Hospital and health system management teams and physicians are struggling with the change management necessary to integrate formerly independent practices into their new homes as part of the hospital and health system hierarchy. Many such hospitals and health systems are working to change their management reporting structure to address physicians’ demands for a level of autonomy, and balancing that desire with the health system’s need to ensure quality and patient satisfaction goals. It’s a difficult transition, and the future viability of the overall organization hangs in the balance.

Panelist Profiles

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Roundtable Highlights

HEALTHLEADERS: Acquisition of physician practices has ebbed and flowed for hospitals and health systems for years. Why is it ramping up this time?

MIKE MURPHY: One of the key drivers this time around is the fact that physicians are creating the demand for employment due to the changing economics around their practices and their concerns about being included in a new system of care as a result of healthcare reform. Health systems are approaching employment of physicians from a healthy level of conservatism.

STEVE MOORE: We’re seeing two or three pressures driving this. One is office-based procedural reimbursements being gutted in the specialty markets over the past three or four years—similar to where the primary care market has been going, in that primary care reimbursements have been ratcheted down significantly to the point where you just can’t see enough patients.

CLAYTON HARBEC: The complexity of managing a physician practice has increased exponentially in just the past five years, partly because a much larger percentage of revenue is coming directly from patients. Because it’s more difficult to collect from patients than payers, physicians are driving less money into their practices. So they’re looking for help from health systems.

KENT WALLACE: The retail marketplace is changing for consumers. But the consumer is driving the access. People want to access their primary care differently. Physicians feel like they have to be aligned with somebody. We’re seeing that on the primary care side, but cardiology is probably the most impacted product line right now. Orthopedics is also heading in that direction. But alignment is what begins to create the desired effect, which is efficient care, better-quality care, and cost savings. When you get that alignment, it’s amazing what can happen from a care standpoint.

MOORE: But we run a great risk once we’ve reduced those costs and standardized. If we’re hiring folks into a fee-for-service model to leverage provider-based reimbursements, at the same time there’s this schizophrenic change in how we’re going to be reimbursed in the future. We’re taking quite a risk on both sides of those equations as we move those folks in.

HEALTHLEADERS: Are you buying into the practice acquisition trend?

WALLACE: You need to start with relationships, whether you’re doing some basic MSO services, whether you’re doing disease registry to get your pay-for-performance dollars, but you want to start to have a relationship particularly with primary care physicians. It may move to an employment situation. But you have to be careful. Sometimes the physicians hospitals strategically acquire are the docs that walk into the CEO’s office and say they’re getting tired of the hassle and would like to slow down a little bit. That’s not a good strategic investment.

MURPHY: Our major focus is on primary care; however, much of the demand is coming from the specialists due to the economic challenges from within their practices. As a physician alignment strategy, specialists are attractive given the amount of care they provide within the health system today. However, as we transition from a fee-for-service to a value-based system of care, acquiring too many specialists could potentially create a future risk. How the timing of this strategy plays out varies in each of our markets.

MOORE: From a strategic perspective, we’re looking at three phases of healthcare delivery. The first is in the acute care facility in the future; we’re looking at lower reimbursement, and we’re looking at an opportunity to have better quality and higher efficiencies. So the physician strategy we have to pursue is around employing hospitalists, intensivists, and then developing some sort of management model with our subspecialties to start to get at the utilization that is driving our costs. The next piece is around bundled payments and readmission reductions, which are going to be big parts of this as we move forward, and only a few of our markets are competitive there. We’re actually looking at trying to put providers into nursing homes now.

WALLACE: And as you transition, you may need to add a physician assistant to a care team. You may need a nutritionist. But right now it’s not being paid for. That’s a problem for a lot of physicians. Too, a lot of physicians are practicing at the lowest level of their license, and I don’t know if we’ve done that to physicians or if the payment system has
done it. If primary care physicians were rewarded for medical home management, I think you’d see some significant savings because they’re the key.

HEALTHLEADERS: Is providing those team-based incentives, for now, up to you?

MURPHY: Health systems are responding. To manage population and value-based care, as we deal with the physician shortage, we are transitioning to a model that increases the size of the primary care team through more physician extenders and health coaches, an essential part of patient-centered medical homes. Some of the most successful practices that are managing under incentive-based care models have an 8:1 ratio of extenders to physicians. This has created a far more effective way to treat chronic disease and improve patient satisfaction. Also, many payer incentives are now supporting this team-based care.

HARBECK: We’re seeing an awakening among hospitals that the foundation for team-building will be the patient-centered medical home. We’re unaware of any medical home pilot that has provided team-based incentives for physicians and failed financially. But there are costs to developing a medical home. Some of our hospital clients are organizing their employed physicians and driving them through the registration process with NCQA or Bridges to Excelence. Then hospitals are going back to payers and renegotiating contracts to reward positive patient outcomes.

