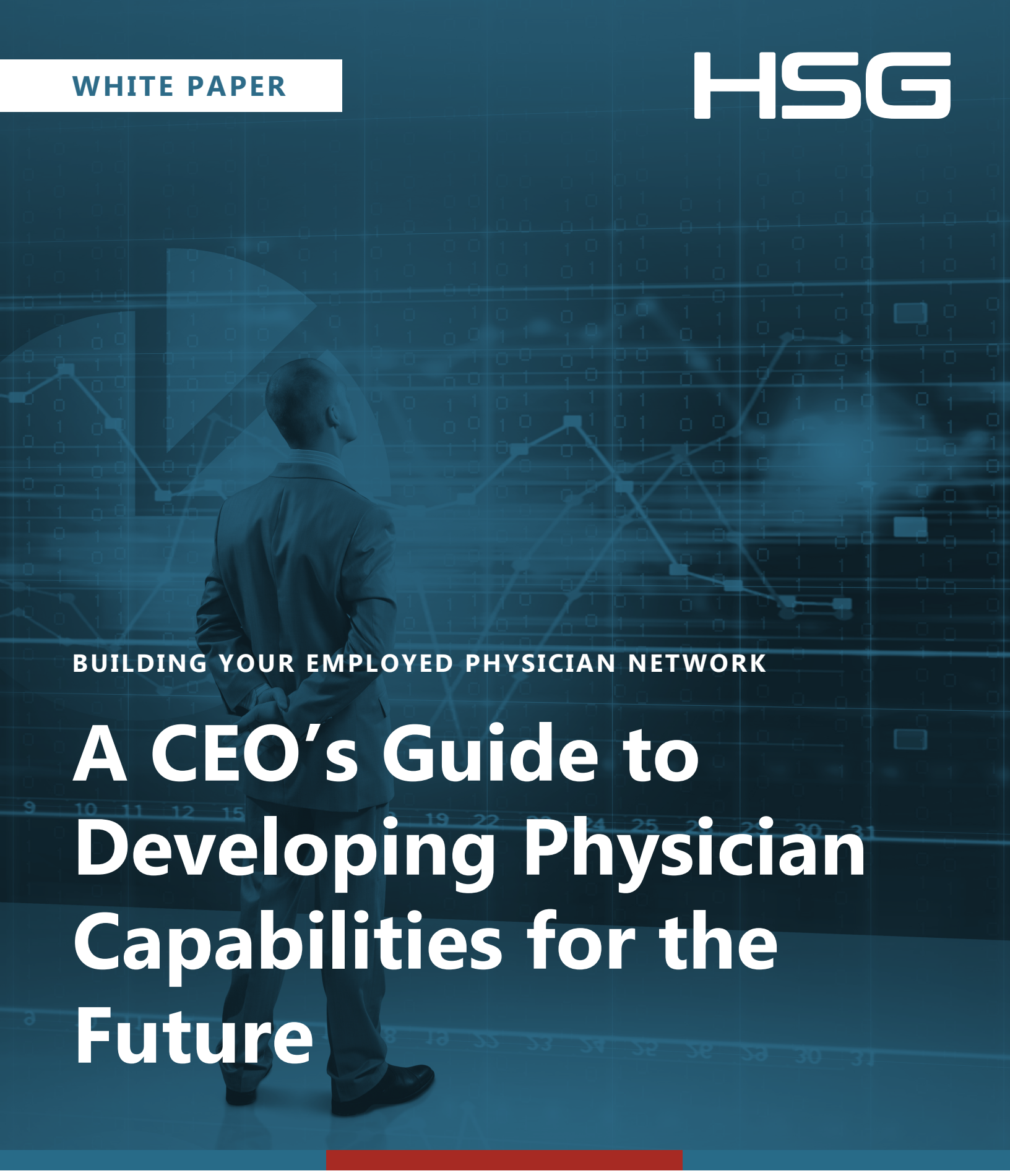
WHITE PAPER

HSG



BUILDING YOUR EMPLOYED PHYSICIAN NETWORK

A CEO's Guide to Developing Physician Capabilities for the Future

NOVEMBER 2020

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HSG builds high-performing physician networks so health systems can address complex changes with confidence.

