

## Healthcare Systems and Services Practice



# Unlocking the potential of academic and community health system partnerships

Alex Harris; Pooja Kumar, MD; and Saum Sutaria, MD

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Faced with increasing challenges to their business model, many academic medical centers (AMCs) are seeking new sources of financial and competitive advantage, including partnerships with community health systems. These arrangements can be difficult to structure, but eight lessons can help AMCs avoid pitfalls and maximize the odds of success.

Academic medical centers face numerous challenges today. Clinical margins are shrinking. Payers are creating networks favoring lower-cost providers. Community health systems are increasingly offering high-end services that threaten patient inflows. Education and research funding has declined. As a result, many AMCs are struggling to sustain the activities that have historically enabled them to fulfill their tripartite mission. To preserve these activities, AMCs are looking for new ways to improve their clinical margins. At the same time, they are seeking opportunities to improve outcomes and the patient experience in response to rising consumerism and value-based care trends.

Many AMCs have viewed increased scale as a way to pursue both goals. Although some AMCs have merged successfully with community health systems, there have also been a number of high-profile deals that went sour.<sup>1</sup> An increasing number of AMCs, including MD Anderson and the Cleveland Clinic, have chosen instead to pursue non-M&A partnerships as a way to access some of the value drivers of scale without the complexities of full integration (Exhibit 1).<sup>2</sup> In many cases, these partnerships have enabled the community health systems to attract new patients and allowed the AMCs to extend or protect their referral networks.

The flexibility that partnership permits provides important advantages for many AMCs, given the restrictions often imposed by their governance and ownership structures. It also allows the community health systems to avoid the added costs of an academic enterprise. Even these deals are not without risk, however. Some AMC–community health system partnerships were unsuccessful because the aspirations were too ambitious or the goals and value drivers were not clearly defined in advance. In other cases, the AMCs over-estimated the advantages they were bringing to their partners. With careful planning, these pitfalls can be avoided.

In this article, we describe the ways through which an AMC–community health system partnership can create value, the options for partnership structuring, and how the choice of value drivers should influence the structure. In addition, we discuss eight lessons AMCs should heed to ensure the best chance of success. Greater detail on the rationale for AMC–community health system partnerships is presented in the sidebar on p. 8.

## How value can be created

A partnership makes sense only when both sides can envision value creation above what either side could produce on its own. The

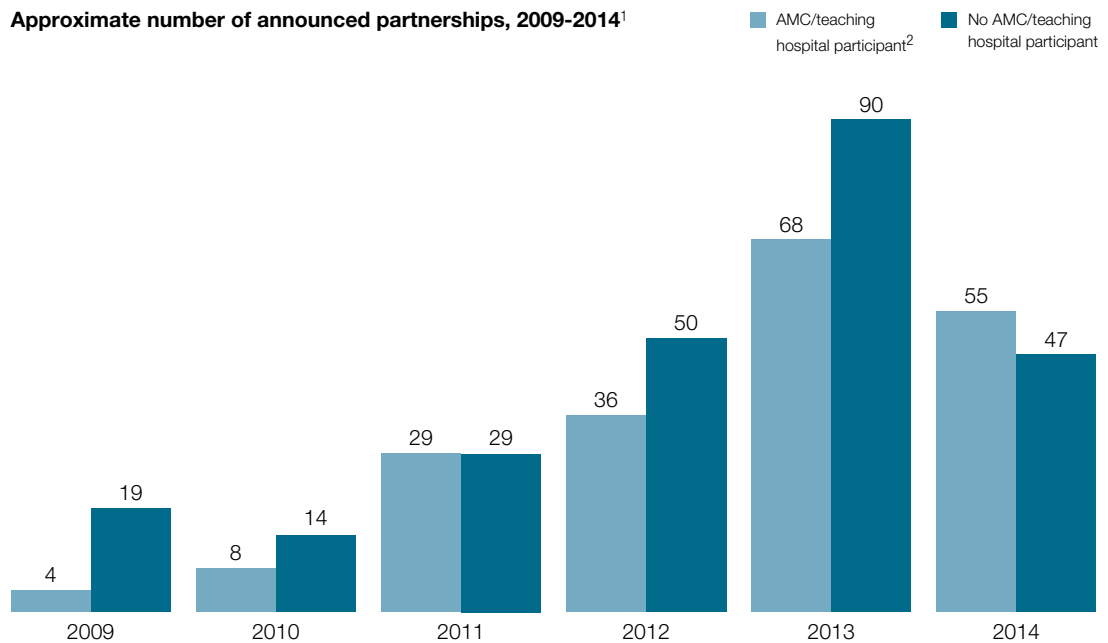
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<sup>1</sup> Among the successful mergers are those undertaken by Johns Hopkins Health System and Partners Healthcare. Examples of unsuccessful mergers include those undertaken by Henry Ford-Beaumont, Hershey Medical Center-Geisinger, WellStar-Emory, and Jefferson-Main Line Health.

