5 INESCAPABLE ISSUES FOR MEDICAL GROUPS

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In this article ...

Making clinically integrated networks truly effective will require physicians and administrators to overcome several organizational challenges. Here are the biggest ones identified by a panel of physician leaders.

THE NUMBER OF PROVIDERS WHO NOW WORK for hospitals and health systems is steadily increasing, and so too are the opportunities for physician leaders and administrative leaders to work together in truly integrated partnerships capable of meeting the demands of an increasingly complex health care environment. New approaches will break down barriers and bring all parties to the table to promote clinical, financial, operational, technological and cultural excellence.

Getting to this lofty goal, however, requires system leaders to abandon historical thinking and other obstacles without silver-bullet solutions. The monumental task of designing and maintaining effective and integrated systems of care is not lost on physician leaders.

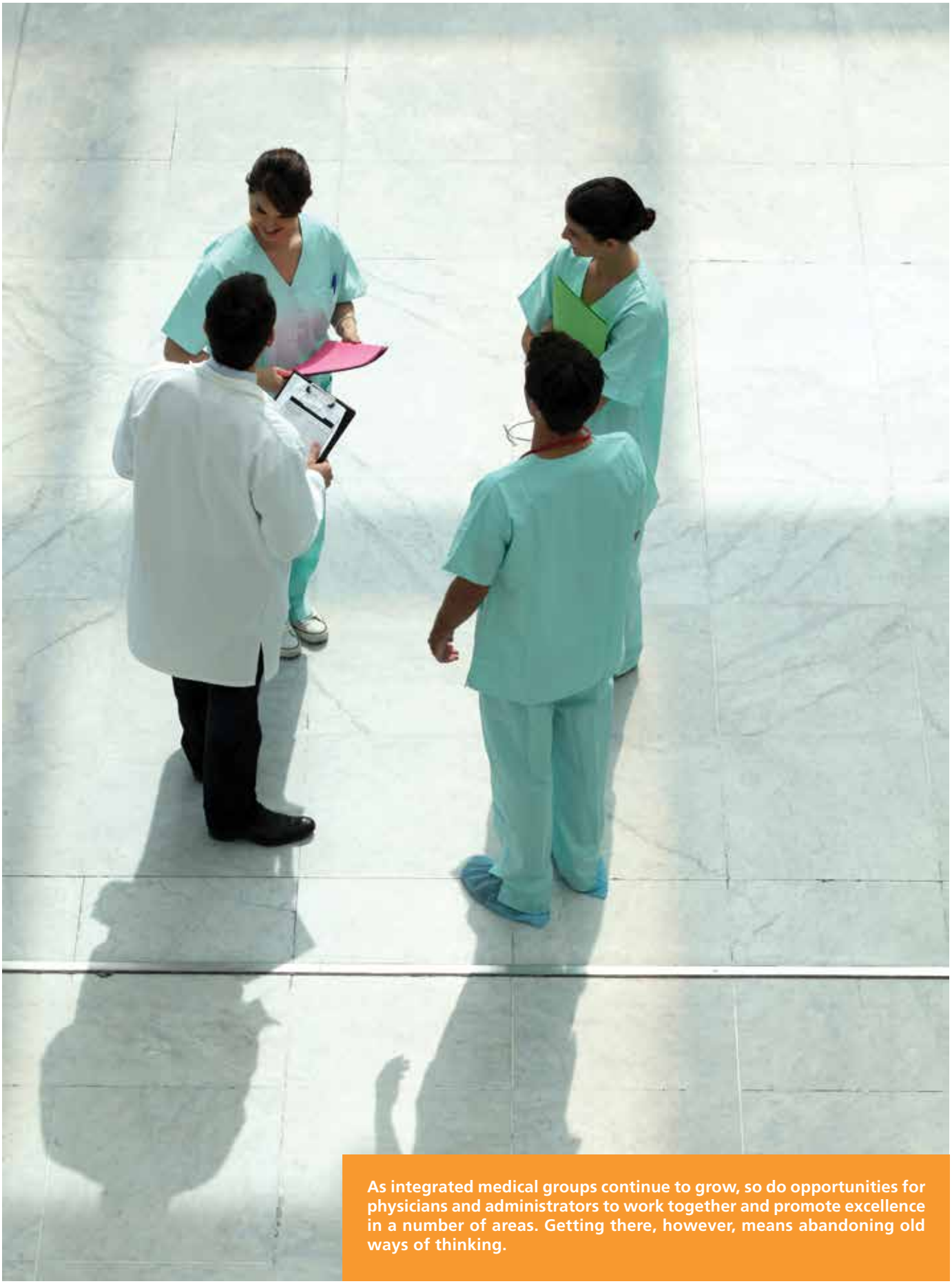
Recently, a group of accomplished physician leaders of employed medical groups from across the country gathered to discuss the internal and external challenges to meaningful integration. The panel identified five critical issues facing integrated medical groups.

