Building strategic value with your medical group

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David W. Miller's professional experience has been shaped by his early career at Norton Healthcare. In their culture, physician leaders were allies of the administration, working together to address common challenges and opportunities. His experience as Vice President of Quality and Managed Care at Norton taught him to value managing variations in care, which only happens with physician collaboration. Those early experiences have been repeatedly reinforced by consulting work, and at HSG we understand the only path to success for hospitals is through strong ties to strong physicians. David's practice focuses on strategic planning with a strong focus on physicians, building physician groups that are strategic assets to the health system, engaging physicians and working with executives to address complex physician challenges related to employed and private physicians. He also advises clients on how their employed groups must evolve. David was an executive at Norton Healthcare for 15 years, with leadership roles in Operations, Physician Services, Quality and Managed Care. He holds a master's degree in Health Administration from The Ohio State University and a bachelor's degree in Management from Virginia Tech.

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Abstract Despite massive investments by health systems in employed physician networks, these networks are often poorly aligned with the health system. At their worst, they operate as a loose conglomeration of practices, with suboptimal quality, financial and operational performance. This paper discusses Mon Health, a growing five-hospital system in West Virginia, and the development of its transformation plan. That effort first addressed the development of a vision of how the physician network would evolve to meet the mutual objectives of the stakeholders and the demands of the market, defined jointly by physicians and executives. The resulting roadmap further addressed issues like quality, provider well-being, strategic growth and physician

leadership. The organisation ensured employed physicians would be integrated into the organisation's leadership and operations, through vehicles like the physician leadership council and dyad leadership of services. Tactics include engaging physicians in service line leadership dyads and advisory board roles, building a shared vision for evolution, defining behavioural expectations for a common culture, and building the management infrastructure to drive these initiatives. The paper also addresses early performance improvements facilitated by this initiative. Ultimately, we will provide a road map for developing a transformation plan to build an accountable, multi-specialty group.

KEYWORDS: physician network, strategy, leadership, shared vision, retention, health system

INTRODUCTION

Health systems across the US have moved to an employment model with physicians and now employ nearly half of the country's doctors, primarily to help preserve volume and patient access. During this employment process, however, many health systems have not focused on how to strategically integrate newly employed physicians. Mon Health was one of those systems, and the result was a loose conglomeration of physicians who were not focused on health system priorities or on building an integrated medical group.

As the leadership team at Mon Health assessed the situation, they envisioned building a strong multi-speciality group that would provide leadership within Mon Health who could

- serve as a voice for the patients, the community and fellow physicians,
- ensure that physician perspectives are incorporated as the system grows and responds to the imperatives of value-based care and
- enhance the health system's ability to effectively respond to challenges.

These concerns about future strategic challenges were the driver behind their initiative to better engage and capture the insights of physicians.

The primary product of the initiative was to create a clear vision of what the physician group needed to become for the system and individual physicians to succeed. Essential to that was transforming the group culture and performance expectations. A second objective was to reinforce the centrality of provider engagement to system success.

MON HEALTH SYSTEM: CURRENT SITUATION

Mon Health System (Mon Health), based in Morgantown, West Virginia, is a growing health system that had three hospitals in 2020. Via management agreements and acquisition, it would soon grow to five hospitals with a variety of subsidiaries. Its primary competition was the state's flagship academic medical centre, located one mile away from Mon's flagship facility. In 2022, the organisation pursued a merger with Charleston Area Medical Centre, the largest private hospital system in the state located 185 miles south 163 miles.

Mon Health's focus on its employed provider network was driven by executive dissatisfaction with the current situation. Two factors were driving this perception:

- The group was not yet a strategic asset for the system and not helping Mon address the changing requirements of the market.

- The physician group was not engaged as a partner with the health system and was not engaged in financial performance, clinical integration and value-based care.

Executive leadership believed that strong physician bonds would be required for the organisation to succeed in the long term. Provider insights would need to be captured if Mon Health was to effectively respond to the pandemic and its aftermath. Provider culture would need to evolve as value-based reimbursement grew in importance. And the physician network and other parts of the health system would have to move in concert if the organisation wished to remain competitive.

The medical group employed by Mon Health had proliferated, employing nearly 400 providers to serve the three hospitals. Those physicians operated in subgroups, one at each hospital, reporting to the local Chief Administrative Officer (CAO). Providers identified with and operated under "their hospital" rather than under the system or the whole medical group. This led to a lack of cultural and operational alignment among the providers. Patients identified with individual doctors and practices.

