Integration of an Academic Medical Center and a Large Health System: Implications for Pharmacy

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Abstract

Objective: To provide lessons learned for colleges of pharmacy and large health systems that are contemplating or in the process of undergoing integration. **Method:** This report describes the merger of an academic medical center and large health system with a focus on the implications of the merger for pharmacy from the perspectives of both a college of pharmacy and a health system's pharmacy services. **Results:** Overarching pharmacy issues to consider include having an administrator from the college of pharmacy directly involved in the merger negotiation discussions, having at least one high-level administrator from the college of pharmacy and one high-level pharmacy administrator from the health system involved in ongoing discussions about implications of the merger and changes that are likely to affect teaching, research, and clinical service activities, having focused discussions between college and health system pharmacy administrators on the implications of the merger on experiential and research-related activities, and anticipating concerns by clinical faculty members affected by the merger. **Conclusion:** The integration of a college of pharmacy and a large health system during the acquisition of an academic medical center can be challenging for both organizations, but appropriate pre- and post-merger discussions between college and health system pharmacy administrators that include a strategic planning component can assuage concerns and problems that are likely to arise, increasing the likelihood of a mutually beneficial collaboration.

Keywords

clinical services, pharmacists, education, management, residency training, programs, schools of pharmacy

Introduction

Academic medical centers or teaching hospitals have teaching and research responsibilities that have cost implications beyond the patient care mission shared with all hospitals. In addition, academic medical centers care for a disproportionate share of patients with no ability to pay, patients with capped reimbursements, and patients receiving services that often lead to financial loss.¹ Academic medical centers may need health system partners to navigate the changing paradigm of health care delivery. This has led some academic medical centers to merge with larger health systems to maintain financial viability to support their missions of patient care, teaching, and scholarship. Such mergers are challenging for the academic partner that is attempting to preserve its teaching and research missions, particularly through co-funded clinical faculty positions, and for the health system that is attempting to provide high quality care in an increasingly competitive market focused on cost containment.^{2,3} The literature is replete with mergers that have failed and lessons learned from these failures including the need for careful execution and planning by a board that is focused on the new

entity resulting from the merger, appreciation for cultural differences and related impediments, limitations of economies of scale and associated savings, and lack of buy-in by key stakeholders.⁴⁻⁶ Furthermore, the effects of mergers on quality of care and patient mortality require substantiation.⁷ This report describes the merger of an academic medical center and large health system with a focus on the implications of the merger for pharmacy from the perspectives of both a college of pharmacy and a health system's pharmacy services. The objective is that it will provide some lessons learned for other colleges of pharmacy and health systems contemplating or undergoing similar integration.

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Historical Perspective

The academic medical center established inpatient services in 1971 with a goal to provide postgraduate training opportunities for the health science professions including pharmacy. The college of pharmacy worked closely with the hospital's Department of Pharmacy and Supply to provide comprehensive pharmacy services that would include direct patient care activities. In 1975, the hospital provided funding for the first faculty pharmacist to perform ward-based clinical services. In 1984, the Arizona Board of Regents (ABOR) approved 2 nonprofit corporations to replace the existing hospital and its medical service plan. One of the nonprofit entities was the University Medical Center Corporation that consisted of the hospital and its general care clinics and the other was the University Physicians Corporation that consisted of the medical practice plan and specialty clinics. The new ABOR agreement specified that the new corporations, in addition to providing patient care, would have funds allocated for ongoing education and research responsibilities. Three additional clinical faculty pharmacists were hired under this new agreement. By 1994, there were a total of 3.5 full-time equivalent (FTE) clinical faculty pharmacists who had co-funded positions associated with one of the university medical center's main or south campuses. Since that time, the relationship between the medical center and the college has generally been positive, which is consistent with the responses from a survey of pharmacy directors at 90 University HealthSystem Consortium academic medical centers.⁸

Description of Health System

Banner Health is a not-for-profit health system with headquarters in Phoenix, Arizona. Banner Health operates 28 hospitals and other health care-related facilities in the United States. Banner Health has approximately 50 000 employees across 6 states and is the largest private employer in Arizona. Banner Pharmacy Services, LLC was created in 2014 as a division of Banner Health. At the time of the merger, the Vice President for Banner Pharmacy Services was a pharmacist who was responsible for not only the pharmaceutical operations across the health system, but also the primary administrative contact with the College of Pharmacy.