<sup>2</sup> McKinsey press search. Also, Levin Associates. *Hospital Acquisition Report*, 2015. April 2015.

## EXHIBIT 1 Non-M&A partnerships between providers are increasing

Approximate number of announced partnerships, 2009-2014<sup>1</sup>



<sup>1</sup>Excludes accountable care organizations.

<sup>2</sup>AMCs/teaching hospitals were defined per the American Association of Medical Colleges' Council of Teaching Hospitals and Health Systems classification.

Source: Press search, Levin

value creation potential must also exceed the deal's resource requirements and coordination costs, as well as the management and governance complexities that arise when a structural relationship with another entity is established. For each partner, the value ultimately created depends on the value drivers being pursued and the project's scope (e.g., inpatient only), level of integration (e.g., joint venture versus affiliation), and transaction terms, including investment and resource commitments.

The traditional business case for scale relies primarily on economies that improve the cost base. However, McKinsey's Smarter Scale Equation work has demonstrated that

value creation can also result from economies of scope, structure, or skill.<sup>3</sup> Simply put, well-constructed health system partnerships can create value in a variety of ways, including patient volume growth, per-case revenue growth, margin enhancement, and margin from new businesses (Exhibit 2).

Many of today's AMC–community health system partnerships focus primarily on *economies of scope*. The AMC gains access to new geographies and customer segments. The community health system can offer high-end services it might not be able to provide on its own (e.g., neurosurgery, cardiothoracic surgery), and can market itself using its partner's brand.

<sup>3</sup>Malani R, Sherwood A, Sutaria S. The smarter scale equation. *The Post-reform Health System: Meeting the Challenges Ahead*. McKinsey & Company. May 2013.

However, *economies of skill* may come into play if the health system gains access to the AMC’s clinical protocols or other drivers of clinical differentiation. The growth orientation of this partnership model usually has a clear potential upside for both partners, and the need for complex management requirements may be minimal, depending on the nature of the partnership (e.g., co-branding versus joint venture). An example of this is MD Anderson and Cleveland Clinic’s service line affiliations focused in oncology and cardiovascular services, respectively.

In other arrangements, the partners may achieve *economies of structure* if care integration increases their attractiveness to payors or employers, which could help bring new patients to the systems. In Pennsylvania, for example, Main Line Health and Jefferson University Hospitals have built a large accountable care organization with a multi-provider collaboration that serves over 100,000 beneficiaries and manages public and private performance-based contracts.<sup>4</sup>

In some cases, an AMC-community health system partnership may be designed to

**EXHIBIT 2 Partnerships can produce a range of value drivers**

<p><b>Economies of scale</b></p>	<ul style="list-style-type: none"> <li>• <b>Purchasing scale/supply chain economics</b> A larger community system can offer higher purchase volumes and a larger sourcing team; the AMC offers expertise in procurement for specialized products and services</li> <li>• <b>Administrative/overhead efficiency</b> Both systems benefit from sharing and streamlining common overhead functions</li> </ul>
<p><b>Economies of scope</b></p>	<ul style="list-style-type: none"> <li>• <b>Access to new geographies/patient segments</b> A complementary pair of health systems improves local market density and access points (e.g., physicians, ambulatory); the AMC offers the community system preferential access to specialists</li> <li>• <b>Non-core business expansion</b> The community system offers access to services businesses (e.g., revenue cycle) and more health plan assets; the AMC offers access to technology, drug-discovery-related ventures, etc.</li> </ul>
<p><b>Economies of structure</b></p>	<ul style="list-style-type: none"> <li>• <b>Increased attractiveness of network to payors</b> The community system offers lower cost of care settings for low-acuity patients; the AMC boasts centers of excellence with potential innovation/quality advantages</li> <li>• <b>Capital efficiency (raising and investing)</b> Together, the partner systems enjoy mutually improved access to capital in public debt and/or equity markets; additionally, a strong-brand AMC may offer philanthropy opportunities</li> </ul>
<p><b>Economies of skill</b></p>	<ul style="list-style-type: none"> <li>• <b>New capabilities for business performance</b> A larger community system offers operational efficiencies in staffing, case management, patient throughput, etc.; the AMC has more robust clinical protocols and quality/outcomes programs</li> <li>• <b>Integrated practice across the care continuum</b> The partner systems improve team-based skills across care pathways and consolidate clinical assets</li> </ul>

Source: McKinsey Healthcare Systems and Services Practice

<sup>4</sup>Delaware Valley ACO website. Who we are. [dvaco.org/about/](http://dvaco.org/about/).

