



## **Reclaiming the Narrative on Who Provides Healthcare AMGA Virtual Executive Roundtable Summary**

*August 26, 2026*

The AMGA Hospital & Health System Advisory Committee convened physician executives and health system leaders to discuss how to reposition the physician enterprise as the front door to the system and a strategic asset rather than a cost center. The session was led by Dr. Ashok Rai, president and CEO of Prevea Health, drawing on AMGA Consulting's white paper, [\*The True Value of a Medical Group in an Integrated Health System\*](#). Structured as an open dialogue rather than a formal presentation, the conversation drew participants from Bronson Healthcare, Cone Health, HCA Healthcare, the University of Rochester Medical Center, and UPMC, who compared how their organizations are shifting investment, governance, and messaging to reflect where care is actually delivered.

### **Key Themes & Takeaways**

#### **1. The 10-to-1 Ratio and the Ambulatory Shift**

- A widely cited industry stat, first surfaced at Epic's user group meeting, holds that roughly ten ambulatory encounters occur for every one hospital-based encounter (ED, imaging, inpatient). Several participants confirmed a similar ratio in their own data.
- Most participants described this less as a new trend than as a heightened focus and greater appreciation for where patient and consumer demand already sits, prompting renewed investment in network and access optimization in the ambulatory setting.
- Despite the shift in where care happens, the public and political narrative still automatically equates "healthcare" with the hospital.

#### **2. From Cost Center to Strategic Asset**

- Multiple organizations are deliberately reframing the medical group's language and identity: One participant moved from referring to the medical group as "the loss" to "the investment," and another made a deliberate leadership decision to shift the dialogue from cost center to strategic asset.
- One leader shared a thesis that future winners will be defined not by hospitals alone, but by an integrated physician and ambulatory enterprise that owns access, aligns providers, and guides patients across the continuum.

#### **3. Capital Investment and Governance Shifting Toward Ambulatory**

- One participating group is establishing its first-ever capital budget separate from the hospitals this year. Another is launching a new enterprise-wide ambulatory operating group on September 1, unifying practice operations, urgent care, and ambulatory surgery under shared-service infrastructure.
- Governance is also moving toward physician leadership: One organization is promoting clinical leaders to "chief" of each of its 11 sections (previously administrators led strategy and budgeting), and another reorganized into true specialty divisions with dyad leadership reporting to a board of chairs with a seat at the C-suite table.
- ROI and capital-planning approaches are evolving beyond a hospital-centric model: for instance, implementing a combined ROI across the faculty practice and hospital margin together, while pro formas separately track impact at the medical group, network, and system level.



#### **4. Matching Ambulatory Growth with Downstream Capacity**

- Participants cautioned that physician and ambulatory growth can outpace the system's ability to absorb the resulting downstream volume. One organization is currently running at 110% ED capacity with boarders, and most physicians there are booked a month to six weeks out.
- A participant described investing roughly \$250 million in physician infrastructure over 17 years and eventually finding its ORs, ASC, and hospital all full—prompting a new \$280 million tower and closer, more proactive coordination between physician-side growth and hospital-side capacity planning.
- Some systems are managing overflow by routing patients to affiliated or partner facilities rather than building all downstream capacity themselves—one actively transfers patients to its affiliate hospitals, and another partnered with LifePoint to open a new rehab hospital as a release valve.

#### **5. Evolving Leadership Structures**

- Several organizations are creating or elevating C-suite roles to reflect the growing physician and ambulatory enterprise: Changes include adding a cabinet-level Chief Physician Executive, creating a Chief Clinical Officer role with broader ambulatory purview, and adding a Chief Advanced Practice Officer.
- Upcoming retirements at some organizations are creating natural opportunities to rethink and reshape leadership structures around the physician enterprise.

#### **6. Reclaiming the Narrative**

- Participants agreed the physician enterprise is the true front door to healthcare, but that public narrative, hospital-centric quality rankings (e.g., “best hospitals” lists), and advocacy funding still center on the hospital.
- Ideas raised included pushing public rankings to recognize medical groups and physicians directly, not just hospitals; better aggregating the physician voice nationally to match hospitals' organizing scale; and partnering with specialty societies to build a unified advocacy message—while being careful not to let any such effort evolve into a bargaining organization.
- An unresolved challenge: Hospital-level quality awards and recognition still accrue to “the building,” even when physicians and APPs are responsible for the outcomes being recognized, and no participant had a model for folding that recognition back to the physician enterprise.

#### **Overall Conclusion**

Reclaiming the narrative on who provides healthcare is as much an internal culture and governance shift as it is an external messaging challenge. Across the participants, the same pattern emerged: Capital, governance, and leadership structures are gradually moving to reflect the reality that the large majority of care—and the growth opportunity—sits in the ambulatory, physician-led enterprise, not the hospital.

That shift requires deliberate language changes (cost center to strategic asset), new budget and reporting structures, and closer coordination so that ambulatory growth doesn't outpace downstream capacity.

Participants agreed the harder, unresolved problem is external: Public rankings, quality recognition, and legislative advocacy remain built around the hospital as the unit of account. There was strong interest in AMGA playing a larger role in aggregating physician voice nationally and partnering with specialty societies to shift that narrative, while being careful not to become a bargaining organization in the process.

*This summary was prepared with AI assistance and reviewed by AMGA staff.*