1. DEVELOPING PHYSICIAN LEADERSHIP

The long-held perspective that administrators run hospitals and physicians run practices does not hold up in the current health care climate. Health care is a team sport, and there's a growing recognition that physician expertise and perspectives must be integrated into all levels of governance and management. This is especially true of any decisions that affect patient care. The key word is "integrated" — all team members are important, and mutual respect is required by all.

As medical groups become more integrated, the importance of (and opportunity for) greater levels of physician leadership becomes more apparent. But the demand for experienced and capable physician leaders far outpaces the supply. Problem is, few physicians have been educated and/or trained in business and leadership.

Traditionally, health systems have elevated physicians into leadership roles mainly because of their clinical proficiency, and perhaps an ability to help alleviate disruptive staff behavior or practices. Though these are admirable attributes, making decisions about the vision and strategy of an organization requires more than clinical experience and likeability.



As integrated medical groups continue to grow, so do opportunities for physicians and administrators to work together and promote excellence in a number of areas. Getting there, however, means abandoning old ways of thinking.

The role of physicians in leadership positions, in both medical group and hospital settings, has changed dramatically during the last several years. Successful physician leaders now must demonstrate a balance of clinical expertise, collaboration, business acumen, strategic thinking, pragmatic decision-making, clear communication and emotional intelligence.

For health systems, future success depends in large part on the ability to intentionally identify, develop and retain physician leaders. Physicians are hungry for education and development in this area, as evidenced by the growing number of physician leadership development programs and the growing ranks of physicians with advanced business degrees. Formal programs are being developed by associations, universities and health systems to groom the next generation of physician leaders.

Beyond training, there's the issue of retaining. Health systems, the panel suggested, need to create clear pathways to leadership roles within the organization. Without real and obvious leadership opportunities, physicians ultimately will leave an organization rather than lead it. As an example, Iowa-based UnityPoint Health has coupled its training strategies with formal talent development and succession planning. More than 60 of its program graduates have filled internal leadership roles — chief executive officers, chief operations officers, chief medical officers, vice presidents, medical directors and more.

Only with strong and effective physician leadership in place, the panel concluded, can the four remaining issues be addressed.

2. SHIFTING TO A PATIENT-CENTERED CULTURE

The demands on physicians are huge. Their days are unpredictable. Because of the intensity of running a clinical practice, in many organizations, patient appointments are scheduled around the availability and individual preferences of physicians. However, the rise of disruptive care models — with consumers who demand accessible, high-value, patient-centered care — is challenging this paradigm.

Patient-centered care has been part of the health care conversation for decades — and prominently so — since the Institute of Medicine identified patient-centeredness as one of the top six attributes of high-quality care.[1] Despite the age of the conversation, and evidence of the benefits, there remains a need for systemwide transformational change in order to shift the culture of care from being physician-centered to being patient-centered.

In most industries, the consumer is king. Consumer-oriented businesses quickly develop and deploy strategies and tactics to deliver what consumers want and/or need. Health care has been significantly slower to adapt to the changing needs of patients. But as health care consumerism continues to grow, organizational leaders must find more innovative and pragmatic ways to deliver care how, when and where patients need it.

Certainly, significant investments and efforts are being made by health systems to accomplish this. The use of electronic health records, engagement with patients through digital portals, introduction of innovative patient access strategies (including telemedicine), use of care teams, focus on care coordination and implementation of new care delivery models all demonstrate efforts toward patient-centered care.