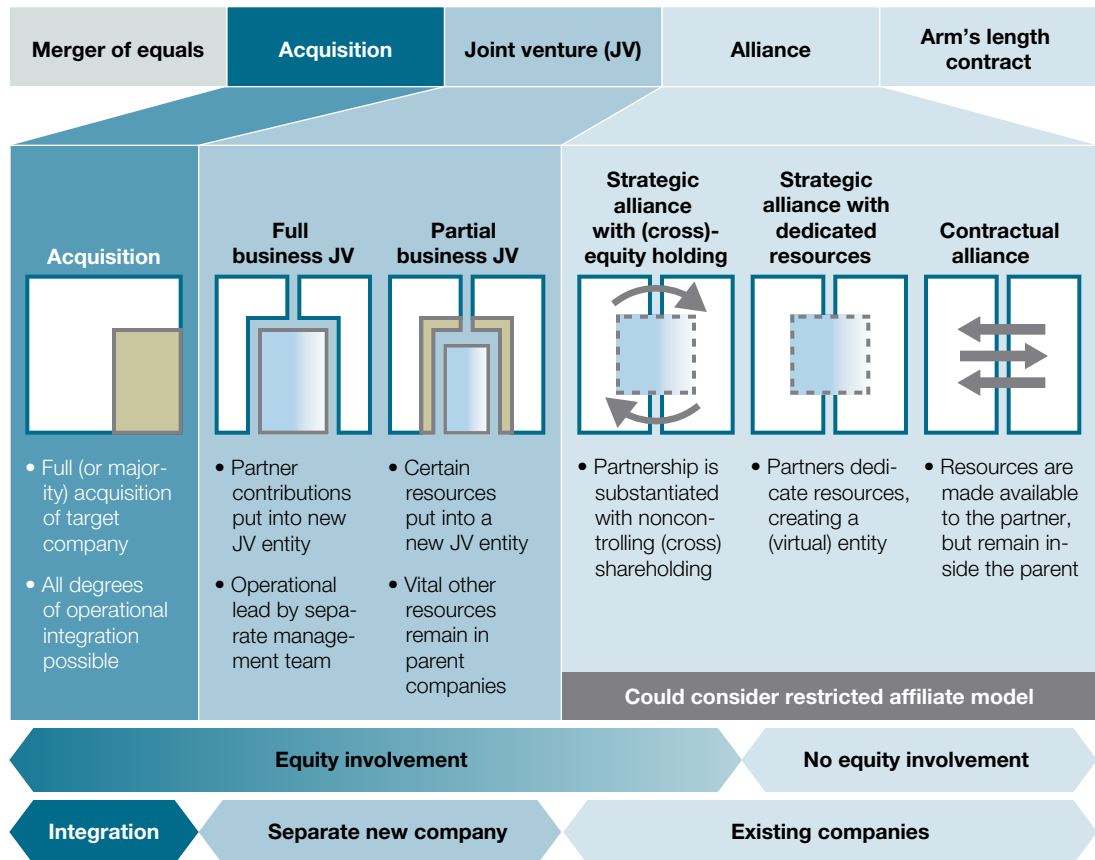
achieve *economies of scope, structure, and skill*. In this type of arrangement, the AMC and community health system coinvest to build new or sustain existing, mutually beneficial delivery networks. In Houston, for example, Baylor and St. Luke’s (which is owned by Catholic Health Initiatives) are partnering to invest—sharing risk and reward—in a teaching hospital that would not have been as attractive an endeavor if either party had built it alone.<sup>5</sup> Both sides profit from the revenues generated by employed physicians, hospitals, and other facilities.

Another example is HCA’s investment in Tulane University Hospital in New Orleans.<sup>6</sup> This arrangement bolstered the AMC’s financial security, while HCA gained prestige, market presence, and tertiary referral service.

### Implications of value drivers for partnership structure

Exhibit 3 illustrates the range of partnership structures that AMCs and community health systems can consider. The choice of value

EXHIBIT 3 Mergers and partnerships can take a variety of forms



<sup>5</sup>Williams L. Bold new alliance among Houston’s leading health care providers to transform care delivery in the region. Baylor College of Medicine press release. January 7, 2014.

