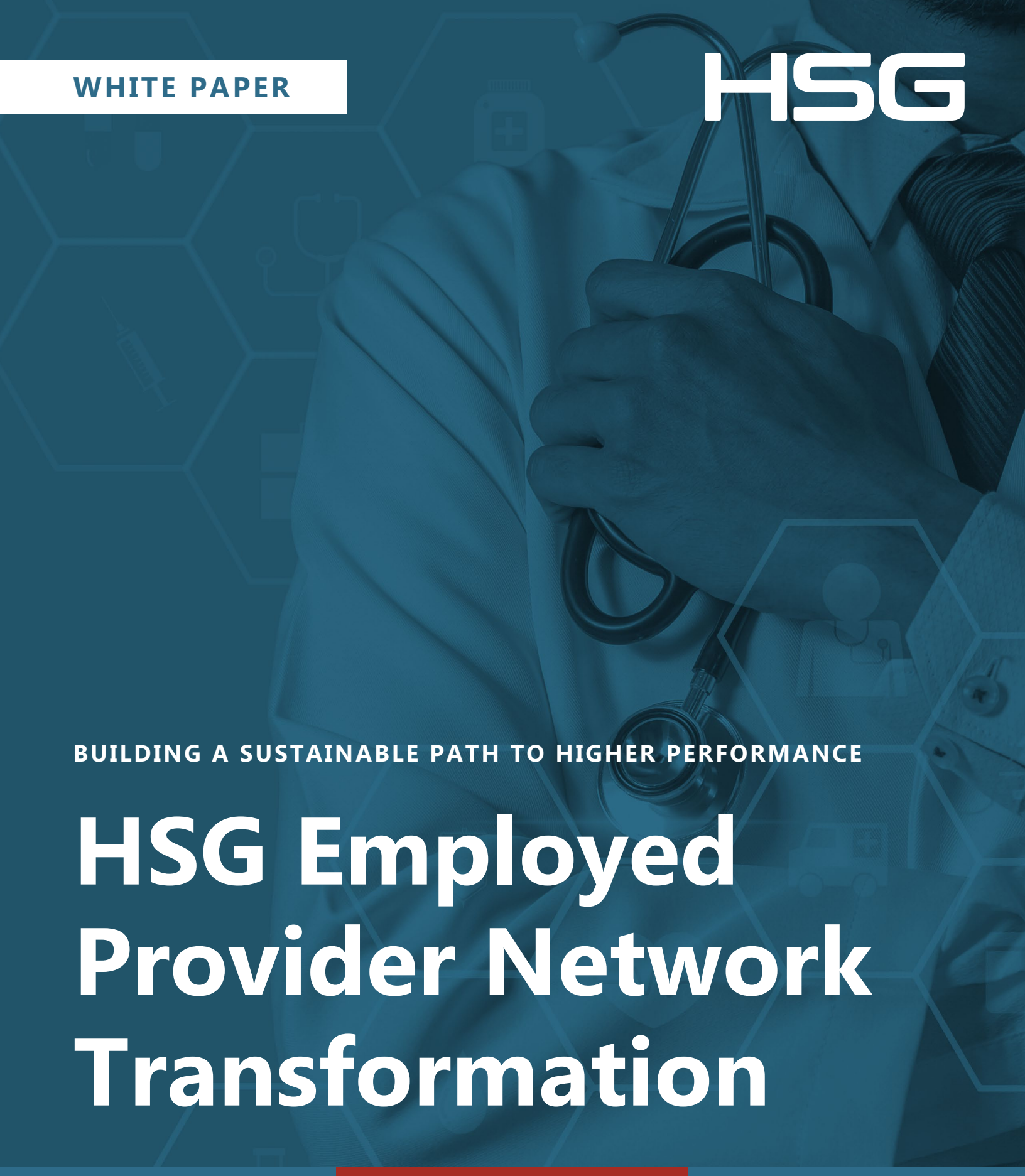
WHITE PAPER



BUILDING A SUSTAINABLE PATH TO HIGHER PERFORMANCE

HSG Employed Provider Network Transformation

APRIL 2021

About HSG

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

SERVICES

PHYSICIAN STRATEGY
Driving a common strategic focus with engaged physicians.

PHYSICIAN LEADERSHIP
Identifying and engaging strong physician leaders is integral to the network's development and success.

PERFORMANCE IMPROVEMENT
Improving the performance of employed physician networks.

NETWORK INTEGRITY
Leveraging HSG Physician Network Integrity Analytics® to create and monitor patient acquisition and retention strategies.

PHYSICIAN COMPENSATION
Aligning physician compensation with health systems and employed network goals.

CONTACT THE AUTHORS

Travis **Ansel**
Managing Partner

(502) 814-1182
tansel@hsgadvisors.com

Dr. Terry **McWilliams**
Director & Chief Clinical Consultant

(502) 614-4292
tmcwilliams@hsgadvisors.com

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About HSG Employed Provider Network Transformation

Utilizing years of network performance improvement experience, HSG partners with employed provider networks to guide their journey toward higher performance. Regardless of the employed network's maturation state, HSG can apply the illustrated three-phase process to achieve progressively higher performance over a 12-18 month time frame.

Through the Shared Vision process, networks develop a multi-year roadmap through which to steer their course to an ideal future state. The process invariably entails review and potential revision of the organizational structure, including physician and advanced practice provider (APP) leadership, necessary to pilot the ship and the associated management infrastructure required to fully support the trek. Building upon this solid foundation, specific assessments and analyses target areas of opportunity leading to specific action plan development, alignment of efforts, and continual improvement.

The transformation process produces tangibly improved provider and staff satisfaction, enhanced financial performance, and an enriched reputation that translates to greater attraction and retention of patients, providers, and staff.

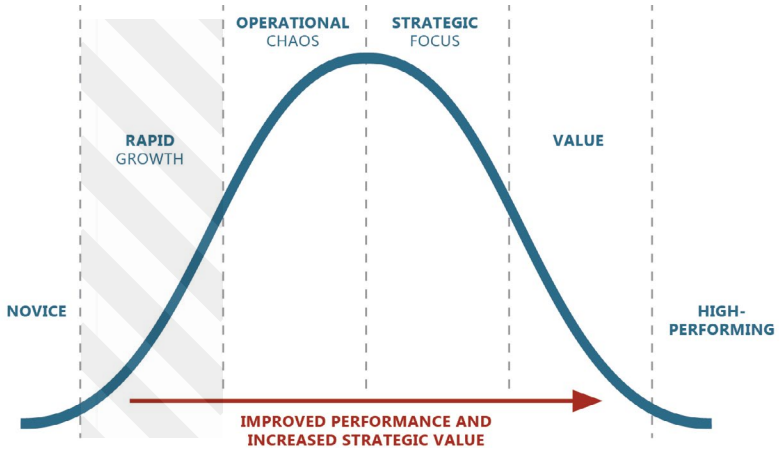
Partner with HSG and make these aspirations a reality. This is how we do it.