Merger Between Academic Medical Center and Health System

Prior to the Banner merger, the University of Arizona Health Network (ie, the academic medical center) was comprised of the employees working at 2 hospitals, clinics, and the University of Arizona health insurance plans and faculty physicians of the College of Medicine. One of the major reasons for interest in the merger from the standpoint of the university and the health network was to bolster fiscal

sustainability, as the network had low operating margins and an increasing debt burden.

In 2014, the University of Arizona Health Network entered negotiations with Banner Health. In the agreement that went into effect in 2015, Banner Health acquired the 2 hospitals on Tucson campuses (ie, formerly University of Arizona Medical Center–University Campus and University of Arizona Medical Center–South Campus and currently Banner–University Medical Center Tucson and Banner–University Medical Center South, respectively) with their existing health plans and faculty physicians, as well as 2 infusion centers. In addition, Banner Good Samaritan Medical Center in Phoenix became Banner–University Medical Center Phoenix for a total of 3 university hospitals operated by Banner Health.

A special provision to the master purchased services agreement was entered into between Banner Health and ABOR (on behalf of the university) in which Banner Health would pay for 4 FTE pharmacist positions, or 8 co-funded clinical faculty pharmacists, who were full-time university employees (1 tenured) previously co-funded by a contract with the University of Arizona Health Network. As the previous and new contracts were based on numbers of FTE positions and not individual faculty-site agreements, and all 8 clinical faculty were retained in their respective practice positions, the new financial relationship had no direct effect on the clinical or university-related responsibilities of individual faculty members. More specifically, the merger did not impact indirect cost recovery, salary relief, or incentives. Instead, the agreement detailed general responsibilities of the University and of Banner Health.

Pre- and Post-Merger Discussions and Agreements

Most of the initial discussions of the implications of the merger took place between the Vice President for Pharmacy Services of Banner Health and 2 administrators from the College of Pharmacy, the Associate Dean for the Phoenix campus and the Department Head of Pharmacy Practice & Science who had his office located in the College of Pharmacy in Tucson. The Vice President for Pharmacy Services works out of Banner Health headquarters in Phoenix, Arizona, so monthly face-to-face meetings were arranged between she and the Associate Dean for the Phoenix campus. Although there were no practice faculty in Phoenix as part of the original contract between Banner and the College of Pharmacy, the College hoped that the contract would eventually be expanded to include Phoenix-based practice faculty either at Banner–University Medical Center Phoenix or in one of Banner's Phoenix-based clinics. Other topics of discussion between Banner Health and the College of Pharmacy included student and resident experiential training in the Phoenix area.

In addition to the meetings with the Associate Dean of the Phoenix campus, there were ongoing telephonic and face-to-face meetings that took place between Banner and the College of Pharmacy in Tucson. The latter meetings were important because faculty contracts, percent effort assignments, annual performance evaluations, and promotion and tenure reviews are developed and administered at the departmental level in the College of Pharmacy. Similarly, postgraduate resident training contracts (PGY1 and PGY2) and nonpaid faculty appointments (eg, experiential preceptors) are made at the departmental level. Prior to the merger with Banner Health, there was a long-standing pharmacy resident training contract between the academic medical center in Tucson and the College of Pharmacy. Basically, the medical center provided pass-through funding to the College to administer the residency program, and the clinical faculty and clinical pharmacists of the hospitals precepted the residents. This arrangement was continued under a new contract between Banner Health and the College of Pharmacy.

Prior to and during the merger with Banner Health, administrators in the College of Pharmacy participated in other meetings involving executives from the medical center and Banner Health. For example, the Dean of the College of Pharmacy and the Department Head were invited to speak with the Academic Management Council (AMC) that was comprised of 3 administrators from Banner Health and 3 administrators from the University of Arizona. The purpose of the AMC is to oversee faculty operations and activities related to clinical care, teaching, and research within Banner–University Medicine, a new division of Banner Health.

While there was broad support for the Banner Health–University of Arizona merger at the highest administrative levels such as the AMC, there were some pointed conversations in the immediate pre- and post-implementation involving the Vice President for Pharmacy Services of Banner Health and the Associate Dean for the Phoenix campus and the Department Head of Pharmacy Practice & Science. The Vice President was supportive of the concept of clinical faculty, but expressed the necessity of transparency and accountability of activities within the practice sites. From the college administrator standpoint, an overarching concern was the longevity of the new contract, as the clinical faculty members associated with the contract are a large expense and vital to the mission of the College of Pharmacy.