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Words from the Team

Dear Colleague:

This whitepaper was created to help executive leaders understand the crucial importance of their employed physicians. While education and journals within the industry remain hospital-centric and even efforts to integrate care (such as CINs) focus on the broader medical staff, our view is that your employed physician network will be the core of your future success. The common denominator for all great health systems will be a high-performing employed network of physicians.

This document will help you understand why building a great employed physician group is critical. It will also help you understand how to do it. And if you are skeptical about this focus, it will help you understand the risks of not prioritizing development of a strong employed network.

We know you will gain insights as your organization charts and implements its strategy. And if you need an outside perspective, HSG can partner with you to assess the strategic and operational performance of your network.

We hope you find this information useful and look forward to your feedback.

Sincerely,

Travis **Ansel**

Terry **McWilliams**

David **Miller**

Your employed physician network will be the core of your future success.

Summary

Your employed physicians are your most important asset. In the evolving healthcare environment, your employed network will be the core of your health system. This document is The CEO Guide to strengthening that core.

The central nature of your employed physician network seems a stretch to many health system executives. In the current mindset, a tertiary hospital is likely the crown jewel of your system, both in terms of brand and profitability. It is the most visible system element. It is the cash cow that facilitates your growth strategy.

For many, employment of physicians has been a defensive strategy designed to protect volume. Health systems have employed doctors when:

- Private practices have floundered
- New recruits required employment
- Coverage of the ED and hospital consultations were not supported by private practices
- A doctor in a strategically critical service line was at risk, or
- A competitor showed interest in a valuable physician or practice

However, the current strategic rationale for employment is changing. **We see this driven by four major factors:**

Growing Accountability for Outcomes – Many payers are committed to the proposition that your health system should not be profitable if it cannot deliver predictable, favorable outcomes, whether related to quality, cost or access. Payers are even competing with you; providing more services such as access via virtual networks or in-store clinics. You will not be able to deliver the desired outcomes without engaged physicians shaping care processes and defining best practices.

Patient Expectations are Driving Care Redesign – Patients expect access on their own terms. Patient access applies equally to physician and hospital services, but the physician office is the tip of the spear. If your health system cannot marshal the resources to make access patient friendly, you are fundamentally at risk. That reality is leading to growth in virtual care, increased use of APPs, and expanded geographic distribution of access points. It is also sharpening the focus on tightly aligning with physicians via employment.

The Shift from Inpatient to Outpatient – We rarely encounter a client with less than 50% of their revenue derived from outpatient services. Nationally, the average is above 55%. Securing provider referral streams for these outpatient services has never been more important. As providers become less reliant on and less naturally aligned with hospital inpatient capabilities, an engaged employed provider network is critical to retaining outpatient volume.

Competition from Private Physicians – Whether profiting from surgeries they perform or profiting from care managed under capitated/risk relationships, doctors are trying to take profit streams that have historically been controlled by hospitals and health systems. We see primary care physicians increasing their income through direct primary care relationships or Medicare Advantage risk contracts. Ditto investment in ancillary delivery models owned by specialists. All of these efforts make private physicians less reliable partners.

Looking down the road to 2030 or 2035, what is your vision for your health system and its employed physician network? We know it must include:

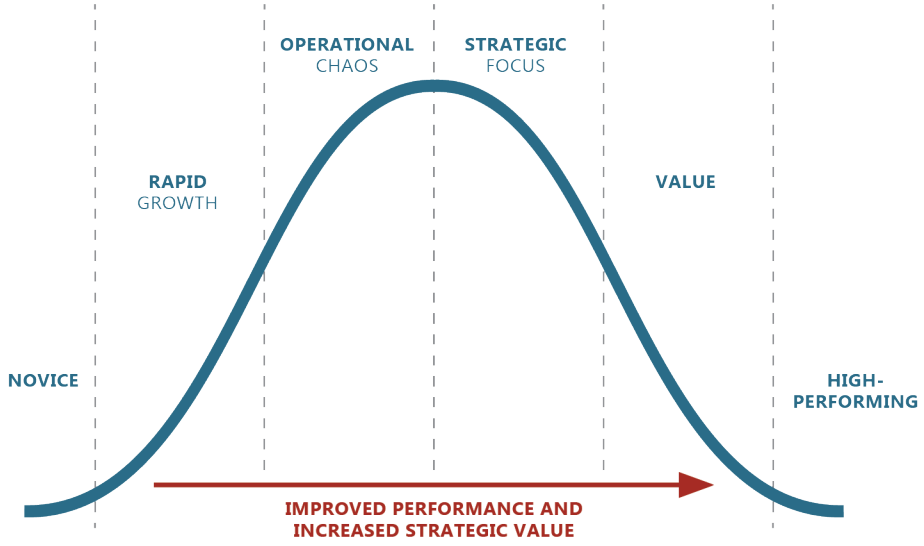
- A more robust and strategic physician employment strategy
- A physician base that you partner with to create a roadmap for the future
- A physician base that you partner with to deliver value
- Data that helps you understand care processes and their effectiveness
- A physician enterprise that is financially sustainable
- A physician enterprise that is a brand asset
- Greater accountability to payers and patients
- A fundamental rethinking of your organizational structure and building the management infrastructure to succeed
- A physician group that evolves to meet the challenges of that market

Resource prioritization will need to change to make this happen. The senior executives engaged in leadership of your system will change, both in titles and in capabilities. Physician leaders will continue to grow in importance and number. Capital resources will be allocated to create differentiated access points and clinical strengths. Marketing budgets will migrate, slowly, from the hospitals to the physicians who deliver care valued by consumers.

These are bold assertions but let us next talk about the experiences that reinforce this growing reality.

How Employed Networks Evolve

Employed physician networks follow a natural evolution. A key role for management is to accelerate that evolution. Starting as a fledgling physician group (Novice Phase), with little infrastructure and no common culture, networks must grow into a strategic force for the health system. In their ultimate phase, high-performing groups produce reliable quality and cost outcomes and manage risk contracts.



In our book, *Employed Physician Networks: A Guide to Building Strategic Advantage, Value, and Financial Sustainability*, we illustrate that evolution with the HSG Physician Network Growth Phases, as shown above. **The definition of each phase follows:**

NOVICE
The phase when the organization starts employing physicians, generally with limited expertise and management infrastructure.

RAPID GROWTH
When organizations see a substantial growth in the number of employed physicians, driven by economic pressure on doctors in private practice and/or competitive pressures between health systems.

OPERATIONAL CHAOS
The phase characterized by growth outstripping management capabilities, leading to operational problems and mounting losses.

STRATEGIC FOCUS
Phase when the health system begins to see the network as a strategic asset, integrates it with the system strategy, and engages the physicians in that effort.

VALUE
When the group can deliver tangible value for the system, including positive performance on value-based indicators.

HIGH PERFORMING
A multi-specialty group that is performing well, able to produce predictable cost and quality outcomes, and able to manage risk contracts.

Today we see many networks moving to the right side of the curve and entering the fourth phase, Strategic Focus. This is happening as health systems are emerging from operational chaos and are actively working to leverage their investment in the employed network. They are also better integrating the health system strategy with network operations – and vice versa.

Wise health systems are also focused on laying the foundational elements of a high performing group. By definition, that performance requires tight integration of health system vision and employed network execution.

Our book, published by the ACHE's Health Administration Press (HAP), is available on the HAP website and on Amazon. Visit **hsgadvisors.com/hsgs-book/hsg-thought-leadership-book/** for more information on how to order.