HSG Employed Provider Network Growth Phases and High Performance

FIGURE 1

NETWORK GROWTH PHASES EVOLUTION

Figure 1 portrays how health-system owned employed provider networks evolve toward high-performing.



Many health system-owned employed provider networks are still dealing with the challenges caused by Rapid Growth:

- Competition between health systems over limited physician resources, requests from physicians to enter employment, or other external pressures resulted in rapid acquisitions, generating precipitous growth in the number of practices and providers the employed network was/is actively managing.
- The growth in practices and providers far outstripped the management capabilities of the existing employed network management infrastructure, which led to difficulties managing even just the daily "firefighting" associated with practice and network operations.
- Initiatives related to making the group of practices an actual "group" fell by the wayside as operational issues mounted, resulting in operations and culture remaining defined at the practice-level, instead of evolving to the network level.
- Subsidies for the employed network rapidly escalated, causing senior executive and board anxiety, resulting in a deceleration of the group's growth, an insular focus on "getting the finances under control," and a further adverse impact on infrastructure support as under-investment in the group broadens.
- Compensation and incentive structures, which were individually negotiated as the practice/providers were brought into the group, remain wildly divergent from specialty to specialty, or practice to practice within specialties, resulting in additional disconnects in provider behavior.
- Progress for the group becomes measured by "how much are we losing" versus "how much value is the network contributing to the organization" resulting in an expansion of the day-to-day functional mindset and forsaking the capabilities a group must build to generate long-term value for the health system.

Beyond these challenges, one common barrier to evolution is that frequently the "Vision" for an employed physician network is tied to the administrative leader of the group or the system CEO – meaning that the vision changes whenever leadership changes, or worse yet, leadership changes so often that a vision is never set for the group, and simply successfully executing the "day-to-day" – and surviving – becomes the vision. While some networks may see day-to-day operational success as laudable, HSG believes that management executives and their teams must evolve beyond solely tackling day-to-day operational decisions and develop a focused, long-term plan for building the capabilities that will generate success into the future – especially given the crucial role of the employed provider network in executing the health system's strategy.

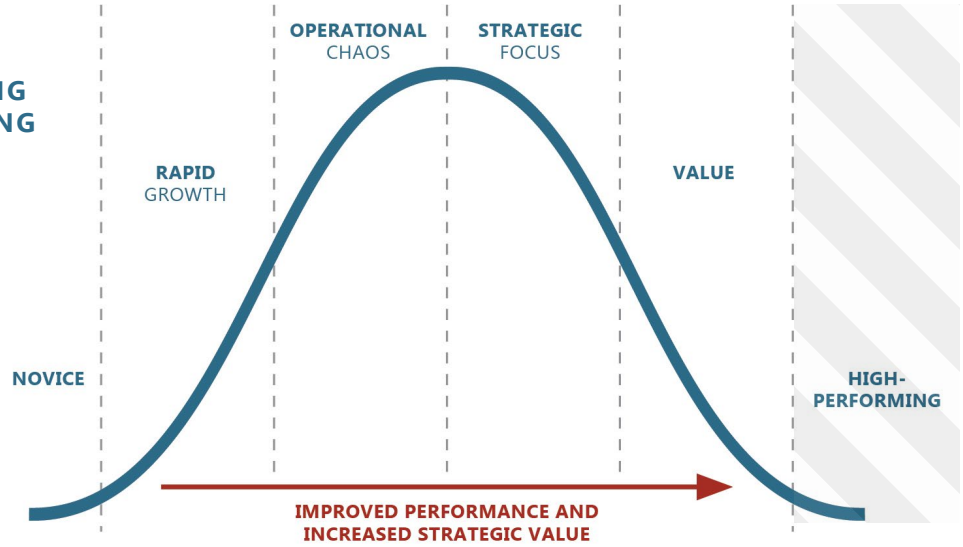
Health systems must embrace the employed provider network's importance to the health system and focus on creating an integrated, multispecialty group adept at delivering the capabilities and patient access the health system needs now and in the future. At its heart, this is foundational to the definition of a High-Performing Provider Network.

> **... focus on creating an integrated, multispecialty group adept at delivering the capabilities and patient access** the health system needs now and in the future.

THE DEMAND TO PURSUE HIGH-PERFORMING STATUS

FIGURE 2

NETWORK GROWTH PHASES HIGHLIGHTING THE HIGH-PERFORMING PHASE



By HSG's definition, at the highest-level, a High-Performing Employed Provider Network (Figure 2) is one that reliably and consistently:

- Embraces a multispecialty group culture that is embedded in both strategic vision and day-to-day operational management
- Fosters an expectation of mutual accountability
- Embodies uniform policies, procedures, and interactional experiences regardless of point of contact
- Produces high-value, predictable results
- Delivers consumer-centric care and service, with a focus on access, engagement, and positive population health outcomes
- Utilizes all providers and support staff at top-of-license and capabilities in a clinically transformed practice model
- Produces predictable, positive outcomes under risk arrangements
- Incentivizes providers with a common compensation philosophy that has specialty-specific variance where warranted, but includes metrics consistent with improving performance expectations
- Integrates robust physician/advanced practice provider and administrative dyad leadership throughout the organizational chart, embodying "provider-led, professionally managed" mantra
- Operationalizes a culture of continuous improvement
- Is financially and operationally sustainable
- Is integrated with health system vision and strategic direction
- Enjoys a recognizable positive brand that is an asset for the network and the health system
- Develops specialized service line capabilities

While this list is not exhaustive nor totally inclusive, the aforementioned traits illustrate functional elements characteristic of networks that attain this level of performance.

