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Integrating Community Hospitals and Academic Health Systems: What Boards Should Consider

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Academic health systems continue to grow in size and scope, typically through acquisitions of or mergers with community hospitals, clinics, and other local care providers. Leveraging a recognized, respected institutional brand, they expand to realize greater efficiencies, economies of scale, and new streams of revenue. Many systems are now massive, highly complex enterprises with regional or even national and international footprints.

We see this as a positive trend. In theory, expansion allows the organization to realize operating synergies across sites, serve more patients and communities, and allocate greater resources to the three vital components of the tripartite mission—education, research, and clinical care. The ultimate goal of such expansion should be to deliver more accessible and safer medical care compared to the pre-merger state. Increasing access to clinical trials and expanding key educational programs are important goals as well.

Successfully integrating community facilities with an academic health system is not easy, and some healthcare systems either fail to achieve this goal or take much longer than planned to achieve it.[1] Boards must not lose sight of this goal when immersed in the toil of forging academic healthcare system expansion.

And, ideally, patients reap the benefits of an organization that advances these components of the tripartite mission and funnels the organization's collective intellect and resources into exceptional care. This includes serving disadvantaged individuals and

1 Nancy D. Beaulieu, et al., "Changes in Quality of Care after Hospital Mergers and Acquisitions," *NEJM*, January 1, 2020.

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communities—an organizational capacity to treat patients equally across a "dichotomy of life and means," as University of Mississippi Medical Center's LouAnn Woodward has said.[2] Health systems that grow by acquiring community hospitals enlarge their service area and can elevate the scope and level of medical care across a larger geography. This expanded footprint may enable better access to care and higher quality of care often benefiting previously underserved populations and communities. Prior to mergers and/or acquisitions, it is mandatory for the "new" system to understand how to best deliver on the promise of "bigger is better."

There are many other challenges to these elaborate academic–community marriages; most noteworthy is the need to align and balance the academic and clinical endeavors. There are subtle and not-so-subtle disruptors at work. The academic and community entities may have differing goals and priorities, definitions/visions of the communities they serve, leadership styles and personalities, compensation levels and models, and more. There can be an inherent mistrust or wariness among the disparate parties of the expanding enterprise. This is especially so among physicians who may see themselves as representing different breeds—the more patient-focused community physicians versus research- and teaching-oriented academic physicians whose clinical work leans toward more specialized, complex, and intensive care or high-acuity patients. Communication and cultural challenges, resource competition, salary discrepancies, and even envy can hinder physician integration and collegiality in such a system.[3]

Misalignment threatens the synergies and benefits mentioned above. In most cases, patient-service revenue for major academic health systems dwarfs the combined budget of the health sciences schools. This would seem to promote the interests of community/care components at the expense of academic and research ones.[4] In other situations, the academic hub—typically the name-brand medical center and medical school associated with a major state or private institution—absorbs the new community facilities without striving to bring them fully into the organizational fold. The merged or acquired hospitals may never feel at one with the organizational whole, with repercussions ranging from low morale to reduced care quality to diminished market competitiveness in the satellite locations. We have seen both scenarios above happen to the detriment of the greater organizations—and to the communities and patients involved.

Before the Merger: Key Determinations

There are steps expanding academic health systems must take to promote alignment and long-term success. Many are at the executive level. A central question lies in whether the organization will opt for a more unified or more decentralized leadership structure for the academic and clinical missions.[5] What will be the operating model? Will it be

2 Gabrielle Redford, "AAMC Leaders to Academic Medicine: We Must Work Together to Solve the Biggest Problems in Healthcare," *AAMC News*, November 5, 2023.

3 Chris D. Stamy, et al., "Community and Academic Physicians Working Together in Integrated Healthcare Systems," *Mayo Clinic Proceedings: Innovations, Quality & Outcomes*, Vol. 5, Issue 5, October 2021; pp. 951–960.

4 Vincent Pellegrini, et al., "Governance of Academic Health Centers and Systems: A Conceptual Framework for Analysis," *Academic Medicine*, Vol. 94, No. 1, January 2019; pp. 12–16.

5 Tony Barbato and Michael Anderson, "Recruiting Leaders for Reorganizing AMCs," WittKieffer, October 10, 2022.

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a decentralized federation of both academic and community hospitals with retained autonomies, or will there be more oversight of assets at the level of new or expanded system leadership with diminished local decision-making authority and governance?