HEALTHLEADERS: But that doesn’t mean you have to own the physician practice, right?

WALLACE: I don’t think it requires ownership. What it does require is an enlightened physician group to understand the information that’s going to be required. Managing physician practices is one of the most challenging things that a health system can do. Most system people are not prepared to manage physician practices. Under fee for service, you are really rewarded for your inefficiencies. I’ve got hospitals right now that are dropping their readmission rates 10% or 15%. They are penalized now for that. But the things that make sense for population management eventually will make financial sense.

MURPHY: There are many other options to aligning with community physicians beyond employment. The goal is to achieve clinical integration. However, many specialists, including cardiologists, orthopedists, pulmonologists, and urologists, are seeking assistance from health systems due to changing economics around specialty care. Health systems are forced to consider employment as a means to provide the level of inpatient acute care needed for their communities. The challenge is that the cost burden shifts to the hospital with potentially little additional revenue to offset this cost.

MOORE: If you have a diminishing fee-for-service environment, you’ll actually want them all to go over to your competitors because essentially you’re going to implode. The quality of care that’s delivered is inversely proportional to the number of specialists per population. It’s directly proportional to the number of primary care physicians per population. If you look at the procedure volumes and hospitalizations per thousand, you require far greater primary and extender populations than you do specialty.

HEALTHLEADERS: In terms of ownership, are you talking about serving on clinical boards?

WALLACE: I like the term citizenship. It is part of that cultural piece where you’re trying to find the right fit because what you’re looking for are people who want to behave as owners versus renters. It would be great if we could clone somebody that has the medical side and the business side.

HEALTHLEADERS: What are the keys to making a transition to owning physician practices successfully?

MOORE: We’re moving significantly away from the productivity-only model. We’re looking at more of citizenship participation, whether it’s on the inpatient side and improving hospital efficiency and quality goals or participating in pay-for-performance opportunities as much as we possibly can. We’re also starting to look at a dashboard for performance that’s very little related to the productivity side.
HARBECK: One of the obstacles to integration is that the financial modeling for practices prior to acquisition is generally incomplete. So you’ll acquire a marginally profitable practice, and almost overnight it will start losing money because you’re now applying hospital overheads to a private practice. And when a practice is losing money, the hospital’s focus for the practice will revert back to physician productivity, not the citizenship necessary to benefit the health delivery network under future reimbursement models.

WALLACE: There’s a real challenge with that. We as hospital executives are great at taking well-functioning profitable practices, stripping the ancillaries, and wondering why we’re losing money. When you go to that provider-based reimbursement, you’re taking away the patient focus. It becomes more inefficient for the patient. And so that’s a challenge because right now it is pretty attractive on the provider-based reimbursement. Whether it’s telemedicine or another solution, our physicians have to be a lot more accessible to the patients. Healthcare providers often make it for their convenience, and we must begin to change that mind-set by putting the patient in the center of care.

MURPHY: What we’ve found useful is to spend a lot of time talking about culture and integration by breaking down what will be the new authority matrix for physicians as they move into this new system. So we have a frank conversation with the physicians and discuss the things that they can act independently on and those that will be under a shared governance model. Questions like, “Are you still going to be able to manage your day and set your own schedules? How will you share leadership and governance in specific service lines?” These conversations get into those difficult areas about how we collaborate. We spend time on that up front. If you do that very well, integrating physicians afterward is a whole lot easier. Unfortunately, with this rush to employ and beat out the competition, some health systems may find a lot more challenge managing their new practices post-acquisition.

MOORE: In my experience, groups of physicians that we’ve brought on board throughout my career have never really had a facilitated discussion like that.

WALLACE: This part about the cultural shaping, the governance, is exactly right on. But we have to think about what physicians want, and I sometimes try to put myself in their shoes. What they’re interested in is economic security, how their lifestyle is going to be impacted, does their opinion count, and probably more important, can I help shape the kind of the care system that I’m involved with and that I’m proud to be a part of. Physicians seem to be most interested in what got them into medicine in the first place—providing exceptional clinical quality care to patients—and helping shape that in this environment is a priority. I think if we hit those marks, that’s going to be a magnet for other physicians who want to partner together.

HEALTHLEADERS: How much of that conversation revolves not just around clinical integration, but transformation of the way they practice medicine?

MOORE: At this point, not much. And it’s predominantly because, except in a couple of markets, we are not very far along that transformational road.

HARBECK: You start by scoring physicians on disease management and outcomes, and by having patients and nurses score them. Then you’ll have system-level clinical and financial scores. No physician wants to be at the bottom of the heap in either category, and that will spur them to change their behaviors in ways that benefit the system.

MURPHY: In our markets, we’re transitioning at many different levels. The more progressive markets are moving toward clinical integration with the payers supporting this transition through new incentive payments. For our practices, this equates to building new physician alignment models through clinical integration. Other markets are still focused in the traditional fee-for-service model.