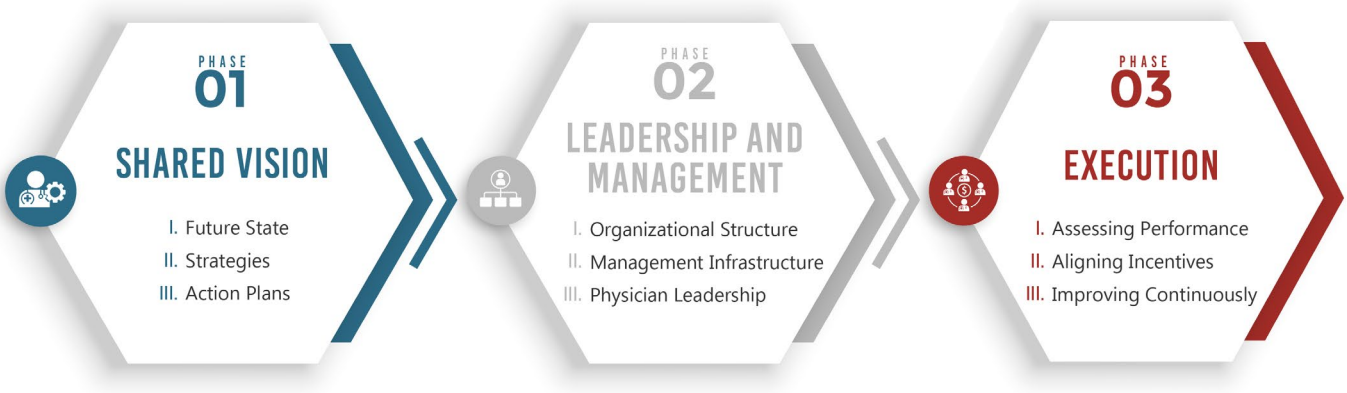
CHALLENGES WITH PURSUING HIGH-PERFORMING STATUS

While most health system leaders and employed providers would agree that pursuing "High Performing" employed network status is a desirable goal, numerous challenges commonly arise on that evolutionary journey.

- An independent provider **culture** that hasn't evolved from a "my practice" or "my service line" mentality since the practices were brought into the network – and which has been reinforced to providers newly recruited into practices with these culturally divisive mindsets.
- An insufficient **investment in management infrastructure**, which strains the limited network resources and results in "daily fire-fighting," mounting frustrations, and staff turnover that feels insurmountable.
- **Incentive structures** that reinforce behaviors that are a part of the past (100% individual productivity) instead of its present or future (evolving non-productivity and team-based incentive models).
- A **physician leadership structure** that is non-existent or not well-utilized or not broadly understood by the employed network or the health system and results in limited effectiveness, mounting frustrations, and potential apathy that precludes moving the group forward and neuters the aspirations of the physician leadership component.
- A **health system leadership culture**, that views the employed provider network as a cost-center, service line, or hospital department as opposed to peer organization and a strategic driver of short-and-long term value.
- **Context.** Perhaps the biggest challenge. What is the imperative to change? What do we/should we change into? With all of the day-to-day challenges – including financial – why invest great effort to shift direction and do something different? And why start today or tomorrow – and how do we start?

Context represents a frequent reason that initiatives to optimize operations or financial performance fails. Especially from a provider perspective, knowing why the initiative is important, why we are doing it now, and what long-term benefit we anticipate it will create sets a context for change and change management. Involving them in the process from the beginning creates engagement that can catalyze the change.

HSG Employed Provider Network Transformation Overview



DEVELOPING A SHARED VISION

Collaboratively defining the Shared Vision of the employed provider network's ideal future state provides the direction and context for how the network will need to evolve to attain that vision. It provides a picture of how the group would look and function in 5-10 years if it develops and matures in an ideal environment. This is the crucial, foundational step toward Employed Provider Network Transformation. Without a defined vision of what the group is working toward, leadership activities end up being focused on the day-to-day; strategy does not progress; capabilities do not progress. Without the Shared Vision, the network lacks a context for change.

OPTIMIZING NETWORK LEADERSHIP AND MANAGEMENT STRUCTURES

Health systems must be willing to elevate the employed network within the health system structure. It cannot be treated as a subservient entity to the hospital(s). Investments in the employed network leadership and management infrastructure must be made proactively with the goal of achieving operational efficiency and a long-term ROI. Employed provider networks must have dedicated leadership and sufficient dedicated support services to execute day-to-day operations as well as develop and execute the strategic capabilities required to fulfill the health system's long-term needs.

The administrative leadership and management infrastructure must incorporate physicians and APPs to maximize effectiveness. The direct input of clinician leaders through dyad leadership structures and Provider Leadership Councils is indispensable to moving the group forward and achieving positive outcomes. These network resources must be guided by the Shared Vision and associated strategies, whose framework provides the context that informs the considerable investments required to transform the network into a higher performing organization.

EXECUTING THE SHARED VISION

The path toward higher performance requires concerted efforts to build upon the foundation laid by the Shared Vision and Optimized Network Leadership and Management Structures. Detailed assessments and analytic action plans related to fulfilling Shared Vision strategies must be pursued and implemented. Mechanisms to achieve tighter alignment and integration within the employed network and with the health system must be explored and realized. Simply identifying and implementing initiatives is not enough. The results of each implementation must be re-assessed and re-analyzed to determine whether the desired results were achieved and how these results might be further improved. The process of improving performance continuously must be embedded in the network culture, processes, and actions.

> **... actively applying continuous improvement processes** will advance the network to progressively higher performance.

Once a strong foundation is created and the path forward is set, performing deeper dives into network function, aligning all facets within the network and health system, and actively applying continuous improvement processes will advance the network to progressively higher performance.

Developing a Shared Vision

Developing a Shared Vision involves three components – defining the network's ideal future state, identifying strategies to achieve that ideal state, and creating and executing specific action plans for selected prioritized potential strategies.