Our book, *Employed Physician Networks*, guides readers through the process with many practical tools and tips, making this a great resource as you strive **to build an engaged, high-performing physician network.**

Leadership Implications

Focusing on developing your physician group, rather than solely focusing on developing hospital operations, will have some practical implications for how the organization runs. First among these is the metrics you monitor. Key Performance Indicators (KPIs) and metrics reported to your Board will evolve – as addressed in greater detail in the next section.

The refocus will also change accountabilities for your executive team. While the following list is not exhaustive, it does reflect the changes you will face as a CEO and addresses the major issues that will drive that change. To gain value from your investment in employed physicians, and better integrate them into the health system, your focus on the following will grow:

- **Clinical Decision Making** – Clinical processes which determine outcomes, will be the driver of the work life of your clinical leader. Reducing variation, eliminating waste and redundancies, and building data and clinical decision tools to drive decisions will be the focus.

- **Physician Culture** – As the CEO, you will need to be intentional concerning the physician culture. Building a culture that engages physicians and reinforces their crucial role will command your attention. Building a culture that values internal referrals and reduces leakage will likewise grow in importance.

- **Patient Experience** – Patient experience in the physician network gets little attention from many CEOs. That will need to change as will the breadth of what is managed. How the patients access services, and the ease of access, will command more of your attention. Integration with access throughout the health system (whether the ED, diagnostic services, or virtual service) will be a vexing challenge. Organizations that make patient access clear, easy, and convenient will be rewarded. This may involve a major shift from being provider centric to being patient centric in all care delivery settings.

- **Financial Management** – Today's world of cost centers and revenue centers will be slowly turned upside down as the market evolves. Notably, the hospital is projected to transform from a revenue center to a cost center with outpatient services, including the employed practices, becoming the emerging revenue centers. Most health systems have no experience managing capitation and you will need that capability. Physicians must understand the nuances as well, as they control the levers that can change performance.

- **Focus of Staff Functions** – Functions such as HR, IT, marketing, and accounting often have a distinctly hospital focus, with the employed networks as an appendage. That will need to change. You will need to recruit leaders for those functions who have a broader perspective and who develop corresponding support structures dedicated to and more responsive to the needs of the physician enterprise, which differ greatly from the hospital environment. Your own expectations of these functions will need to evolve with the new reality.

Leadership Implications
continued

- **Payer Relations** – As your health system develops greater capabilities in managing the care continuum, you will want to develop different relationships with payers. Having an executive with the expertise to work with insurers to define mutually beneficial relationships based on outcomes will be crucial. The role will also include working with self-insured employers to do the same. These skill sets and interfaces will help you reap financial rewards from your expanding care management capabilities.

> **... gain value from your investment in employed physicians,** and better integrate them into your health system.

Evolution of Key Performance Indicators (KPIs)

One clear change required when your focus shifts to the employed network is your key performance indicators. We see clients adding the following types of indicators.

- **Network Integrity** – This measure of patient retention and leakage is crucial to most networks. It represents your effectiveness in retaining patients, which has both quality and economic implications. Short term, the revenue impact is the most crucial. Longer term, the ability to retain patients in a tightly managed network, where the physicians are working together to ensure care is coordinated and best practices are used, will have both a quality and cost effect. Our favorite measure of network integrity is Patient Share of Care™. It measures patients who have a relationship with an employed primary care provider and the capture of revenue from that patient's healthcare encounters. Hence, it encompasses patient loyalty, referral management, the array of services offered by the system, and service access in one metric. The indicator is expressed as the percent of patient revenue captured by the health system.

- **Subsidy of the Network** – This measure of losses against relevant internal and external benchmarks is always of interest to boards. It measures the degree to which the health system is underwriting physician network operations and the degree to

which operations are optimized. Justification of the subsidies may reflect preserving access, providing a community service, investing in physicians to support a priority service line, or simply reflect supply and demand that are out of alignment for a particular specialty.