WALLACE: When you start with the physician group, whether it’s cardiology or primary care physicians, if they’re an enlightened group, they’re working on their metrics and the way they deliver care. How do we begin to take some shared risk? You’re kind of moving up this curve, but if you don’t have the good raw materials there with that practice group, then you’re not going to be successful when you do get to a fee-for-health strategy. If you start with good talent, then you’re going to be well-positioned in the next few years.

MURPHY: Operationally, we struggle with going from a health system where the focus is on larger blocks of information and dollars to the practice level where the copay is the margin. That’s a very different focus than in an acute care hospital. The challenge is transitioning to this operational focus. As a
big system with 45-plus hospitals and approximately 500 practice locations, we had to get our arms around this. As we acquire new practices, we have to be sensitive to the fact that these new practice leaders bring a new perspective compared with acute care.

HEALTHLEADERS: How do you make the transition such that your physicians are able to practice at the top of their license?

MURPHY: It’s part of a shift to team-based care. One of the key innovations we’ve implemented is the addition of health coaches in primary care practices. Health coaches look at patients who are coming into the practice in advance and prepare for the preventive care they should receive when they arrive. In addition, we work extensively with our Lean resources to address process redesign within the practice to optimize patient flow. This redesign is critical as well for the implementation of our EMR systems.

WALLACE: The retail side of the business is critical. Each health system has to look at how they’re going to have this retail distribution in the marketplace. You’ve got the Minute Clinics, the Walgreens, those kinds of things. You’ve got your urgent care clinics, and in some markets a freestanding ED. You’ve got to make sure that you’ve got the services that patients need. The extender piece is going to change even though there are state regulations that sometimes prohibit some of that. You’re going to have this huge jump in demand. The states are under tremendous financial pressure.

HARBECK: There is a lot of experimentation going on. For example, when a diabetic patient has an appointment, someone might meet with him or her beforehand to do all the prework. All the care posts for that appointment could be handled by a nurse practitioner or other extender. I keep coming back to the medical home as the basis for the care-quality measurement at the physician practice. Getting care quality under control for your employed and even affiliated physicians is absolutely key to the success of a health delivery network, whether it’s an ACO or not.

HEALTHLEADERS: What remediation efforts have you studied to deal with the influx of patients that will come in 2014?

WALLACE: We have used more extenders than we have in the past, but I don’t think we’ve got any magic bullet.

MOORE: When the payment model will pay either a midlevel or a physician, you have a problem. If they won’t pay for a telemedicine consult, then you’ve got a problem. Besides that, the margin between the average salary of a primary care physician and the average salary of a midlevel practitioner right now is at the smallest level of difference than it’s ever been. Primary care docs can’t afford midlevels in the current cost structure.

WALLACE: It’s the same dilemma that a primary care physician has when a Walgreens or an urgent care clinic opens. That’s part of his or her patient base. You can’t strip that out of there, so this gets back to that practicing to the level of your license and who they should be seeing.

WALLACE: We created an intensive care manifesto where we want certain things to occur in our intensive care units. As we’ve required some multidisciplinary rounds, it’s amazing the kind of care difference and the savings that you get. But physicians are not used to working as a team.

HEALTHLEADERS: Let’s talk about alternatives to full acquisition. Are those strategies still applicable under reform?

MOORE: We’ve seen a lot of movement toward that dyad leadership model. We’re starting to bring our medical directors into an operational role and matching them with an operational leader. Some parts of our organization have created interdisciplinary leadership teams where physicians and the operations team are actually running the facility, making capital decisions, running the ORs. We have a number of physician service agreements where they’re now fully running our inpatient and outpatient ORs with great cost reductions and improved quality scores. The amount of joint venturing that we’re doing anymore has dwindled.

MURPHY: Many of these ideas are still applicable. The challenge is reacting in the current fee-for-service model of care and yet trying to build these new relationships as we transition to a value-based care system. The opportunity is to convince physicians that they need to align and work with your system in new ways. From an inpatient standpoint, clinical comanagement and gain-sharing are all good tools to achieve an initial integration strategy but not as applicable as a broad alignment strategy in which you’re focusing on the continuum of care, which includes ambulatory, home care, and long-term care.
THE GOVERNMENT GIVES YOU NEW STANDARDS.

THE PAYERS GIVE YOU NEW REQUIREMENTS.

THE BOARD GIVES YOU NEW DEADLINES.

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While everyone else comes to you with mandates, we come to you with help. Help attracting and retaining the physicians you need to meet the changes just ahead. Help we deliver through expert consulting or turnkey solutions, whichever works best for your hospital system. Either way, you end up with cost-effective, scalable results that get physician alignment on track — and the world off your back.