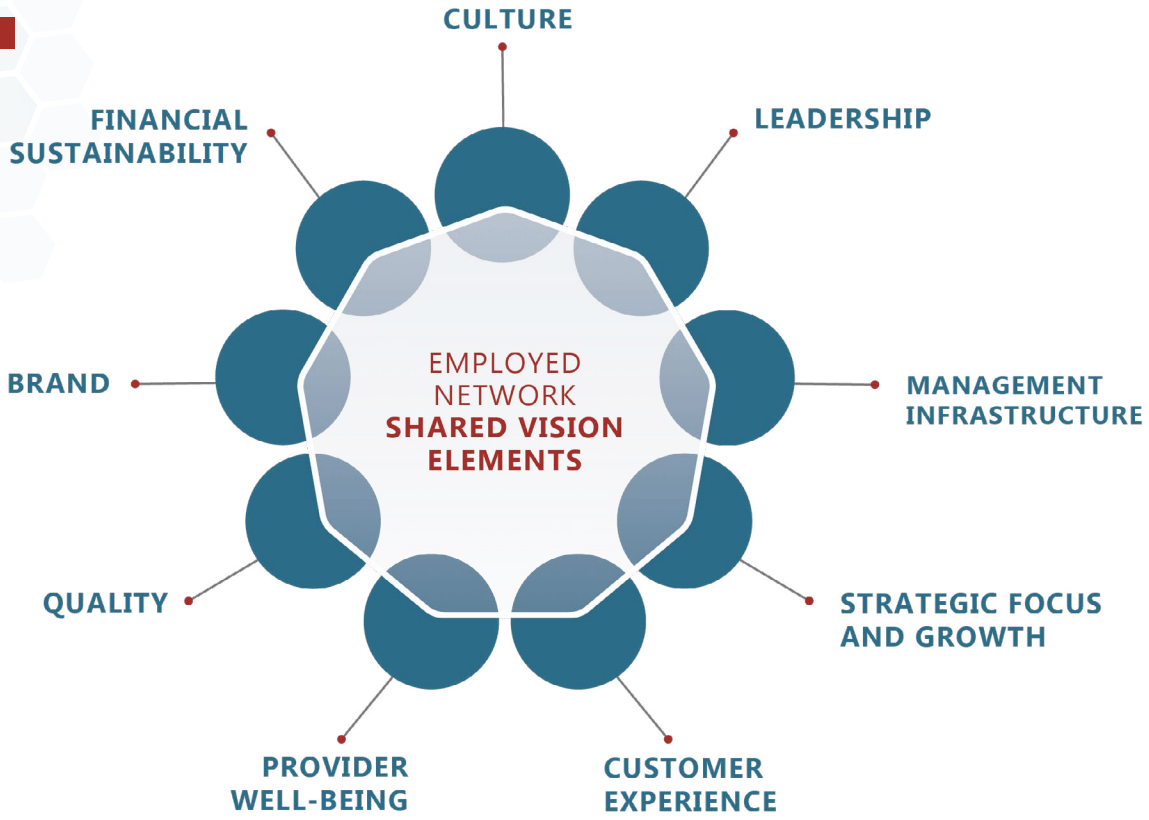
DEFINING A SHARED VISION

Employed provider networks without a defined and clearly conveyed vision of their future course typically find themselves stuck in their progression – regardless of where the network is at the time.

The Shared Vision becomes a beacon that illuminates the future, draws the network together for a common purpose, provides the foundation from which strategies necessary for success arise, and establishes or reaffirms the framework for a common network culture that transcends individual components. The Shared Vision must explicitly define the ideal future state of the employed network and define the roles and mutual accountability for providers, administration, and all staff necessary to achieve that state. The Shared Vision becomes the roadmap that guides the network's journey forward and becomes the context for needed organizational change.

Although every employed network's specific circumstances are unique, common elements tend to emerge as networks contemplate the characteristics required to become a higher performing organization (Figure 3). These elements tend to be interrelated as initiatives in one area often affect and spill over into other areas.

FIGURE 3



CULTURE

This element outlines desirable characteristics for an evolving group culture, how the network will be defined within the health system, and how the network will be defined in the community. The process requires developing common philosophies, uniform policies and procedures across practices, and a universal contracting structure.

LEADERSHIP

This element defines the network organizational structure and the importance of physician leadership within it. This often involves formal positions in the structure for physician leaders – often in a dyadic relationship with administrative leaders – and a provider leadership council.

MANAGEMENT INFRASTRUCTURE

This element ensures that skill sets match the clearly defined roles and responsibilities of operational positions within the organizational structure and that adequate levels of dedicated support services exist to permit efficient, effective, nimble operations. These resources must be progressively developed and expanded as the network grows and matures.

STRATEGIC FOCUS AND GROWTH

This element addresses how the organization will manage strategic initiatives related to the employed network and how it integrates with health system strategy. Factors include strategic expansion and positioning of clinical capabilities in the communities served that maximize access

to care – both with existing and incremental resources defined in a current Health System Medical Staff Development Plan. This element often also includes how the network will evolve its value-based care delivery and population health management capabilities.

CUSTOMER EXPERIENCE

This element includes how the network proposes to interact with all internal and external network customers. Patients are obviously the most important external customer and most organizations adopt the concept of placing the patient at the center of network decision-making processes. This philosophy becomes embedded in the organizational culture and developing mechanisms to measure, monitor, and enhance patient experience and engagement becomes a focus.

PROVIDER WELL-BEING

This element is emerging as a foundational consideration for employed networks and includes developing mechanisms to actively monitor and improve provider and staff wellness – and reduce the risk of "burnout." Points of emphasis include both individual and organizational interventions.

QUALITY

This element establishes or expands a comprehensive network quality plan based on sound performance improvement methodologies. Comprehensive quality in this context involves clinical quality, patient safety, operational efficiency, citizenship, and patient experience. Specialty-specific measures, metrics, and objectives are created, measured, internally reported – and performance improved.

BRAND

This element requires maturation of most of the other elements to create a brand that reliably delivers on its promises in every interaction at every location. The brand reflects a uniform experience among the practices, buoyed by consistent policies and procedures and a consistent look and feel.

FINANCIAL SUSTAINABILITY

This element defines financial sustainability and how it will be monitored and managed. This element invariably addresses a unifying and affordable provider compensation philosophy/ framework and how the network will attract and retain patients.

Once developed, the Shared Vision should guide and inform day-to-day decision-making. It forms the bedrock of shared expectations that determines behavioral norms – and the group's culture. It becomes the basis for strategy development. It ultimately shapes the design of the network – but must be re-evaluated regularly to ensure that it remains pertinent as the network and its environment changes.

Developing a Shared Vision: Developing Potential Strategies to Achieve the Shared Vision

As noted, the Shared Vision document becomes the basis for strategy development within the employed network.

The narrative associated with each Shared Vision element forms the basis for determining how aspects of the element, and the ideal future state it represents, can be achieved. These are the Potential Strategies to achieve the various aspects of each Shared Vision element. Attaining the Shared Vision is a marathon, not a sprint – worked toward over years, not days or weeks – and requires persistent diligence.

The number of Potential Shared Vision Strategies will exceed the network's bandwidth to immediately achieve them. Thus, the Potential Strategies are prioritized for implementation. Initial prioritization places each Potential Strategy into broad time frames – immediate/short term … within the first 6 months; intermediate … the next 6-18 months; and long term … 2 years or more into the future. The Potential Strategies in the immediate/short term category can be further prioritized for action plan development.

IMPLEMENTING ACTION PLANS

Potential Strategies categorized for immediate implementation and execution undergo action plan development. The action plan determines exactly how the network intends to accomplish each of the selected Potential Strategies, including any financial modeling associated with action. Action plan development transforms Potential Strategies into Actual Strategies. Implementing, executing, monitoring, and modifying strategy action plans converts Shared Vision idealism into concrete results and outcomes. This work becomes one of the essential roles for the leadership and management structure.