- **Performance on Risk Contracts** – This KPI has two core elements: spending on patient care vs. target (medical loss ratio in insurance terms) and performance on quality indicators that are hurdles to receiving incentives. The measure for the spending is a percentage of the target. This measure will place focus on the total cost of care. At the board level, the metrics for the quality hurdles can be simply yes/no, the quality targets were hit or not. Alternatively, reporting actual achievement versus target on each quality metric can provide a greater level of detail and permit insights into performance improvement successes over time.

- **Patient Access** – The best way to measure access is to establish standards by specialty for how long it takes to get an appointment, and report exceptions. Third next available appointment by appointment type, by provider, and by practice is frequently used to reliably measure patient access, as the next available appointment introduces special cause variation like late/recent cancellations of appointments to the equation.

- **Quality Goals** – Your network should have annual clinical quality improvement goals, often related to your efforts to improve population health or risk contract performance. These goals, such as the number of patients receiving a screening test or a vaccine, should be limited in number but reflect either improved or more comprehensive patient health initiatives.

- **Patient Experience** – Patient surveys remain the best measure of this issue. Many health systems routinely report inpatient satisfaction or ED satisfaction to the board. The performance of the physician practices must also be measured, reported, and actively addressed.

- **Volume** – To the traditional health system measures of admissions, ED visits and surgeries, you will need to add information on your primary care panel sizes or numbers of encounters – total or by type. These metrics highlight volumes at the beginnings of the care process, with associated implications for downstream revenue, or specific areas of focus for the organization, such as numbers of new patients or Medicare Annual Wellness Visits.

- **Physician Manpower** – If you have done your planning correctly, you have defined the number and types of physicians/ APPs needed to serve your community and implement your strategic plan. For the latter, if you have an objective to achieve 45% market share in orthopedics, how does that translate to the numbers and locations of physicians and APPs. A measure of the completeness of your network, the percentage of target numbers for primary care, surgical specialists, medical specialists, and hospital-based specialties, is the best measure.

The issue of KPIs and dashboard is given a more thorough treatment in Chapter 11 of our book, ***Employed Physician Networks: A Guide to Building Strategic Advantage, Value, and Financial Sustainability.***

Taking Action: Assessing your Network

Understanding the performance of your employed physician network, and its placement in the HSG Physician Network Growth Phases, should be your first priority. **HSG's assessment process drives answers to the following twelve questions.**

Leadership and Direction

1. Do you have the appropriate physician leadership structure to drive group success?
2. Do you have a strategy and a clear vision, and is that integrated with the health system strategy?
3. Do you have the management infrastructure needed for success?
4. Have you worked with the physician leadership to intentionally develop the culture needed to build a high performing group?

Quality

5. Do we have a quality improvement plan for the group?
6. Is that quality improvement plan integrated with the health system plan, across the continuum?
7. Is provider compensation aligned with quality goals, as well as financial goals?

Financial

8. Is your network financially sustainable and have you systematically analyzed the opportunities for improvement?
9. Can we collect more revenue on our current volume?
10. Can we reduce expenses on our current volume?
11. Can we produce more volume without increasing providers and staff?
12. Should we cut ties with non-productive providers?

Taking Action:
Building a Shared Vision

A common challenge in employed networks is the reality that the end game has not been identified. Frequently the physicians and the executives of the health system do not have a common understanding of what they are together trying to create. The physicians are not clear about what the health system needs from the group (other than referrals) and the health system leadership does not fully understand the aspirations of the physicians.

In this vacuum, we recommend developing a Shared Vision. The vision statement is a narrative description that articulates how the group will ideally look and function in 5-10 years and is developed jointly between physician and administrative leaders. Our white paper, Building a Shared Vision, provides more details and insights. You may access it on our website at **hsgadvisors.com/white-paper/shared-vision-roadmap/.**

There are 9 core elements your Shared Vision should address.

Taking Action: Building Physician Leadership & Engaged Physicians

As accountability for clinical quality and costs grows, how are you going to be successful without the help of your physicians?" You are not.

Employed physician networks that are functioning well have strong physician leadership from two angles. They have capable physician leaders at the executive level and a Physician Leadership Council (PLC) that can influence and bring along their peers as the vison is implemented.