Governance is critical. Board members must anticipate and take confident steps toward alignment for the good of the evolving organization. For the purposes of this article, we direct our advice to the parent board and those leaders determining the academic health system's overall governance structure. Having witnessed and participated in numerous major academic–community mergers, we see the following steps as essential in the run-up to the integration.

Governance is critical. Board members must anticipate and take confident steps toward alignment for the good of the evolving organization.

Establish and get buy-in for the *why* of the merger. This is a joint responsibility of both the primary board overseeing the entity and the executive team. The *why* must clearly outline the practical business case for the merger or acquisition in clear and simple language. It must also be inspirational in terms of being a win-win-win for the tripartite elements. The board must ask itself: what truly makes us excited for this new direction? If it can't formulate a compelling response to this question, it will struggle to convince its constituents across the organization that the *why* is worth it. As mentioned previously, the *why* must ultimately benefit patients and the communities served by the new integrated system. This *why* will be relevant and meaningful to staff at all levels. And the *how* must be carefully and clearly delineated and, most importantly, achievable in a pre-specified timeframe.

The *why* messages external constituents as well—especially the communities served. It must highlight the benefit to those beneficiaries of the system's expanded capabilities in clinical care (community leaders), research (study and clinical trial partners and affinity groups), and education (medical students).

Determine rules of engagement. Once the new entity is formed, how will decisions get made? Who will make them? The key considerations to this end have to do with ensuring all parties in the organization either have a say in decisions or have confidence in those representing them. What model of representation will there be for the AMC and community hospital(s) in setting the agenda for the merged entity? Buy-in becomes important for these rules of engagement, too. They must be communicated (and re-communicated) systemwide at each stage of the transition.

Select board structures and competency-based board membership. There are a myriad of options to consider for governance. All of them likely include a new, larger centralized board.[6] However, the responsibilities of the new system board can be variable and relationships between the primary and subsidiary boards must be clearly delineated, even if that includes a planned evolution of those relationships; complications arise in

6 Ramya Chari, et al., "Governing Academic Medical Center Systems: Evaluating and Choosing Among Alternative Governance Approaches," *Academic Medicine*, Vol. 93, No. 2, February 2018; pp. 192–198.

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instances in which an organization is "intentionally or unintentionally vague about the delegation of duties between parent and local boards."[7]

There must be some thought as to the composition of a new system-level board. Selection of its members is extremely important as they collectively must represent, align, and support the *why* and ultimately the *how*. Forming a new board can send a message of "systemness" by including representatives from the legacy boards of both the academic and community hospitals as well as members new to the organization that can enable it to fulfill its mission. Incorporation of new members reflecting the demographic of the expanded service area is a worthwhile strategy. Ensuring the selection of those representatives is done with an eye toward those who can envisage the needs of the whole versus the needs of parts.

While the subsidiary boards that comprise the governance branches of the new organization will necessarily consist of site- or community-based representatives, at some point they must adopt a more competency-oriented model of governance that aligns with long-term needs and strategy. It may be helpful for board members to designate a target date for transitioning from advocating primarily for the organization from whence they came to advocating for the needs of the broader, integrated organization. This can seem arbitrary, but it is essential in helping directors at both the parent and local board level understand that they are expected to make a mental shift toward the needs of the whole organization.

More nuanced questions related to governance will need to be addressed, pertaining to strategy, fiduciary responsibility, executive oversight, and more. The "board's orientation and thinking need to expand," requiring directors to adopt a learning mindset.[8]

Reimagine the organizational structure, the leadership team, roles, responsibilities, and scope. Much depends on whether the new organization comes together via incremental growth usually with an AMC adding one (or more) community hospitals at a time or by the merger of two or more mature systems each with its own leadership team in place. In the former situation, the board, CEO, and leadership team are in place and in the latter case, it's common for an entirely new board and leadership team to be developed.

Evaluate cultural challenges and potential organizational incompatibilities. This is situation-dependent, but common roadblocks include:

- Failure to master community and patient engagement in a large, dispersed organization.[9]
- Academic clinicians failing to appreciate and acknowledge the expertise of their community-based peers; conversely, staff and physicians at community hospitals and clinics dismissing their academic counterparts as esoteric or "ivory tower."