Further thought leadership provides greater details of various facets of the Shared Vision Phase, including the following:

- **Shared Vision: Roadmap**
  www.hsgadvisors.com/white-paper/shared-vision-roadmap/
- **Shared Vision: Elements**
  www.hsgadvisors.com/physician-leadership/nine-elements-of-an-employed-physician-group-shared-vision/
- **Shared Vision: Intent and Process**
  www.hsgadvisors.com/physician-leadership/employed-provider-network-shared-vision-process-and-intent/

Optimizing Organizational Structure, Management Infrastructure and Network Leadership

With the Shared Vision defined, the next logical step is optimizing the network's organizational structure, management infrastructure, and physician leadership to support execution of the Shared Vision.

ORGANIZATIONAL STRUCTURE

Employed networks vary in the degree of organizational structure design and effectiveness – often, but not always, based on the degree of maturity on the Growth Phases curve.

For instance, the structure that exists in most employed networks characteristic of Operational Chaos is largely a result of piecemeal additions made over time as new practices were added. The origins may date back to initiation as a hospital department that was functionally managed as a new service line – or as outcroppings of hospital-based service lines with added office practice components. Networks such as these often lack centralized management and may have individual practices reporting across multiple executives. Some networks may functionally be unmanaged, with practices largely running as they did when they were acquired. In some cases, the network may be no more than an amalgamation of the still existing corporate structures of the practices who were acquired in the network's early development. Invariably, these networks have not critically nor comprehensively evaluated their organizational structure to ensure maximum effectiveness.

More mature networks may have operations under better control but still may lack "adequate" dedicated support services.

For networks to successfully evolve the capabilities the health system needs, the Organizational Structure must support all aspects of effective operations. Executives in these organizations may perceive the need for change but encounter significant internal barriers to doing so. Barriers may include:

- Disruption to provider/practice autonomy
- Momentum perpetuating status quo
- Lack of context with which to engage providers and senior system leaders
- Ongoing financial challenges
- Lack of leadership structures to effectively engage providers and create change
- Time and effort consumed with fire-fighting in daily operational issues

Investing in resources to implement structural changes often represents a significant barrier for the organizational mentality.

While there is significant variation organization-to-organization in what makes an "ideal" organizational structure, the following tenets tend to guide the optimization of organizational infrastructure in a post-Shared Vision process:

- **Elevate the Employed Provider Network.** The employed network should be a peer of the hospital(s) and other organizational entities within the context of the health system structure. In many health systems, the employed network is subservient to the hospital – leading to the impression within the network of being less important and less well supported. This conceptual shift often represents a significant swing in cultural mindset and operational functional state.

- **Build Dyad Leadership.** Dyad leadership teams consisting of administrative and provider pairs should be utilized throughout the network – from the executive level to the regional/divisional level and the practice level. Infusing physician leadership into the formal organizational structure unifies reporting relationships which further optimizes operations. Individuals placed in these roles may require training, coaching, and mentoring to be an effect team.

- **Align Specialties.** Grouping practices by specialty aligns philosophies and operational approaches, which facilitates management and promotes cohesion. At the simplest level, grouping primary care, medical subspecialties, and surgical specialties in separate divisions is a place to start this thought process.

- **Consider Geography**. In larger networks, grouping like-specialty practices by geographic location/spread allows more efficient utilization of management resources and permits greater onsite management presence.

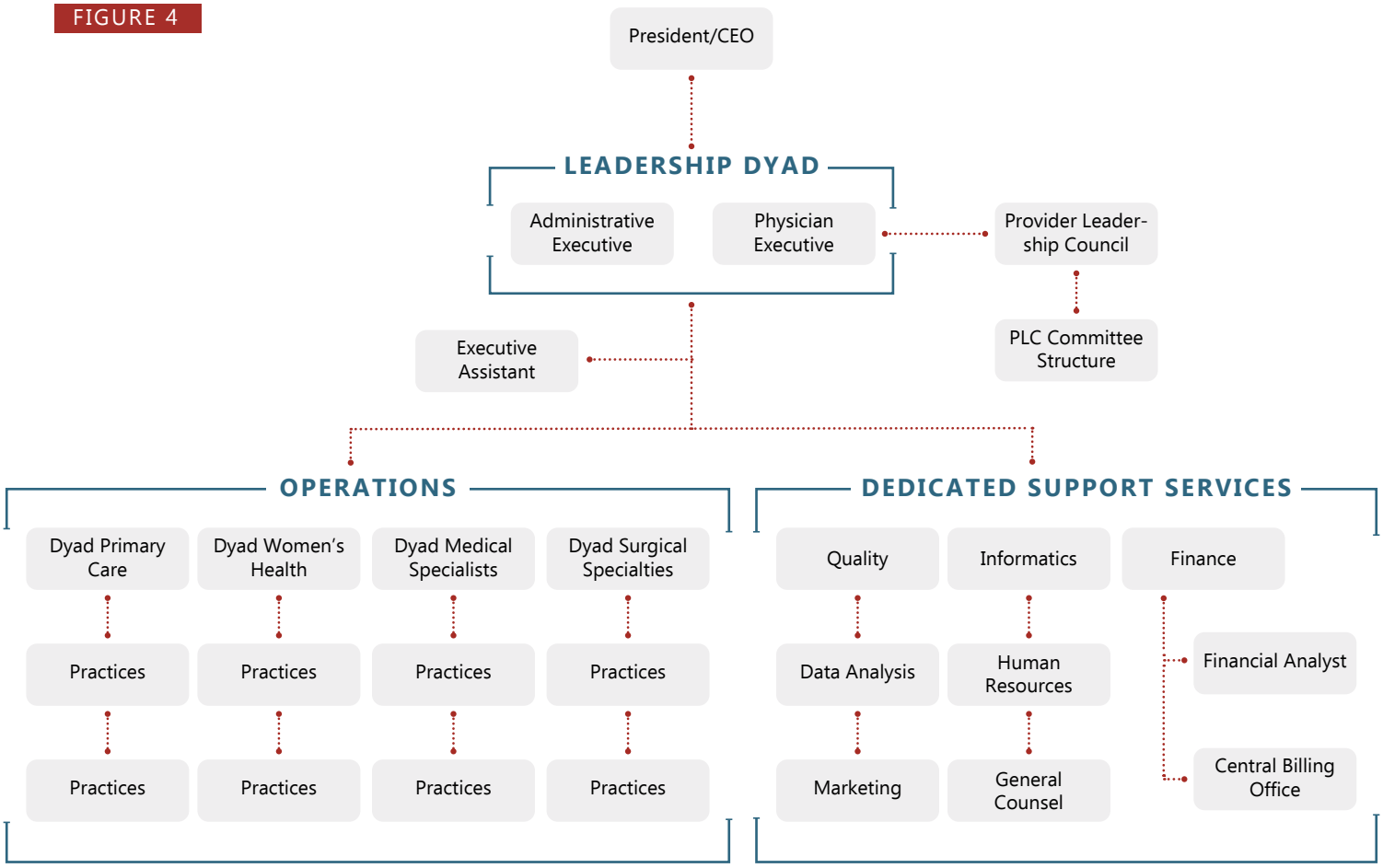
- **Focus on Span-of-Control.** Networks should target an organizational structure that promotes a span of control of 5-7 capable direct reports throughout the management structure – with onsite leadership at the practice level. This allows realistic interactions related to monitoring, supervision, and mentoring. Many employed provider networks experience a mentality focused solely on overhead and subsidy reductions, leading to lack of investment in leadership and management staffing. This results in a management span of control that is wildly out-of-line with reasonable expectations and the predictable inability to effectively manage the network and achieve improved outcomes.

