communication, trust, respect, work environment, reflection and sense making, and leadership vision. After applying this combined system engineering and adaptive reserve approach, access increased 12 percent despite a 31 percent increase in new patients in the last 24 months. We also ensured that 60 percent of our patients are seen within two weeks. Applying these analytics, we can also predict which currently well-performing clinics will develop access issues in the future, and address it before a crisis develops.

Our systems approach improves patient access, allows leadership to determine how factors at one clinic can impact another's efficiency, and can provide analysis of a clinic's resiliency in the face of the stress of expansion.

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Cam Patterson, MD, MBA

CHANCELLOR

University of Arkansas for Medical Sciences

Almost two years ago, I left my position as Vice President and COO at New York Presbyterian/Weil Cornell Medical Center and my family and I moved to Little Rock, where I became the fifth chancellor of the University of Arkansas for Medical Sciences (UAMS), the only academic health center in a state of three million people. At the time, UAMS was facing financial challenges, including a projected $72 million deficit. Through a lot of hard work by our team, that picture changed dramatically. We balanced the budget and ended last year with a $40 million margin.

One of the first things we did was develop a 10-year strategic plan. We examined all areas of our operation to determine the most efficient ways to meet the needs of our rural state with its high incidence of poverty and poor health.

We reorganized our clinical operations, including our academic health center, and eight regional campuses under a statewide health system. We looked at our practice plan. The big issue there was determining our primary care footprint, including physician practice partnerships. UAMS has agreements with nearly every hospital and clinic in Arkansas either through our regional campuses or through our 24/7 digital care programs, such as caring for strokes and providing maternal fetal medicine. The creative challenge is how to have enough physician bandwidth for your practice base and your referral base without sinking yourself in cost.

As part of our process, we reworked some compensation models, linking productivity with upside and downside risk for providers and moving away from RVU-based performance assessments.

We are figuring out the proper cadence as we transition from fee-for-service to at-risk reimbursement. One size doesn't fit all markets in this model. Our market has been slow to move into at-risk models. Our strategy is to move quickly so that when the pivot occurs we're ready to make the change, leveraging our size and our differentiated physician workforce to the local market.

We didn't build our practice model on acquisition. It's not necessary to buy a practice for it to be part of our network. Public/private partnerships with other providers, community leaders, and elected officials have been key to our success. They help us better serve our state while generating revenue, GME programs, and more than $10 million in annual state support for our push for National Cancer Institute Designation.

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