Owing to these realities, the network had limited ability to benefit from economies of scale. There was limited ability to share best practices and share management expertise. The physician networks were largely responsible to the individual hospital CAO, not to the system goals. All of this limited the ability of executive leaders to align the physician network with the overarching system strategy.

From the CEO's chair, the imperative was to forge one group, engage and develop physician leaders and work with those leaders as partners to drive the strategy and culture of the health system. In this paper, we will discuss how that was done, but we will first address the conceptual framework utilised in transforming loosely organised physician networks into a multi-specialty group performing at a high level.

BACKGROUND: EVOLUTION OF EMPLOYED PROVIDER NETWORKS

As hospital-employed networks grow into large groups, they go through a predictable evolution. The framework of this evolution was utilised to educate the physicians at Mon Health, help them diagnose the current situation and guide them as they created a road map to a desired future. Depicted here as a bell curve, there are six phases in the transformation.[1]

Novice phase. The health system employs physicians, often out of necessity, with little infrastructure to manage the practices. No infrastructure is built to support the practices in terms of revenue cycle, IT or HR. No thought is given to engaging the physicians. In many ways, the only thing that has changed is the tax ID number.

Rapid growth. The second phase is rapid growth, as health systems are asked to employ more physicians. The result is a burgeoning hospital-employed group, with the number of doctors and their management requirements outstripping the physician group's management capabilities. Financial performance deteriorates.

Operational chaos. The result of phase two is chaos. Few formal systems, minimal management infrastructure and poor management information are all aspects of this operational chaos. The resulting lack of control over performance leads to mounting financial losses and physician dissatisfaction. The physician network is also detached from the strategic direction of the system.

Strategic focus. Over time, most networks address their operational deficiencies. Losses are understood if not under control. The management structure is expanded as resources are added. Attention turns to utilising the physician network to gain a strategic advantage, with physician leadership councils engaged in strategic discussion (Figure 1).

Value phase. In this phase, the physician network is developing the capability to meet value-based buying requirements. Physician leaders are becoming important leaders within the health system, and the centrality of the physician group to system success becomes more visible.

High performing. A high-performing group has broad physician engagement and a clear vision and can deliver predictable results. The group can manage risk contracts, producing the results required to improve quality and build financial success.

As health systems build a strategy for their physician network, the goal is to move systematically toward the right side of this curve in Figure 1. In each step, the goal is to engage physicians, maximising their contribution to the health system. It is also to align their efforts with the system's overall strategy.

BACKGROUND: TRANSFORMATIONAL CHANGE

Working with hundreds of physician networks, HSG's team has observed three essential elements to transforming such networks: shared vision, strong leadership and management and superior execution.[2] Mon Health engaged HSG to help build the first two elements of this triad.

Having a shared vision that defines what you need the physician group to be and how it needs to evolve is crucial to long-term success. What is the ideal future state? What would make the physicians proud of the legacy they had helped build? Engaging the employed providers at Mon Health in that discussion provided both clarities of purpose and buy-in to the vision. We will address that more fully in the context of Mon Health later in the paper.

A second essential element is strong leadership and management. Leadership

Figure 1 This bell curve shows each of the six phases in the transformation process as they correlate to the organization's performance and strategic value; the further along your transformation is, the more strategic and high performing you can become

is crucial to communicating and sharing the vision, 'rallying the troops', ensuring it is operationalised and making necessary adjustments. Management is essential to implement the vision, drive operational improvements, monitor progress and adjust when required.

Most hospital-employed groups are under-resourced when it comes to management. They focus on saving a full-time employee (FTE) but not on the leadership and management capabilities required for success. That routinely leads to performance issues and slow progress in achieving the vision (Figure 2).

Under "Leadership and Management" in the graphic, you will note three distinct elements of success. We want to address two in greater detail here. The first element, Organisational Structure, highlights five issues:

- Elevating the Provider Network within the system so that it is as important in the organisational chart as one of the system hospitals.
- Building Dyad Leadership, with physicians and business executives working together towards mutual goals.
- Aligning Specialities, generally into groupings like primary care, medical specialties, surgical specialties and hospital-based specialties, owing to their common challenges and systems.
- Addressing Geography; at Mon Health, with hospitals 30 miles apart or more, geography created some organisational chart issues.
- Focusing on the span of control, as massive spans can hinder efforts at execution.

The second important element is building an effective provider leadership structure. Mon Health developed a Provider Leadership Council (PLC) that collaborates with executives to implement the shared vision. The PLC will also consider adjustments to that vision, new strategic challenges, provider compensation systems and other matters important to the network's transformation. Earlier, we noted Mon Health's need to have physicians working with the system to evolve and achieve success. This group of leaders is a focal point for that aspiration.