<sup>6</sup>Tulane Medical Center website. About Tulane Medical Center. tulanehealthcare.com.

drivers helps determine which partnership structure is most appropriate, since it strongly influences the level of integration required.

The level of integration, in turn, influences the results that can be achieved. For example, consolidation (e.g., through creation of a shared services infrastructure) is usually required to derive full value from back-office efficiencies. In this case, a joint venture may be appropriate, especially if consolidation requires extensive sharing of resources and/or capital. Lesser value can be obtained from back-office efficiencies if a less consolidated model (e.g., joint purchasing) is used. When the partnership has a narrow scope or focuses only on intangibles such as brand, non-equity partnerships (e.g., alliances) may be appropriate.

Each type of integration involves specific actions. For example, back-office integration often requires IT investments and headcount reductions. In contrast, partnering on clinical programs may entail changes to physician practice and the health systems' cultures but not a large-scale consolidation of resources.

As Exhibit 4 shows, AMC–community health system partnerships can take a variety of forms. The structures vary significantly in their “stickiness”—in general, the tighter the integration, the harder the deal is to unwind. However, as tightness increases, so does the complexity of execution and requirements for execution planning. These activities, if not executed well, can create problems that ultimately reduce the amount of value created.

Note, however, that design choices may be restricted by the AMC's mission, governance and/or ownership structure, or other issues. For example, board or university leadership approval may be required for decisions about how funds can be used.

## Getting it right: Lessons learned

To succeed, AMC–community health system partnerships must overcome many hurdles, not least of which is the need to make the partnership compelling to each side. AMCs should heed eight important lessons if they want these deals to succeed.

**Don't get swept up in a vague vision—define specific sources of value.** Too often, we have seen partners come together around vaguely articulated gains (e.g., the “halo effect” of the academic mission) rather than a clear, quantitative definition of where partnership value will come from. Although co-branding may be an important element of the deal, it is critical that both partners be very specific—and aligned—about how much value they expect to create (for patients as well as themselves), why the value created will be greater than what either side could achieve on its own, and what role each partner will play in creating value. Partnerships that do not do this up front are set for failure.

A realistic appraisal of both sides' strategic advantages can help direct the initial value scoping. Among the questions to ask: Does the AMC bring a physician group or set of specialists with a strong reputation among community providers and patients? Are the community health system's acute care

facilities in favorable demographic geographies? Does the community system provide cost-of-care advantages on a severity-adjusted basis? Does either side have an advantage in care coordination

or patient experience? Does one system have expertise in managing specific asset types (e.g., ambulatory surgery centers)? Exhibit 5 describes other potential advantages that should be explored.

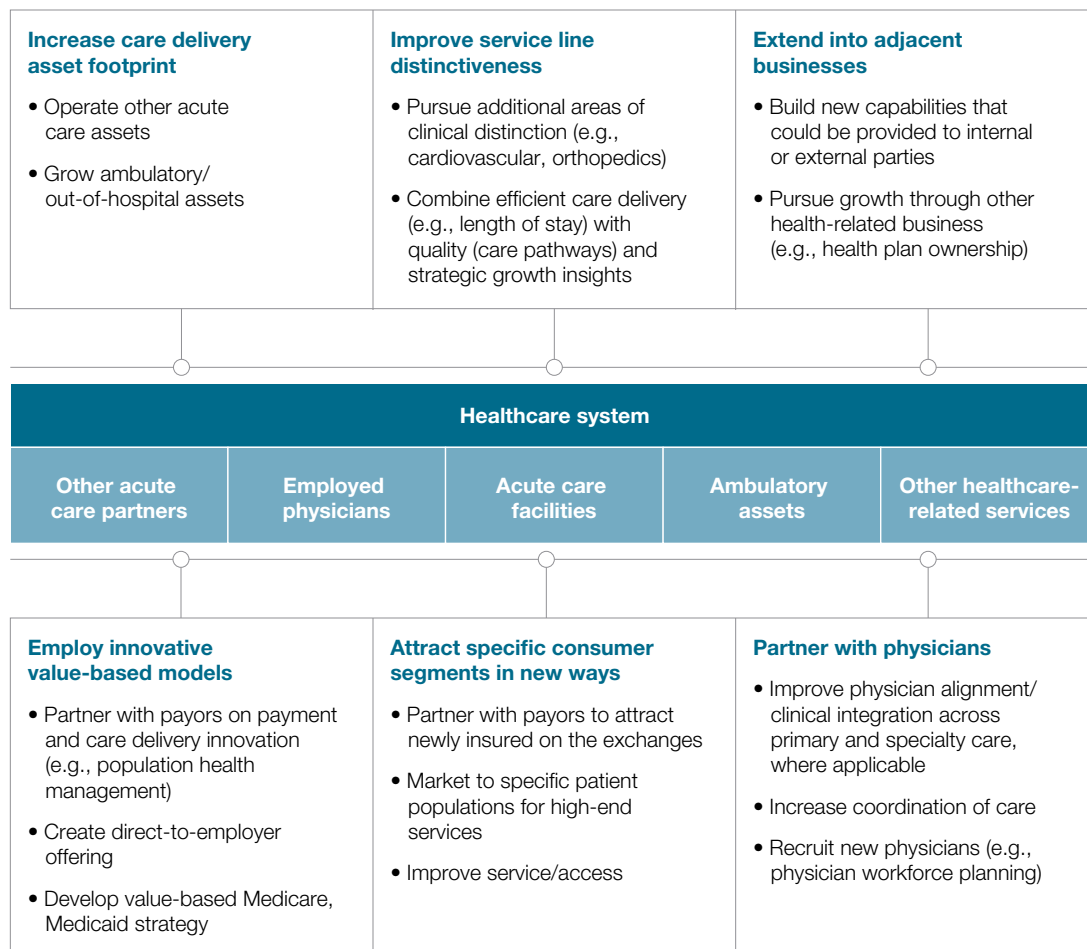
#### EXHIBIT 4 Current AMC partnerships vary widely