Dr. McWilliams' article on this topic provides significant details about this important area of focus. The article, *Physician Leadership within Employed Provider Networks*, can be accessed on the HSG website at **hsgadvisors.com/physician-leadership/physician-leadership-within-employed-provider-networks/**.

Taking Action:
Management Infrastructure

Many health systems are building physician enterprises that produce tens of millions of dollars in revenue and yet manage them on a shoestring. Having the right executive resources is critical as your network grows.

HSG encounters a variety of deficiencies with management infrastructure but will focus on four here.

1	**Lack of Dedicated Resources** – Whether related to marketing, HR, IT, quality improvement or other functions, the employed group begs and borrows resources from the hospital or health system – resources that are not dedicated to nor always cognizant of the unique differences between the practice environment and the hospital.
2	**Excessive Span of Control** – With a laser like focus on FTEs, the group is starved for resources and management is spread so thin they cannot achieve operational efficiencies let alone make progress on the strategic agenda.
3	**Gaps in Capabilities of Practice-Level Leadership** – Lack of experience and knowledge at the practice level leads to problems. Mentoring and training at this level will help address this deficiency.
4	**Lack of Standardized Processes Leading to Daily "Fire Fighting"** – Failure to dedicate resources to systematize scheduling, revenue cycle, and other processes creates unnecessary variation and promotes ineffective management.

To explore these areas in greater detail and learn more on this topic, you may download our white paper on this topic, *Management and Infrastructure Development*, at **hsgadvisors.com/white-paper/management-and-infrastructure-development/.**

Taking Action:
Financial Sustainability

Subsidies to employed groups are a continuous challenge. An aggressive and comprehensive approach to evaluating and improving financial sustainability of the employed physician network will produce a great ROI.

Core questions driving the evaluation of financial sustainability were outlined in the "Assessing Your Network" section on page 12 and are expounded upon below.

- **Can we increase collections on existing volume?** This addresses revenue cycle, contracting, coding, fee schedules, payer mix and other related issues.

- **Can we decrease expenses on existing volume?** This question drives consideration of provider mix, practice staffing levels, overhead in the group, provider compensation and economies of scale that can be driven by consolidation.

- **Can we generate more volume with existing providers and staff?** Scheduling practices, referral retention, and patient access are key drivers here. This area also forces you to consider whether cutting providers who cannot meet productivity or service expectations is necessary to achieve future success.

- **Do we have the required organizational capabilities to make these adjustments?** At its core, this is about the infrastructure required to implement and manage change.

A detailed summary of how to address this issue is included in our article published in the January 2020 edition of *MGMA Connection Magazine*. *"Cutting Losses in Hospital-Employed Physician Networks"* can be found at **hsgadvisors.com/articles/cutting-losses-mgma-connection-magazine/.**

> **An aggressive and comprehensive approach to evaluating and improving financial sustainability** of the employed physician network will produce a great ROI.

Taking Action: Clinical Management Data and Information

Most of the information systems we see in client organizations evolved from the hospital environment of care. That is especially true of the single platform EMRs. In these systems, the modules for the ambulatory practice environment vary widely in their effectiveness and ease of use in the office-based practices.

As a result, many employed provider networks experience enormous gaps in management information and report writing capabilities required for efficient operations and data driven decision-making, and in clinical information at the point of care which impairs provider productivity and efficiency. These circumstances create barriers to achieving the vision, enhancing accountability, and improving financial performance.

A plethora of systems are being developed to provide better clinical data to employed networks. The major EMR firms obviously have resources and various modules that attempt to address these needs.

Identifying systems that can produce meaningful management information and focus on driving significant financial improvements is a must. HSG advocates organizations perform quality due diligence when deciding on a system.

Taking Action: Aligning Provider Compensation with Health System Objectives

While engaging physicians in the critical challenges facing the group is crucial, supporting that engagement and alignment through the provider compensation plan is likewise important. Compensation models and associated incentives must reinforce the priorities of the health system. Both the system priorities and the incentives should be expected to evolve as the group progresses through the HSG Physician Network Growth Phases.