Infusing physician leadership into the formal organizational structure unifies reporting relationships which further optimizes operations.

MANAGEMENT INFRASTRUCTURE

Management infrastructure reflects the resources that build out the organizational framework and optimize network function within the **Employed Provider Network Organizational Structure** (Figure 4).

FIGURE 4



One portion of the organizational structure focuses directly on practice operations. Attention to management infrastructure for this portion of the organizational chart ensures that all positions have well defined roles and responsibilities and that the individuals selected for these positions have the requisite skill set and capabilities to be effective. This ensures that practice operations can be optimized, effective, and efficient. These individuals may require additional training, coaching, and mentoring to acquire the entire skill set required for their role.

An important aspect of this operations area is individual practice management. This facet is often not clearly designated on the organizational chart and its presence is highly variable between networks. Instilling day-to-day management presence and local responsibility for practice operations is key to front line effectiveness and efficiency. Just as practice staffing, service volumes, and scope complexity varies between practices and specialties, "levels" or "tiers" of practice manager skill sets, and dedicated segments of FTE status can also

vary between practices. Practice management resources should not be viewed with a "one size fits all" mentality and the required presence can be customized relative to the specific situation. However, the constant in this equation is having designated, dedicated day-to-day management resources within the practice.

The other portion of the organizational structure defines the dedicated support services needed to support network operations and functions – and adequately staffing these resources. These dedicated support services do not need to reside within the employed network hierarchy, they can be health system shared services. Regardless of where these resources are housed, they do need to be dedicated to the employed network and cognizant of the differences in business operation requirements between office-based practices and hospital departments – and possess the correspondingly different skill sets. If shared services relationships are poorly defined and access to them is not guaranteed, the network may lack necessary support.

Some aspects of the management infrastructure will be directly driven by Shared Vision elements. An example is having sufficient infrastructure to support a comprehensive office-based quality program that is linked to, but distinct from, the hospital/health system quality infrastructure. The comprehensive office-based quality program informs system structures (such as individual provider credentialing) but addresses office-specific initiatives and requirements, such as Merit-based Incentive Payment System (MIPS) and accountable care organizations (ACO) reporting. A second example is the progressive requisite to develop standardized processes, policies, and procedures to unify operations, avoid waste and redundancies, and develop a common brand across the network. A clear organizational structure with adequate management infrastructure is foundational to achieving these desired outcomes.

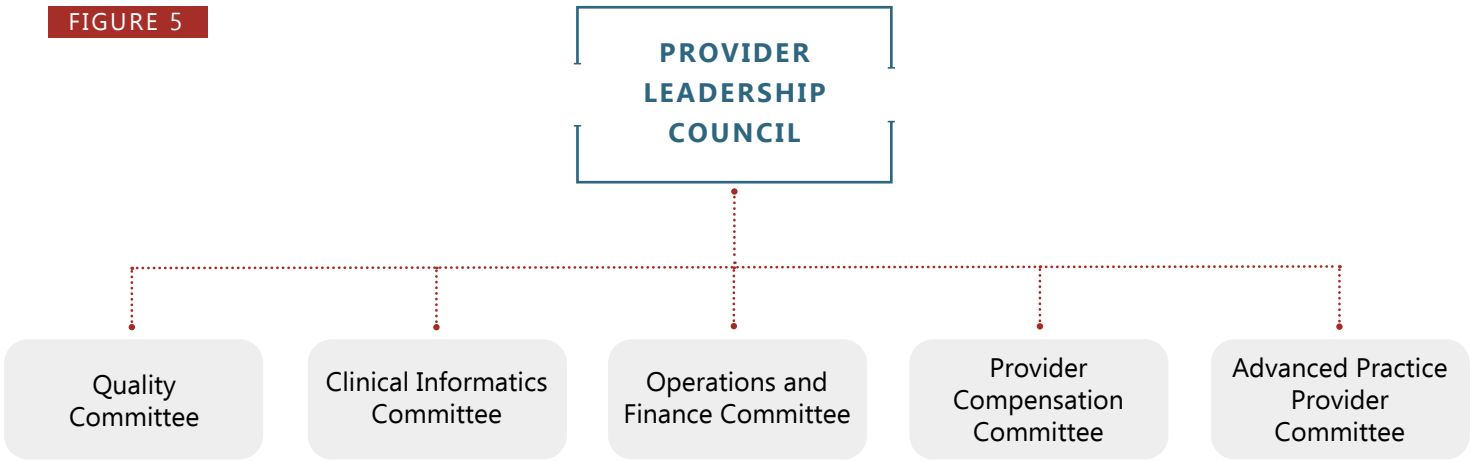
PHYSICIAN LEADERSHIP

A key component of the network organizational structure and management infrastructure is physician and APP ("provider") leadership. The importance of directly involving providers in the strategic planning and operational problem-solving and decision-making processes within the network has received heightened focus as the transition to value-based care has evolved. Directly involving provider leadership also increases engagement, enhances alignment, improves outcomes, promotes recruitment and retention success, and mitigates burnout risk.

Designating formal provider leadership positions at all levels of the organizational structure was previously alluded to as part of the dyad leadership structure. Establishing dyad teams involves more than just designating individuals for the roles. The pairs' interrelationships must be considered during the selection process and fully cultivated thereafter. The joint and individual roles must be well-defined and must be known to all staff. Doing so maximizes each dyad's effectiveness and ensures that individual strengths are used synergistically to benefit their respective areas.

A second recommended component for injecting provider leadership into the organizational structure is incorporating a **Provider Leadership Council** (PLC) and its associated committee structure (Figure 5).