	Entity	Scope	Value drivers	Structure
<b>Joint venture</b>	<b>Duke University Health System</b> LifePoint Health	<ul style="list-style-type: none"> <li>Acute care assets in specific geographic markets; initial focus on rural facilities in the Carolinas</li> </ul>	<ul style="list-style-type: none"> <li>Access to new geographies and customer segments</li> <li>Administrative and purchasing scale</li> <li>Attractiveness of network to payors</li> <li>Capital efficiency</li> </ul>	<ul style="list-style-type: none"> <li>Joint venture that acquires or partners (under other structures) with community acute care facilities</li> </ul>
<b>Minority stake with operating alliance</b>	<b>University of Michigan Health System (UMHS)</b> MidMichigan Health	<ul style="list-style-type: none"> <li>Acute care assets in specific geographic markets</li> <li>Capabilities (e.g., clinical data analysis, telemedicine)</li> </ul>	<ul style="list-style-type: none"> <li>Access to new geographies</li> <li>Capital efficiency</li> </ul>	<ul style="list-style-type: none"> <li>UMHS owns minority stake (less than 1%, with opportunity to buy up to 20%)</li> </ul>
<b>Non-equity alliance</b>	<b>MD Anderson Cancer Network Certified Member Program<sup>1</sup></b>	<ul style="list-style-type: none"> <li>Clinical programs (oncology)</li> </ul>	<ul style="list-style-type: none"> <li>Access to new geographies and customer segments</li> <li>Attractiveness of network to payors</li> <li>New capabilities for core business</li> </ul>	<ul style="list-style-type: none"> <li>Fee for services and selective use of brand</li> </ul>
	<b>Cleveland Clinic</b> MedStar Health	<ul style="list-style-type: none"> <li>Clinical programs (cardiovascular)</li> <li>Capabilities (e.g., clinical protocols)</li> <li>Non-core business expansion (e.g., devices)</li> </ul>	<ul style="list-style-type: none"> <li>Access to new geographies and customer segments</li> <li>Attractiveness of network to payors</li> <li>Capital efficiency</li> <li>Non-core business expansion</li> </ul>	<ul style="list-style-type: none"> <li>Clinical innovation “alliance” with fee to Cleveland Clinic for clinical and management services, and shared research infrastructure</li> </ul>
<b>Contractual alliance</b>	<b>University of Louisville Hospital (ULH)</b> KentuckyOne Health	<ul style="list-style-type: none"> <li>University medical center</li> <li>Combined medical staff of 3,000 physicians</li> </ul>	<ul style="list-style-type: none"> <li>Access to AMC faculty resources</li> <li>\$50 million economies of scale</li> <li>Investing \$1.4 billion over 20 years in teaching/research</li> </ul>	<ul style="list-style-type: none"> <li>Joint operating agreement</li> <li>KentuckyOne manages all hospital operations</li> <li>ULH keeps ownership of assets and management</li> </ul>

<sup>1</sup>Through this program, Anderson partners with community hospitals across the country.