The third element is essential to any management success: execution. Without clear direction (shared vision), execution will not focus on the levers of success. Without management talent and depth, execution will not happen. But execution also requires accountability and focus that can drive the transformation. Building accountability for physicians in new leadership roles is difficult and often requires tough decisions, but it is a requirement for progress.

Figure 2 There are three essential elements to transforming networks: shared vision, strong leadership and management and superior execution

MON'S GOALS FOR A MULTI-SPECIALITY MEDICAL GROUP

Executives defined several goals for the group's integration and discussed these with physicians to lay the groundwork for change. Overall, the goal was to transform a loose confederation of practices into a unified, cohesive multi-specialty group. This would require a centralised organisational structure and common culture. Policies and procedures would need to be standardised around best practices. As this transformation was underway, the group needed to accelerate its focus on quality, value-based incentive performance and meeting community access needs.

A second goal was related to a strategic pillar in the Mon Health strategic plan. That pillar envisioned a provider-led care team, empowered to improve quality, reduce clinical variation, manage cost and develop a systematic approach to clinical care within the Mon physician enterprise. One of the important tactics envisioned was a formalised physician leadership structure within and across the entities of Mon Health. The previously discussed PLC is the manifestation of that in the medical group.

A third goal was to develop an integrated brand. Rather than focus on the practice or the hospital, there was a desire for a Mon Health brand to communicate the health system's value proposition. During the project, a common group name was approved by the steering committee as the first step in that process.

A final goal was to elevate the medical group to the level of the hospitals and other entities within the health system. This was a recognition of the crucial nature of the physician enterprise, its role in driving the system to new models of care and its leadership role in value-based incentives. The medical group and its leadership were given greater roles within the system, rather than reporting to the hospitals.

CREATING A SHARED VISION

The first important output of the transformation effort was the development of a shared vision. This document, developed jointly by representative physicians and health system executives, described how the physician group would operate and perform and what its role would be five years in the future.

The vision statement is three pages long, providing a detailed narrative and guidance on the sequencing of the potential tactics. This approach was taken for two reasons. First, it was deemed essential to define tactics, not platitudes, as executives and physicians work together to articulate their vision. A goal was to ensure alignment and avoid misunderstandings.

Additionally, the detail creates an excellent educational tool. The detailed vision was used to explain the intent to all physicians, office staff, new recruits to the group and others within the health system that may question the investment in a physician group.

The initial step in creating the vision was to appoint a steering committee to guide the process. With 15 members, that committee included multiple physicians, a nurse practitioner, health system executives, physician group managers and finance and marketing representatives.

Two information-gathering activities preceded the first meeting: interviews with about 30 individuals (including the steering committee members) and an online survey of providers. This allowed for the development of a baseline understanding of their perceptions and aspirations while also communicating that this was an organisational priority.

Creating the vision took four meetings and many hours of physician time. The initial meeting addressed the fact-finding. Subsequent meetings focused on reviewing drafts (with the initial one prepared by the consultants), refining the document and addressing how the results would be communicated throughout the physician group.

The final step was an all-provider meeting, at which the draft vision statement was reviewed, with edits and additions considered. There was a discussion about how to start implementation, with five priority areas of focus defined for the next year. This process resulted in a high degree of understanding, general acceptance and significant engagement by the providers.

The committee ultimately defined nine elements for inclusion in its vision statement. We discuss those elements next and address their significance.

1. **Multi-speciality group culture.** Build a culture where group members act as one in furtherance of quality, access and financial goals. The culture also focuses on building a supportive environment in which physicians can grow and learn but are also accountable for their practice's performance and individual performance.
2. **Leadership.** Create a PLC to collaborate with executives to make the vision a reality. Two elements are envisioned to foster this leadership. First, the development and training of potential leaders is a high priority. Likewise, transparency around the system's vision and goals to help physician leaders understand how the pieces of the system work together and how the physicians' efforts contribute to success.
3. **Management infrastructure.** Commit the resources and create management depth that will allow the group to implement the vision and meet its objectives. This addressed direct management from the office manager level upwards also included a clear delineation of resources that would be directly held by the group (IT support, for example) and resources that would be drawn from corporate resources (marketing, for example).
4. **Quality.** The group established a Mon Health Medical Group Quality Plan that is comprehensive and focused on value-based requirements and that builds reporting capabilities at the provider level. It was also designed to address care across the continuum and feed into the service line quality plans.
5. **Provider and staff well-being.** Retention of staff and providers who understand our vision is crucial to success. The pandemic likely magnified this issue. The engagement of providers and staff was a big part of building well-being, as was helping providers and staff understand the bigger vision and how they contribute to the organisation. Over time, this principle has had a direct effect on policies within the group as well.
6. **Engagement.** There are three parts to this element; first, engagement with patients on their terms to ensure the experience was positive, their questions were addressed, and they participated in care planning. Second, engagement with other provider entities to ensure seamless transitions of care and to build referral relationships. Finally, engagement with non-employed physicians to build collegial relationships and avoid adversarial interactions.
7. **Brand.** A principal goal was to identify as one cohesive group. A common name was the first step. Common policies followed closely. Building a common look and common experience are longer-term goals.
8. **Strategic focus/growth.** With the PLC, develop growth strategies, define supporting tactics, monitor progress, and adjust as needed. Essentially, the health system was systematically tapping into the physicians' insights about the market and the opportunities it presented.
9. **Financial sustainability.** To work together to meet financial goals and requirements. This required financial