More Recent Developments

The conversations and meetings between administrators in Banner Pharmacy Services and the College of Pharmacy became less philosophical and more strategic and practical over time as a trusting relationship was established. Reporting relationships and evaluation procedures were developed for the clinical faculty at their respective practice sites. It was important to develop and implement faculty evaluation criteria satisfactory to both parties. As we started this work, we

realized that Banner Health's clinical pharmacy practice evaluation was very similar to the scale used by the Department of Pharmacy Practice & Science as required by University of Arizona annual performance guidelines.

There was agreement between administrators with Banner Pharmacy Services and the College of Pharmacy concerning the importance of credentialing of clinical faculty. Job postings for co-funded clinical faculty positions state the requirement for PGY2 specialty training or equivalent experience. Furthermore, clinical faculty candidates are expected to have board certification in their practice specialty or commit to obtaining it within a defined period of time after hire. Currently, all clinic faculty covered by the affiliation agreement have at least one board certification.

A joint strategic planning session was organized to create a shared vision and goals. The participants addressed unique accountabilities, and organization-specific challenges that might impact the ability to achieve mutual goals. For each of the themes and associated projects, details were formulated by purpose, short-term deliverables, resources to engage, and vehicle to move the work. This strategic planning retreat was a crucial step in the development of the relationship between Banner Pharmacy Services and the College.

One area of concern for the College of Pharmacy during the merger process related to the experiential education of students, as new standards released by the American Council on Pharmacy Education (ACPE) in 2010 increased the expectations for Introductory Pharmacy Practice Experiences (IPPEs) in the first 3 years of the curriculum and increased the number of required rotations for Advanced Pharmacy Practice Experiences (APPEs).⁹ Academic medical center hospitals were particularly affected by these changes, due to the substantial numbers of pharmacy students receiving their experiential training at those sites. Therefore, it was imperative from the College standpoint that we maintain our long-standing collaborative relationship with hospital administrators, and in particular, the directors of pharmacy, during and after the merger. The College has been assured by administrators from the University and Banner Health that the teaching mission would not be compromised by the merger and for the most part that turned out to be true. The major impact from the standpoint of experiential services personnel in the College was increased paperwork related to onboarding of students for rotations in the Banner hospitals. Onboarding is often referred to as organizational socialization, which is basically when new employees, or in our case students, adjust and integrate into an organization and its culture. Increased experiential personnel time was needed to process the Banner onboarding requirements. However, it is important to note that the rigor and time associated with onboarding vary by institution and have increased in some of our other College training sites, so it is difficult to know if the impact on our experiential services personnel would have occurred over time regardless of the merger.

Benefits of the Merger

The merger with Banner Health has led to an injection of capital to support new programs, construction, and renovations at practice-related facilities. For example, the University–Banner Health partnership led to the receipt of a multimillion-dollar grant from the National Institutes of Health to participate in the Precision Medicine Initiative Cohort Program, which is expected to create new health care jobs in Arizona. With respect to construction, Banner is in the process of building a new 9-story, \$400M tower for Banner–University Medical Center Tucson. The academic medical center in Phoenix provides an additional training site for students and postgraduate trainees.

With respect to the College of Pharmacy, progress has been made on a number of fronts since the contract for clinical pharmacy faculty services was signed in 2015. For example, relationships between administrators of Banner Pharmacy Services and the College of Pharmacy have been strengthened. This is partially evidenced by 2 additional co-funded clinical pharmacy faculty who have been hired to practice at Banner–University Medical Center Phoenix. These new hires have practice schedules, clearly delineated responsibilities, and facility contacts (supervising pharmacist, supervising administrator, supervising physician) at their practice site.