FIGURE 5



These Councils report to and augment the executive level dyad leadership/management team and provide a mechanism to involve providers more fully and more comprehensively in the employed network's problem-solving/decision-making processes. The benefits of establishing a Provider Leadership Council includes the following:

- **Soliciting strategic and tactical input from direct care providers.** Direct involvement in these areas at all stages of development predicts more positive results and more immediate provider "buy in" and ownership.
- **Reviewing practice performance.** Established operational (financial, productivity, and efficiency), clinical quality, patient safety, and patient satisfaction metrics should be reviewed through a dashboard format on a regularly scheduled basis. This provides the Council with the opportunity to help replicate positive practices and identify potential areas for improvement.
- **Presenting potential new initiatives.** The PLC is an excellent mechanism through which to vet proposed initiatives – regardless of source.
- **Promoting "ownership" of practice function and initiatives.** Abdicating, or abrogating, this important responsibility will result in subpar network performance.
- **Establishing the desired culture.** The PLC creates the foundation for a common culture within the network and Council members serve as role models for peers and colleagues.
- **Educating and grooming future leaders.** PLC or PLC Committee membership introduces prospective leaders to the network/hospital/health system perspective and promotes a collective rather than individual focus that can differentiate potential leadership candidates and allow early development of leadership characteristics.

Keys to PLC success include defining form and function in a detailed, well-written, formal Charter that serves as a reference to anchor Council activities and deliberations. Form elements include PLC composition, which should include representative physicians, APPs, and network leadership that is relatively inclusive to achieve the broadest input but small enough to be able to effectively make decisions.

Successful PLCs are supported by a committee structure that accomplishes the detailed work of PLC functions and ultimately drives the PLC agenda. The PLC becomes the focus for evaluating and achieving the Shared Vision – including monitoring the status of prioritized potential strategies and re-evaluating them over time – and the PLC Committees become the vehicle to develop and attain a large portion of the associated strategic initiatives. This effort allows agenda creation and action to shift from being solely driven by network administration to being driven by the PLC and its committees and supported by network administration. An effective committee structure also involves more network providers in network functions in a multispecialty, multidisciplinary manner and promotes greater ownership in network actions and outcomes.

Determining effective PLC Committee structures will depend on specific network characteristics but a common framework is noted in Figure 5. As with the PLC, individual committees are chartered by a formal charge and positional membership that delineates the committee's primary responsibilities and serves as an anchor for committee function.

The following additional resources provide detailed information about Leadership and Management phase elements:

- **Dyad Management and Leadership Councils in an Employed Network**
  www.hsgadvisors.com/white-paper/dyad-management-and-leadership-councils-in-an-employed-network/
- **Mastering Dyad Management**
  www.hsgadvisors.com/articles/mastering-dyad-management/
- **Physician Leadership Within Employed Provider Networks**
  www.hsgadvisors.com/physician-leadership/physician-leadership-within-employed-provider-networks/
- **5 Common Physician Leadership Council Mistakes for Employed Physician Networks**
  www.hsgadvisors.com/articles/5-common-physician-leadership-council-mistakes/

Executing the Shared Vision

With the Shared Vision defining the network's desired future course and the Organizational Structure, Management Infrastructure, and Physician Governance providing a solid operational engine, developing and executing upon a philosophy of continuous improvement toward higher performance will position the network to produce tangibly improved performance and outcomes and ultimately lead to achieving High-Performing status.

Most importantly, this should include:

- Comprehensively assessing the state of network financial and operational performance and adapting and leveraging performance improvement plans.
- Aligning provider compensation and staff performance incentives with desired behaviors that support shared vision and health system strategies.
- Setting organizational expectations to continuously improve operational, financial, quality performance, customer service, and all other aspects of network function.

ASSESSING PERFORMANCE

HSG's Influencing Factors for Network Improvement (Figure 6) defines the general categories of performance improvement that networks should regularly evaluate and review within the newly optimized management and leadership structures.

FIGURE 6

HSG'S INFLUENCING FACTORS FOR NETWORK IMPROVEMENT

Network Improvement Opportunities	Influencing Factors
Can we collect more revenue on our current volume?	• Managed care strategy and rates • Fee schedule • Payer mix • Revenue cycle effectiveness
Can we reduce expenses on our current volume?	• Provider total compensation • Provider mix (physicians vs. advanced practitioners) • Staffing levels and professional utilization • Staffing total compensation • Administrative overhead • Practice overhead • Practice consolidation
Can we produce more volume without increasing providers and staff?	• Retention of patients/improvement of network integrity • Coding and documentation • Provider schedules/scheduling templates • Remove barriers to patient access • Remove barriers to efficient practice operations • Care management • Top-of-license provider usage
Should we reduce our provider complement?	• Mismatch with current/future health system strategic needs • Opportunities to move practice to independence or aligned 3rd party (FQHC, etc.) • Realization that practice/provider is not going to meet performance standards

Determining the current state of employed network function in these areas and comparing current performance against past performance and current, comparable cohort benchmarks identifies areas for further assessment and analysis with subsequent determination of specific improvement opportunities and development/implementation/execution of specific actions plans.

Detailed information about these processes is available at www.hsgadvisors.com/network-performance-improvement/network-performance-improvement/.

ALIGNING INCENTIVES

The Shared Vision process is intended to provide alignment and integration within the network and lay the foundation for a common culture. Developing an effectively functioning Leadership Structure supported by sufficient Management Infrastructure should promote these outcomes. Action plans associated with the Shared Vision Culture element frequently provide mechanisms that promote alignment and integration of factions within the network. For instance, developing a strong communication plan and convening regularly scheduled network meetings at the network level (e.g., network all-provider meetings), operations level (weekly operation team meetings), and practice level (monthly staff meetings that include providers) help assure delivery of a common message that aligns individual and group thought processes and actions.

One area that crosses Shared Vision areas and outcomes is aligning compensation incentives for management, providers, and staff. While the assessment, analysis, design, and implementation processes for each of these categories differ, the common element is that the components should directly align individual efforts with each other and with network and health system organizational goals and objectives. Pursuing this approach advances organizational alignment and promotes integration within the network and between the network and the health system.

Aligning compensation is an extensive undertaking on its own – especially physician and APP compensation. Employed networks may have a head start, but inherent limitations, through human resources processes. For instance, management positions may already have incentive bonuses aligned with health system priority objectives which are translated to the employed network's role in these initiatives. In addition, most health care organizations require annual performance reviews for employed staff based on established performance objectives against which their actual performance is assessed. Appropriately tying the performance objectives for individual employed network roles in a uniform manner, linked with network goals and objectives, promotes both alignment and integration across the network.

The complexity and lift of aligning provider compensation with organizational goals and objectives depends on the employed network's maturation along the HSG Employed Provider Network Growth curve. A network in the Operational Chaos phase usually has multiple agreements and compensation model parameters in place based on individual negotiations conducted during the Rapid Growth phase. The variability creates an administrative management burden and an impediment to developing a common culture. However, until the network develops an adequate leadership and management infrastructure to drive the process, it may not be able to accomplish anything beyond addressing outliers with a large misalignment between productivity and compensation.