Source: Organization websites, news search

**EXHIBIT 5 A range of strategies can be uniquely enabled by partnership**



Source: McKinsey Healthcare Systems and Services Practice

Articulating the value each side can contribute helps inform the types of initiatives that could be enabled by the partnership. For example, service line-focused strategies can be successful when one partner has specialists or other elements of program distinctiveness that could benefit the other, the two sides' geographic footprints are complementary, and they could both draw volume share from a common competitor. Co-investment in the distinctive

program could create significant combined value with lower risk and capital requirements for each side.<sup>7</sup>

*It's not just about value—can you work together?* Often, partner selection happens opportunistically because of the competitive dynamics in a particular market. If these deals are to succeed, leaders on both sides need a deep understanding of the range of stakeholders who will have to be involved

<sup>7</sup>This approach can be used not only with distinctive programs but also with distinctive assets, such as infusion centers.



and whether these stakeholders have a common commitment to working together to achieve the value at stake.

Partnerships involving AMCs typically require the input and effort of individuals from

the health system, university, and school of medicine (including key faculty). The structural relationships among these stakeholders, their incentives, and their decision rights vary from AMC to AMC. Similarly, the relationship between these stakeholders

## The case for AMC–community system partnerships

Several trends are putting pressure on AMCs to increase clinical margins so they can cross-subsidize their education and research activities.

- **Service-level margin decreases.** Top-line pressures are mounting as public and private payors limit reimbursement growth and supplemental hospital funding (e.g., disproportionate share payments). However, AMCs have less flexibility in managing costs than community competitors typically do. For example, they must maintain a broad set of training programs, and their clinical staff contains a much higher proportion of specialists.<sup>1</sup> Because of the specialty-heavy staffing, labor costs are typically much higher at AMCs than at community health systems.
- **Network pressures.** An AMC's higher-cost infrastructure usually places it at a cost-of-care disadvantage compared with its non-teaching/research competitors. McKinsey's proprietary database of exchange filings through 2015 shows that more than one-third of the lowest-priced silver plans excluded AMCs.
- **Community competition.** Many community health systems are expanding their of-

ferings and creating new access points so they can compete for higher-acuity patients. HCA, for example, added about 20 trauma centers to its system within a three-year period.<sup>2</sup> These moves further threaten the traditional AMC referral base (they do, however, give physicians and consumers greater choice of where to seek care). At the same time, many AMCs are feeling pressured to diversify their offerings so they can attract lower-acuity patients (e.g., by developing population health management capabilities).<sup>3</sup>

- **Declining funding for education and research.** In 2014, the number of NIH grants declined by 24% from the previous year; per-grant allocations were 13% lower than they had been in 2011.<sup>4</sup> The nearly \$15 billion of public spending for graduate medical education is also under review—a recent Institute of Medicine panel recommended that new allocation methods be considered, which has caused significant concern in the AMC community.<sup>5</sup>

These trends have created a number of strategic imperatives for AMCs (e.g., clinical volume growth, cost containment, patient experience improvement, and capability building). Many

<sup>1</sup> On average, an AMC's clinical faculty (excluding pediatrics and emergency medicine) includes twice as many specialists as family or internal medicine providers. (American Association of Medical Schools. US medical school faculty. 2013. [aamc.org/data/facultyroster/reports/367218/usmsf13.html](http://aamc.org/data/facultyroster/reports/367218/usmsf13.html)).

<sup>2</sup> Galewitz P. Boom in trauma centers can help save lives, but at what price? *Kaiser Health News*. September 2012.

<sup>3</sup> Association of American Medical Colleges. *Advancing the Academic Health System for the Future*. March 2014.

<sup>4</sup> National Institutes of Health. Funding Facts. [report.nih.gov/fundingfacts/fundingfacts.aspx](http://report.nih.gov/fundingfacts/fundingfacts.aspx).

<sup>5</sup> Institute of Medicine. *Graduate Medical Education That Meets the Nation's Health Needs*. June 29, 2014.

and the local community varies. Mapping these stakeholder relationships carefully helps ensure that plans are developed early to mitigate potential problems. For example, it may be important to address the implications of reputation concerns, “town–gown”

perceptions between physician groups, or a department-specific history of competition.

Many organizations fail to proactively diagnose and manage cultural differences in the mistaken belief that such differences

AMCs think that scale can help them address these imperatives and remain competitive. However, any AMC contemplating a scale strategy must ask itself: Can the benefits it is seeking to attain through scale best be achieved through organic growth (solo action) or inorganic growth (a structural arrangement of some sort with another health system)? And if a structural arrangement is preferable, what sort of arrangement should it be?