DEFINING PATIENT-CENTERED CARE

"Health care that establishes a partnership among practitioners, patients and their families [when appropriate] to ensure that decisions respect patients' wants, needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care."

Source: Institute of Medicine, 2001

However, the shift has been spotty, and it won't happen organically. Focusing on patients requires a purposeful, dramatic and sustained change in the mindsets and practices of physician leaders and clinical staff. Supporting this shift should be a solid structure or framework for creating and maintaining a patient-centered culture.

The Commonwealth Fund, a foundation promoting health care excellence, identifies seven factors that contribute to successful patient-centered care: strong leadership (administrative and clinical), a clearly articulated strategic vision, proactive engagement with patients and their families, a supportive work environment for caregivers, systematic measurement and feedback, a well-designed and functional physical environment, and appropriate technological resources.[2] Together, these factors offer a foundation for medical groups and health systems to build a patient-centered culture.

All competitive, operational, strategic and financial advantages of a patient-centered care model aside, placing patients at the center of care is also simply the right thing to do. That might sound banal, but that does not make it any less true. Health care and physicians exist for one reason: to take care of the people and communities we serve. Health systems can and should be focused specifically on meeting the needs of patients, not physician schedules. We have advancements in industrial engineering, technology, integrated systems, design thinking and process improvement to take on that challenge.

3. BUILDING INFRASTRUCTURE AND EFFICIENT PROCESSES

A health system without a strong infrastructure and standardized processes is not really a system. Instead, it is an organization of a collection of disparate parts, predisposed to delivering fragmented care. In a climate where physician groups are being acquired and folded into larger health care organizations, the need for connectivity, coordination and communication is ever more crucial.

Hospitals and health system-employed medical groups, as standalone budget items, often show red ink. A natural reaction is to focus solely on driving productivity and cutting expenses. While both approaches have some merit, they miss the mark. The missing component is investment in the

infrastructure required to create a rewarding practice environment. Doing so also helps drive market share while promoting operational proficiency, higher quality and ultimately an improved organization-wide bottom line.

Many organizations have figured this out, including Mayo Clinic, Cleveland Clinic and Virginia Mason. Patient-centered care is an unachievable goal without investing in the environments of those who deliver the care. By building a solid infrastructure and efficient processes, we have the opportunity to combat unnecessary challenges in the workplace, reduce physician burnout and foster a productive and loyal workforce.

A comprehensive infrastructure connects all parts of the system while standardized processes enable greater operational, financial and clinical alignment. Through consistency and standardization, federated health care organizations can become truly integrated systems. For the patient, this means a more consistent and coordinated experience throughout the continuum of care. For the provider, it creates a more supportive and satisfying practice. For the system, efficiency and productivity improve while waste and costs are reduced.

Recognizing the need for and importance of a solid infrastructure is easy. Fully realizing the benefits of an IT platform, however, can be more difficult. Too many organizations fall into the trap of overinvesting in expensive systems and underinvesting in their proper implementation, support and ongoing optimization. High rates of provider dissatisfaction with EHRs and drags on productivity are evidence of this fact. On the contrary, a responsive and robustly supported infrastructure offers access to critical information when and where providers need it in order to improve performance and effectively manage the health of the population.

Provider organizations increasingly are accountable for the quality of care they provide. Prevailing medical groups and hospitals are acutely aware of what it means to operate as a system and the type of information they need to deliver optimal care. They also are aware of the limitations of existing IT systems and, therefore, the additional technology solutions necessary to elevate performance. Further, high-performing organizations recognize the value data holds in analyzing the present and future course of the health care system, as well as in designing the best strategies for improving patient care, access, outcomes and costs.

4. ALIGNING CLINICAL MISSION AND BUSINESS MODEL

The emergence of value-based reimbursement and collaborative care models not only encourages closer connections between care delivery and total costs, but also will, in certain instances, financially reward or punish organizations when clinical and financial integration are not achieved.