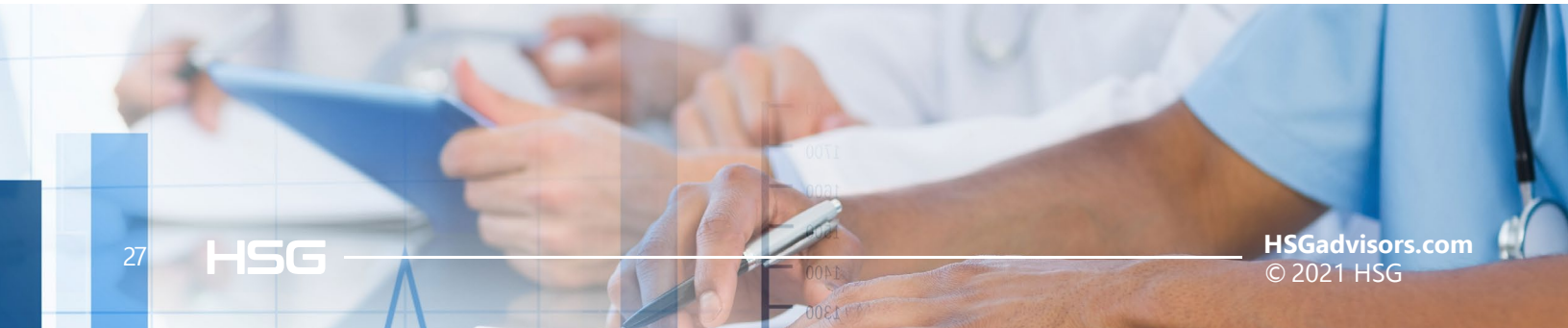
As the employed network comes out of Phase 02 (Leadership and Management) of this transformation process, it should be starting to achieve Strategic Focus performance and can start developing a cohesive, comprehensive compensation strategy based on a common framework within and across specialties. While productivity will remain a focal point of the compensation model, progressively incorporating nonproductivity incentives and team/group incentives become essential to align and integrate individual effort more fully. Details can be explored through www.hsgadvisors.com/physician-compensation/.

The employed network can link compensation initiatives with standardizing provider employment contracts into an "evergreen" model whose body contains the legal aspects of employment and whose individual exhibits contain position descriptions, benefits, and compensation parameters. The exhibits are more personalized and more readily modifiable, e.g., annual benefits updates. At the same time, the network can consider transitioning APPs from at will employment arrangements into contractual employment with incentive-based compensation based on utilization patterns. Details can be found at www.hsgadvisors.com/physician-compensation/advanced-practice-provider-app-compensation/.

IMPROVING CONTINUOUSLY

A key requisite for achieving and sustaining higher performance is embedding organizational expectations to continuously improve operational, financial, quality performance, customer service, and all other aspects of network function.

Phases 01 and 02 (Shared Vision and Leadership Management, respectively) of the employed provider network transformation process allude to the need for organizations to do more than just design and implement change. The changes must subsequently be executed as designed and then modified or further improved as circumstances change. The Shared Vision section expressly states this concept with the necessity for regular review and revision – not less than annually. The Leadership and Management section (and their respective areas within the Shared Vision) express the need to continually re-evaluate the adequacy of these areas – particularly with additional network growth. Regardless of direct application, all organizations benefit from implementing and executing a preferred continuous improvement methodology that is applied across all functional areas. Formal improvement methodologies and philosophies constantly evolve and HSG is not advocating a particular methodology be adopted. Rather, we advocate that a continuous improvement mindset permeates the network and touches all functional areas. The exact methodology is deferred to that which the network or health system chooses.



The simplest philosophy to continually improve and achieve higher performance is represented by the PDCA/PDSA performance improvement methodology. PDCA (or PDSA) is an acronym for Plan, Do, Check (Study), Act. The Plan phase encompasses the initial assessment and design phases of the change/improvement process. The Do phase involves the initial implementation of the designed change/improvement. The Check (Study) phase involves evaluating whether the implemented change achieved its intended results and represents an actual improvement – rather than solely a change. The Act phase involves determining whether the implemented change/improvement is being executed as designed, whether additional modifications are desirable, necessary or beneficial, and how improvement can be sustained. The decisions made in this phase leads to additional planning/design, implementation, re-assessment/monitoring, further analysis, and further change. Thus, the PDCA cycle is truly a never-ending cycle. The methodology is presented more as a philosophical mantra than a recommended modality. The framework's philosophy tends to be compatible with any selected improvement methodology.

Many organizations focus heavily on the Plan and Do phases of the PDCA cycle and develop the talent and resources to be very adept with these steps. However, those who fail to achieve or sustain improvement find that they do not sufficiently emphasize the Check (Study) and Act phases that assure processes are being executed the way they were designed, that ensure outcomes can be measured and monitored to ensure that the change represents an improvement, and that proceeds to revise processes or continue to execute well designed processes so that results can be further improved or sustained, respectively. Energy needs to be continually infused to improve and to sustain improvement. Otherwise, entropy sets in, processes devolve, and performance suffers.

A mindset to continuously improve performance must permeate the entire network in order to achieve and sustain higher performance, regardless of the stage of network maturation or the specific performance improvement methodology employed. A mentality that drives actions to continually improve individual and network performance powers the network along the Growth Curve.

> A mindset to continuously improve performance must **permeate the entire network in order to achieve and sustain higher performance...**

Getting Started

Using data gathered from dozens of engagements and thousands of respondents to the HSG Network Evaluation Survey, we have identified two elements that drive overall physician satisfaction with their employed provider network – having a common culture and having adequate management infrastructure. Details of these results are available at www.hsgadvisors.com/articles/the-importance-of-physician-culture-and-management-infrastructure-in-provider-perceptions-of-employed-group-performance/. These results support the impressions expressed in HSG's 2019 publication *Employed Physician Networks: A Guide to Building Strategic Advantage, Value, and Financial Sustainability* – that key elements for moving an employed network forward along the Growth Curve include a shared vision and adequate management infrastructure. As outlined above, these elements form the foundation for our Employed Network Transformation process.

The importance of these elements makes empiric sense. The collegiality associated with being part of a group whose culture embraces common values and a common vision is a satisfier. Likewise, having the management expertise and administrative support to drive that vision and culture through daily operations, and avoid or address day-to-day hassles, is critical.

Why delay? Start the journey toward higher performance through our Employed Network Transformation roadmap and realize the benefits for your organization.

HSGadvisors.com | info@HSGadvisors.com