The choice between M&A and other forms of structural partnership is highly dependent on local market characteristics and the specific goal(s) both sides want to pursue. Partnerships typically provide greater flexibility—they permit the AMCs to maintain existing governance and ownership structures, and they shield community health systems from the full financial burden of an academic enterprise. An AMC, for example, may be owned by a public entity and/or have funds flow arrangements with a medical school or broader university. Specific decision rights (e.g., investment capital) may be held outside the core AMC entity. Although the governance and ownership structures can help support the AMC’s tripartite mission, they often limit the feasibility of full integration with a community

health system. Furthermore, the complexity of these structures and the restrictions they impose often make full integration less desirable for the community health system, which may fear constraints on its ability to make decisions and execute plans. Differences in governance and ownership structures can more easily be managed in a partnership than in an M&A deal. Both sides can take proactive steps to ensure that the arrangement conforms to, but also maximizes flexibility within, the AMC’s requirements.

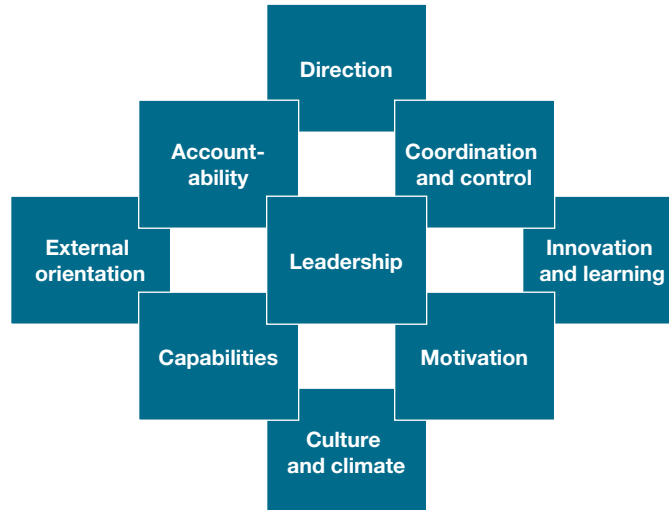
Partnerships also allow both organizations to maintain autonomy in many areas. For example, an AMC’s teaching and research missions are not necessarily consistent with the focus of a community health system. A partnership, unlike M&A, requires both systems to pursue only those strategic opportunities and related value drivers that are consistent with the partnership’s goals (e.g., growth in a specific clinical program). Both systems retain flexibility to pursue other initiatives as long as those initiatives do not conflict with the partnership goals. Partnerships also give both sides the ability to change or add partnerships over time as their strategic imperatives evolve in response to market uncertainties.

cannot be quantified or tactically addressed. McKinsey's Organizational Health Index (OHI) has helped a wide range of potential partners identify cultural differences with a level of detail that enables corrective

action (Exhibit 6). For example, the OHI might flag the fact that the potential partners have different leadership styles and decision-making approaches. The partnership can be structured to account for

## EXHIBIT 6 Organizational practices can be compared across partners

### Outcomes



### Practices

#### Leadership

- Authoritative leadership
- Consultative leadership
- Supportive leadership
- Challenging leadership

#### Direction

- Shared vision
- Strategic clarity
- Employee involvement

#### Culture and climate

- Open and trusting
- Internally competitive
- Operationally disciplined
- Creative and entrepreneurial

#### Accountability

- Role clarity
- Performance contracts
- Consequence management
- Personal ownership

#### Coordination and control

- People performance review
- Operational management
- Financial management
- Professional standards
- Risk management

#### Capability

- Talent acquisition
- Talent development
- Process-based capabilities
- Outsourced expertise

#### Motivation

- Meaningful values
- Inspirational leaders
- Career opportunities
- Financial incentives
- Rewards and recognition

#### External orientation

- Customer focus
- Competitive insights
- Business partnerships
- Government and community relations

#### Innovation and learning

- Top-down innovation
- Bottom-up innovation
- Knowledge sharing
- Capture of external ideas

these differences, reducing the risk that critical decisions cannot be made.

**Ensure that clinical leaders are engaged early on.** Many failed partnerships could have been saved had clinical leaders been involved, and core clinical issues prioritized, early in the process. Too often, the “business” aspects of the deal overshadow such critical elements as clinical integration, physician engagement, and clinical governance. When these elements are left until late, the employed and aligned physicians on both sides often distrust the agreement, which can poison the partnership.