Productivity remains central to most compensation plans as an objective, measurable proxy of provider effort and because insurer payment schemes focus reimbursement on piece work in the fee-for-service model. Slowly and inevitably, compensation incentives based on non-productivity measures such as clinical quality, population health, patient experience, operational efficiency, and provider citizenry metrics are being incorporated into plans, as is performance under risk contracts.

Our article, *Physician Compensation Models: Non-Productivity Incentives*, outlines our work with clients on this issue and can be found at **hsgadvisors.com/articles/physician-compensation-models-non-productivity-incentives/.**

Taking Action:
Building the Provider Team

Defining the provider network required to implement your strategic plan is an important factor in success.

To understand the needs, a traditional physician needs analysis, defining the specialties in deficit supply in the market you serve, is a foundational document. However, the numbers alone are not sufficient to drive progress and create success.

To that foundational evaluation, you need to add a strategic physician analysis that addresses such questions as:

1. **What physicians and APPs are needed** to implement your service line priorities?
2. **How many PCPs do you need** to drive volume to your specialists and to your hospitals?
3. **Where should providers be located to improve access?** To drive patient acquisition? To attract the payer mix you need to succeed?
4. **How does your mix of employed providers need to evolve** as the degree of your risk contracting evolves?

Our article published by Becker's Hospital Review provides a more complete list of considerations. That manpower planning article can be found at **beckershospitalreview.com/hospital-physician-relationships/physician-manpower-planning-in-the-era-of-employment-are-you-asking-the-right-questions.html.**

Taking Action:
Building a Risk Contracting Strategy

With fee-for-service rates flat, your clearest path to revenue growth may be to move upstream to take risk and/or displace insurers. **To prepare for this opportunity you need to:**

- Understand the baseline cost performance of your employed PCPs, via assessment by an actuarial firm or experimentation with one-sided risk contracting. Medicare Advantage plans provide a great opportunity in many markets to participate in one-sided risk arrangements.

- Understand your cost performance vs. your competitors.

- Work with your PCPs to develop a plan to better manage care, including:

    - Redesigning care delivery processes within the practices; that approach should consider augmenting practice resources with care coordinators and social workers to address social determinants of health

    - Adjusting provider compensation models to align incentives

    - Identifying information needed by the physicians to manage care

- Evaluate the impediments to performance improvement. Those are generally the incentives of service lines or institutes (and associated specialists) within the health system, which have the incentive to drive volume and charges.

- Improve network integrity, which will make specialty cost more predictable and care coordination more manageable.

Employed Physician Network Taking Action Checklist

Your investment in physician employment is significant, but the payback can also be just as significant. As your group matures, and grows in its ability to produce predictable clinical outcomes and costs, that payback should grow. The following are the key actions to ensure that you can build the group your health system needs.

- [ ] Incorporate employed group metrics in the corporate dashboard.
- [ ] Routinely report employed group metrics to the Board
- [ ] Complete a comprehensive assessment of your employed physician network
- [ ] Create a shared vision for the employed network
- [ ] Utilize the shared vision to build a strategic plan, with priority tactics defined
- [ ] Engage group physician leaders in health system leadership
- [ ] Build a Physician Leadership Council to help operationalize the vision, guide strategy implementation, and build the desired culture.
- [ ] Develop a strong management infrastructure that is capable of driving the strategic plan and creating and sustaining positive change.
- [ ] Maintain a focus on financial feasibility and optimum operational performance.
- [ ] Ensure the Board understands financial performance relative to benchmarks.
- [ ] Employ management information systems that provide the needed information and promote accountability.
- [ ] Employ clinical information systems that provide the needed information and promote accountability.
- [ ] Align provider compensation with health system objectives.
- [ ] Build the provider team needed to meet the health system's strategic goals.
- [ ] Systematically accrue the knowledge and capabilities required to manage risk contracts.

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