ACADEMIC – COMMUNITY INTEGRATION IN HEALTHCARE TODAY

OPTIMIZING THE OPPORTUNITIES

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A Little About Us

**Bob Colvin**
- 20+ years health system CEO
- CEO of 650 bed teaching hospital
- Co-founded private medical school
- Past Chair of Georgia and Idaho Hospital Associations
- Strategic consultant

**Charlie Powell**
- 20 years medical group leadership
- CEO/COO roles in private and employed medical groups ranging from 25 to 560 providers
- Experience in national health systems and physician practice management company
Goals For Today

- Understand how and when the integration of academic and community health systems makes sense.
- Discuss what needs to happen to maximize these opportunities.
- Understand how KentuckyOne Health and the University of Louisville are pursuing integration and the lessons learned.
The Academic Enterprise

- **Positives**
  - Traditionally the highest levels of care available: faculty, trauma, neonatal, transplants, specialty surgery, and research.
  - Structured to deal with most complex cases.
  - Supply of new talent – access to the best and brightest.
  - Often a quality “brand.”
  - Access to research trials.
  - Subsidy funding for select components.
The Academic Enterprise

- **Weaknesses**
  - Relatively inefficient model.
  - Traditional silo approach to each academic program.
  - Not market oriented.
  - Best talent is often “diluted” to other systems.
  - Episodic care.
  - Training programs *can be* patient *dissatisfiers.*
  - Brand may be pulled down by “weaknesses.”
  - Geographically isolated.
    - Often inadequate network and entry points.
  - Inadequately funded research.
So, Why Integrate?

- The survival of the academic enterprise depends on it.
- Reimagined and restructured, the academic enterprise strengthens the regional health system.
- At its best, the new integrated system has nearly unlimited potential to reshape healthcare.
Capitalize on the Positives

- Concentrate highest level services in system.
  - Realign clinical talent and/or expand brand.
- Retain the best and the brightest talent.
- Coordinate training programs.
  - i.e. Family Practice, Internal Medicine, mid-levels.
- Reorient training programs at source.
  - Distributed, market based, clinically focused.
- Solidify high-level brand.
Minimize the Negatives

- Revise vision and mission of academic enterprise to patient/market focus consistent with system.
- Fully connect to patient-focused clinical network.
- Integrate academic leadership into system leadership.
- Don’t overlay old structure over (or under) new.
- Eliminate underfunded research/distraction.
- Refuse to accept traditional academic model as market “limiter.”
“It is time for academic medical centers and their medical schools to end this irrational cross-subsidization of their tripartite mission and ensure that each part is self-sustaining.”

C.J. Lockwood, MD
Sr. VP and Dean, USF Health
Academic Model Variants

- Memorial University Medical Center
  Savannah, Georgia

- Idaho College of Osteopathic Medicine
  Idaho State University, Boise campus - 2022

- Kaiser Permanente School of Medicine
  Pasadena, California - 2019
Memorial University Medical Center

- Approximately 110 funded residency slots.
- Partnered with Mercer University for medical school and academic umbrella.
- Mercer University gets state subsidy funding for medical school.
- Research is relatively limited and “pragmatic.”
- Memorial Health is now finalizing relationship to become part of Novant Health.
- Win for all three.
The Relationship Defined

- Joint operating agreement for University of Louisville Hospital.
- Support of academic programs.
- No legal connection of University of Louisville physicians and KentuckyOne Health medical group.
Facility Integration

- Service lines
- Support departments
- Leadership
Supports facility integration.

Leverages state-wide network of community physicians and tertiary specialties.

What has been considered?
Integration Models

Medical Staff Collaboration

Service Line Integration

Integration of Clinical Information and Support Services
Academic/Community Collaboration

Academic
Clinical
Research
Teaching

Clinical

Community
Clinical
(Minimal Research and Teaching)
Key Concepts

**Trust**
- Historical dynamics
- Winners and losers

**Communication**
- Formal and informal leaders
- Dispel rumors
- Calm fears

**Perseverance**
- Set vision
- Leadership support
- Stay on course
- Manage the detractors
- Find “wins”
Key Objectives

- Improved outcomes for our patients and the community.
- Combined strategic and operational approach to clinical care model.
- Optimized quality and performance metrics and standards.
Discussion

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