Physician buy-in is crucial because partnerships often involve significant governance changes that affect care delivery. For example, the partners may agree to establish a unified governance structure for both sides or combined clinical councils for specific service lines. Thus, from the initial stages of negotiation onward, both the AMC and community health system should:

- Make it clear that they respect their physicians and the relationships those physicians have with their patients.
- Communicate early and often with all of the physicians who will be part of, or affected by, the partnership—employed, affiliated, and important independent physicians, as well as physician administrators. These physicians should be given a clear explanation of the partnership’s goals and kept informed as negotiations proceed.
- Make certain that physicians are involved in the deal’s design early on. Some physicians, for example, could be asked to

serve on committees making design recommendations/decisions or to give targeted input to those committees. Service line chiefs should have the chance to comment on a range of design decisions.

**Start with a simple set of value drivers and build from there.** A partnership can offer multiple strategic advantages, but stretching its scope to encompass them all can lead to an overly complex set of requirements that exceed both sides’ capacity for change. Instead, the partners should focus at first on a finite set of goals that can be achieved within roughly six to twelve months, yield sufficient benefits to demonstrate the partnership’s value, and allow for further expansion. For example, the partners could consider integrating one service line before expanding to others, or jointly negotiating key contracts (e.g., narrow networks). This approach allows the partnership to undergo an initial proof of concept. Furthermore, early successes can build momentum and help change the minds of stakeholders in each organization who were not initially enthusiastic about the deal.

Plans for expansion should take the complexities associated with increasing levels of integration into account. Each side must have a clear definition of how the new strategies will create value above the added costs required to manage complexity.

**Details matter—develop compelling financial terms.** A number of initial terms must be articulated carefully. In addition to the partnership’s goals, scope, and structure, the terms should cover how resources will be committed to the partnership and how any value created will be divided. The terms

should be built around the primary value drivers each side is pursuing and the overall value expected to be created. They should also detail the level of resource commitment from both sides and what those commitments should translate to in terms of “ownership” of future value. For example, if the deal calls for one partner to buy an equity stake in the ambulatory assets of the other partner, the two sides would have to agree on a valuation that would translate the initial investment into a stake in the assets’ cash flows. The go-forward cadence of profit distribution would also need to be articulated.

*Breaking up is hard to do—but in some cases may be necessary.* Even a handful of potential partnership conversations can create expectations and a sense of momentum that is hard to break. As the two sides are developing the partnership’s terms, they need to carefully consider what each of them can do outside of the partnership (e.g., compete in certain geographies), how long the partnership contract will last, and what exit terms should be included. Often, during the early stages of a partnership, organizations are reluctant to consider how they would dissolve the arrangement if it were to become necessary. Articulating an exit strategy that permits each side to minimize potential future losses can ensure that if one or both partners chose to walk away, both sides would be protected. Although these terms need to be spelled out, they should be flexible enough to permit for changes in the partnership over time.

If the two sides cannot reach agreement on any of these principles, it may be better for them to walk away. Given the range of

management priorities system leaders must prioritize, walking away is often wiser than struggling to consummate a partnership that will require significant management time and energy without a clear path for delivering value.

*Design a robust governance model.* All partnerships need a governance model to ensure that leadership remains actively engaged in direction-setting and performance. The partners should establish a regular meeting cadence for their governance and operational committees, agree on the scope of decision rights that will reside with each committee, and install a robust performance management system that includes agreed-upon implementation deadlines and outcome-based performance metrics for each major value driver.

Beyond the governance and operational committees, the organizational structure can vary significantly depending on which partnership structure is being pursued. For a joint venture that involves development of a new entity, for example, the partners may need to create a new organization with a dedicated board, management team, and framework for how the joint venture will interact with the parent organizations. The complexity and breadth of this organizational design is significantly greater than that required for a clinical programs-focused partnership; in this case, a clinical and administrative leadership structure can be overlaid on the existing organizational structures of each partner. McKinsey’s Organization Practice has a wide assortment of tools that can help potential partners determine the optimal organizational structure.

Create sustainable economics and funds flows for both parties. While the specific financial terms for value creation need to be compelling for both sides, it is also important that the overall economics be sustainable for both parties. Many AMCs use funds flows to support their tripartite mission, and some of the value created through the partnership can be directed toward this goal. However, we have encountered numerous examples of academic departments that used a potential partnership as an opportunity to ask for very high levels of support—this disconnect between financial ties and overall value creation can kill a partnership. Thus, the economic commitments made by

both partners must be realistic and reflect overall value accrual.



As pressure on the healthcare industry intensifies, non-M&A partnerships may become increasingly attractive to academic and community health systems alike. By carefully selecting a partner, developing a robust structure and mutually beneficial terms, and engaging with key stakeholder groups, both sides can partner to provide better care and experience to patients and significantly improve their strategic position for years to come. ○

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