7 Tara Bannow, "Experts Praise Centralizing Health System Control," *Modern Healthcare*, March 24, 2018.

8 Daniel Harrison and Neelam Patel, "Governing the Evolving Academic Health System," *Academic Health Focus*, The Governance Institute, February 2022.

9 Consuelo Wilkins and Philip Alberti, "Shifting Academic Health Centers from a Culture of Community Service to Community Engagement and Integration," *Academic Medicine*, Vol. 94, No. 6, June 2019; pp. 763–767.

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- Researchers taking advantage of access to new communities without acknowledging their community collaborators as essential, equal partners.
- The failure of all parties to embrace a spirit of interdependence, and/or infighting among AMC and community hospital peers.

Academic health system boards must ask: how will we build a culture in which divergent personalities, people, and goals unite under a shared mission?

Assess other incongruities. As organizations and personnel blend together, academic health systems will find themselves with peculiar predicaments: physician peers earning dramatically different salaries; nurses and staff with contrasting expectations and ideas of proper protocols and workplace behavior; and disagreement over where key meetings should be held, who gets plum parking spaces, or which EHR system to adopt. Issues previously unimagined will crop up; the board must allocate time and energy in supporting the executive team's efforts to solve them.

Anticipate attrition and collateral damage to minimize and manage it. Not everyone can get what they want in this new organization. It will force key personnel (board members included) to make difficult decisions about their futures, meaning some will leave. Anticipate which people meet the strategic needs of the new entity and should be consulted and prioritized as decisions are made. Resist making decisions aimed at satiating important people, but get in front of these issues as a means of retaining individuals who figure to be key contributors in the future.

After the Merger: Sustaining and Building

Preparing for an inevitable merger or acquisition is half the battle. The other half comes when the ink is dry and the integration begins. The primary board must embrace the big picture and consider taking the following actions:

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Get through the growing pains. Accept that there will be a learning curve and that not everything will go as planned. Even if leadership has anticipated the cultural challenges and ironed out incongruities within the new system, there will be others. There will be turbulence as people adapt to new structures and roles. Many will long for "the way things used to be."

Anticipate conflicts and bruised egos among board members. Many directors will find they have less authority and autonomy than before. Perhaps they knew this but the reality now sets in. Some who have always willingly given their time and funds may find they now have little control over either. Board members are increasingly likely to have conflicts of interest, which may need to be addressed.[10] The new governance model

10 Alex Kacik, "Conflicts of Interest Complicate Hospital Boards," *Modern Healthcare*, May 16, 2022.

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won't run smoothly from the start. Board leadership needs to anticipate these issues and mitigate as best they can.

Maintain organizational balance. As the more centralized organization takes root, there can be a natural favoritism toward the most successful elements to the detriment of the pre-established mission and strategic balance. As with a democratic government, the board can impose checks and balances and periodic reviews of "the state of the union" to ensure that the organizational *why* and tripartite synergies hold firm.

Evolve focus and mission over time. The board must become a body that puts the whole entity above its myriad components. This can be done (as previously stated) by encouraging members to broaden their scopes over time. This will also require the recruitment of new board members, including those unfamiliar with the organization. Implement rigid term limits to ensure governance turnover and the eventual transfusion of new blood to keep the board vital.

Most importantly, a major merger or acquisition (or series of them) can be a time for an organization to reimagine its model of governance entirely, addressing questions related to, for example, how to identify future board talent (moving beyond volunteer members from the community) and whether compensation for board directors is warranted.[11] The new, larger academic health system's governance should be a living, breathing entity that evolves and improves over time.

Key Board Takeaways

- Before proceeding with an academic–community merger or acquisition, the parent board must determine the *why* of the decision and communicate it clearly to key constituents.
- The *why* must clearly indicate the benefits to each element of the tripartite mission.
- Integrating academic and community facilities is an opportunity to shift governance from being more representation-based to more competency-based.
- Boards of the "new" system must expect growing pains while continually re-evaluating their role to ensure they balance governance priorities among academic and clinical interests.

11 Michael Ugwueke, "Disruptive Change Calls for Bold Governance," *BoardRoom Press*, The Governance Institute, June 2024.

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