Ongoing Challenges

As identified in a previous paper describing a relationship between a health system and a college of pharmacy, there are ongoing discussions and challenges related to communication, reimbursement for clinical services, and integration and documentation of activities by college and health system pharmacists.¹⁰ Discussions with clinical faculty members a couple of years after the merger reveal different perceptions of the impact of the merger depending on the individual clinical faculty member. For long-standing clinical faculty who were part of the previous contract with the university medical center in Tucson, much of the initial trepidation related to practice site responsibilities associated with the merger has subsided. It is now apparent that for clinical faculty, there was relatively little change in their day-to-day practice responsibilities apart from the need for increased documentation of interventions by some faculty. Many complaints related to the documentation procedures were secondary to the introduction of a new electronic health record and were shared by many of the nonfaculty clinical pharmacists employed by Banner. This is not to imply there is always consensus on practice issues between pharmacy personnel at the College and in Banner Health. For example, Banner Health is a proponent of consistent clinical practices, defined by clinical consensus groups, related to medication prescribing and monitoring. This type of practice has been documented in the literature to decrease variation and improve outcomes across the continuum.¹¹ On

the contrary, many of the clinical faculty are experts in their areas of specialization and have their own perspectives on when and how standardization should occur. Several pharmacy as well as physician faculty members participate on several of the clinical consensus groups, which will provide an opportunity to reach shared best practices. As with any change of this magnitude, there is a natural tendency to compare how things are expected to be done under the new versus the old system. This is true for all of the pharmacists, regardless of whether they are hired by Banner Health or the College. One example of a not unexpected before–after system comparison by faculty and nonfaculty pharmacists was the institution by Banner of a peer-review process during annual evaluation procedures. Apart from peer review, there was relatively little change in the annual evaluation process procedures for clinical faculty.

There is one issue resulting from the merger that has been difficult to resolve because it involves research activities beyond the direct control of the leadership of Banner Pharmacy Services and College of Pharmacy administrators. New submission procedures for human subjects research has been an overarching and somewhat unexpected impediment to research performed by clinical pharmacy faculty, students, and postgraduate trainees such as residents. Prior to the merger, the basic procedures for institutional review board (IRB) submission and approval were the same for all clinical faculty in medicine, nursing, and pharmacy. During the merger contract discussions, administrators at the College of Pharmacy were told that clinical faculty would be covered by the signed affiliation agreements between Banner Health and the University. After the merger, it became apparent that the research component of the affiliation agreement between Banner Health and the University was written solely to cover faculty physicians and their trainees. In essence, clinical pharmacy faculty were in limbo as they did not have a Banner Health employee number that would allow them to use the Banner approval process for research, nor were they covered by the University research affiliation agreement. Additional paperwork (Banner Research Plan) with individual reliance agreements were required for project approval for any faculty and trainees not covered by the affiliation agreement. Leadership of the 2 organizations is actively engaged in rectifying the issue, but this is a lesson learned for the processes of integrating research agendas of 2 organizations. Another concern by some of the more research-intensive clinical faculty and nonfaculty pharmacists has been the difficulty in accessing patient information for retrospective quality improvement and research projects. In the past, there was a pharmacist employed by the academic medical center who had expertise in informatics and was very helpful in facilitating data access by faculty and nonfaculty pharmacists. This informatics pharmacist was moved out of pharmacy during reorganization under Banner. Since that time, there have been ongoing challenges related to data retrieval. On a positive note, if the access issue can be resolved, there is

potential for much greater sample sizes for future studies given the large number of hospitals and clinics in the Banner system.

Lessons Learned from a Pharmacy Perspective:

- Have an administrator from the college of pharmacy directly involved in the merger negotiation discussions, or at least having timely access to the results of the discussions, to help ensure that contract arrangements with medicine are applicable to pharmacy; if not, pharmacy-specific contract discussions should be pursued as early as possible.
- In conjunction with the overarching merger issues being dealt with by the new board of trustees, have at least one high-level administrator from the college of pharmacy and one high-level pharmacy administrator from the health system involved in ongoing discussions about implications of the merger and changes that are likely to affect teaching, research, and clinical service activities.
- With respect to teaching, have focused discussions between college and health system pharmacy administrators on the implications of the merger for experiential training of students (ie, IPPE and APPE rotations), pharmacy residents, and other postgraduate trainees.
- With respect to research, have focused discussions between college and health system pharmacy administrators on the implications of the merger for research-related activities, particularly access to patient data and IRB or other necessary approvals.
- Anticipate concerns by clinical faculty members affected by the merger and communicate ongoing updates about the process with an emphasis on pharmacy-related changes and assurances concerning job security to the degree possible.

Conclusion

The integration of a college of pharmacy and a large health system during the acquisition of an academic medical center can be challenging for both organizations, but appropriate pre- and post-merger discussions between college and health system pharmacy administrators that include a strategic

planning component can assuage concerns and problems that are likely to arise increasing the likelihood of a mutually beneficial collaboration. Furthermore, such an integration has potential benefits to both organizations.

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