reporting to the physicians and accountability among them for financial results. It also gives the providers a more significant role in financial planning and allocation of resources.

As a side note, it is worth reminding the readers that this is a five-year plan. That horizon was often noted during the process to remind providers that this was not a sprint; the vision would not become a reality overnight.

A final task for the steering committee was to review the vision's elements, define the first few steps in the road map for each and prioritise actions for the first year of the journey. That was done, and those priorities became the strategic priorities for year one.

STARTING THE JOURNEY

A top priority was evolving the management infrastructure of the group. Without management horsepower, very little transformation would happen. The existing management structure was inconsistent with the group's size and scale. The organisation had created a business with tens of millions of dollars in revenue, with very few incremental management resources.

As part of that effort, dyad management teams were formally added to the organisational structure. Most of those physician roles are part-time, with doctors still practising medicine. That helped with the affordability, plus the credibility of the physician leaders with their peers.

The organisational structure plan included the creation of the previously mentioned Mon Health Medical Group PLC and a supporting committee structure. This committee structure facilitated the involvement of additional providers to focus on quality, clinical informatics, operations and finance. It also included representation from the various system hospitals, including all CAOs.

The initial reaction was positive. Most participants appreciated engaging the physicians and Advanced Practice Providers (APP) in problem-solving, decision-making and strategic planning. It has also provided an appreciation for the complexity of some of the decisions required.

EARLY RESULTS

These changes were undertaken to improve the ability of Mon Health to serve patients and engage physicians as Mon Health responded to a market increasingly focused on value-based measures. Hence, one of the important measures for management is physician engagement, as measured by a biannual survey. In 2020, the employed physician's average response related to the degree of engagement was 3.75 on a 5-point scale. In the 2022 survey, that number had risen to 4.07.

The efficiency of care is an essential output in a value-based care environment. Mon Health's ACO provides a good measure of the overall efficiency of care, for one population of patients. From 2020 to 2022, the cost per member per month declined by US$45, a US$500 + reduction annually. That improved performance led to greater incentive payout to both the providers and the health system.

An element of the vision was to develop an integrated quality plan for the medical group. The initial plan focused on preventative care, and the group improved the number of patients receiving mammograms by 7 per cent. A smaller improvement was made in colorectal screening as well.

The financial performance of the employed network improved dramatically. From 2019 to 2022, the per-provider subsidy to the group declined from US$275,000 to US$149,000. With well over 100 providers, this was a significant change, and much of that improvement was driven by physician leadership, physician engagement, clear

expectations and transparency related to financial performance.

The medical group also contributed to financial improvements on the hospital side of the financial statements. One example relates to penalties for overutilisation, which declined by 14.5 per cent.

Finally, the flagship hospital's star rating from Centers for Medicare & Medicaid Services (CMS) has increased to 4. Results are trending in the correct direction, although there remains significant work to do. But the foundation of engaged physicians is in place and is a key catalyst in these improvements.

CONCLUSION

In summarising the benefits of this initiative, Mon Health leadership identified three major upsides. First, bringing elements of the disparate employed provider networks together to create a shared vision for a cohesive, integrated employed network was very beneficial. It provided a strong framework for positive change and a road map for how to attain Mon's desired ideal future state.

Developing a consolidated organisational structure with embedded formal physician and APP leadership was likewise beneficial. Both through the physician executives associated with the dyad leadership structure and the PLC and its committees, physician engagement grew, providing a vehicle for sustainable change and higher performance.

Finally, the leadership recognises this as a starting point. As the infrastructure develops and matures, Mon will be better able to unify and standardise complex functional areas such as compensation models, practice optimization and revenue cycle. These initiatives will help ensure financial sustainability in the near future. It also provides a platform to standardise care management, which should be invaluable as the health system is increasingly required to assume risk.

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