To thrive in a value-based environment, provider organizations will need to operate under payment systems that include shared financial risk involving a variety of upside and downside risk options. Improving care quality while simultaneously lowering costs is simply not feasible if the care delivery and financial goals are not intertwined. Clinical and financial integration produces "strong physician-hospital links, coordinated systems of care, geographic reach, quality management, contractual capabilities, utilization controls, financial strength, organized oversight and economy of scale."[3]

For health systems to realize tighter alignment, there needs to be a clear and consistent expression of the organization's clinical mission and transparency between administrators and physicians regarding the business model under which the organization operates. This begins when there are clearly defined clinical, financial and operational performance expectations and routine reports that inform future organizational decisions.

Systems are trying to identify the right mechanisms to better connect delivery of care with financial realities. Value-based reimbursement models, such as ACOs and bundled payments, represent efforts currently underway. The Commonwealth Fund's Breakthrough Health Care Opportunities program,[4] which provides grants to explore new approaches and incentives aimed at encouraging providers to make decisions that align with the clinical and financial goals of value-based care, is another example. Locally, health care systems are increasingly seeking provider incentive structures that incorporate productivity metrics into physician compensation.

Provider compensation design is a natural point of entry into organizational discussions revolving around aligning how care is delivered with how care is reimbursed. Physicians should be compensated fairly and equitably for their clinical contributions. Rightly or wrongly, how physicians are compensated is a reflection of how much or little they are valued by the organization. On the other hand, physicians need to understand that how they are paid needs to be congruent with how systems are paid. Health system leaders must collectively seek solutions to attract and retain physicians by maintaining compensation levels that are competitive in the market, while ensuring that those arrangements are not bankrupting their organizations.

The misalignment between clinical mission and business model in the current environment is the fact that organizations are living in two worlds — fee-for-service and value-based reimbursement. Leaders speak about value, but the bottom line, for many, is still driven by volume. This schizophrenia becomes more acute at the sharp point of care. Does the physician compensation system reward volume or does it reward value? Are our visions and strategies aligned with our compensation models, or are we telling physicians to do one thing while giving them financial incentive to do another? Not having answers to these questions only compromises leadership credibility and physician engagement.

Conversations about compensation can be difficult, but that is not an excuse for not having them. Systems that relieve tension and navigate complexity are those that elevate patients to the top of the discussion. If health systems are in the business of providing patient care, then how can we align care delivery with our business model to best serve our patients and communities?

5. PHYSICIAN AND ADMINISTRATIVE PARTNERSHIPS

Now more than ever, health system administrators and physician leaders must form collaborative, productive relationships. Historically, stakeholder groups have been segmented into autonomous compartments, each containing physicians, hospitals, ancillary services or other post-acute care services.

Administrators focused on managing the many moving parts in a complex institution and establishing a strategic path for the organization. Physicians emphasized patient care, independence and unilateral decision-making.

Maintaining a structure where physicians do clinical work and administrators take care of the business inhibits the creation of an integrated health system. Truly integrated systems do not encourage or protect organizational silos, but rather put system needs ahead of historical practices.

Payment reform programs and accountable care models that shift the focus from volume to value are eroding the boundaries between inpatient and outpatient care. The obvious implication is that administrators and physicians now have a vested interest in formally partnering to deliver coordinated, high-quality and cost-effective care. Conversely, failing to align these two groups not only prevents health systems (and physicians) from enjoying the rewards associated with success under value-driven models, but also subjects them to new penalties associated with costly and disjointed patient care.

Unlike most providers, system administrators bear the responsibility for developing and executing the business strategies necessary to reach value-based goals. Yet to do this effectively, they need engagement from physicians, who possess the intimate insight needed to identify areas of inefficiency and variation in clinical care. Additionally, it is to administrators' benefit to work collaboratively with physicians to ensure that the policies developed to hit cost targets align with clinical goals and are met with physician buy-in.

Incentives for physicians to participate on leadership teams are equally strong. With about half of physicians now working for hospital-owned health systems, they want to play a meaningful role in decision-making. From a financial standpoint, value-based reimbursement models, such as the Medicare Access and CHIP Reauthorization Act and mandatory bundled payments, are powerful reasons for physicians to engage with hospital leaders to improve care delivery, as their performance is increasingly tied to cost and quality outcomes.

Although most organizations are beginning to recognize the value of parity and embrace the concept of integrating physicians into leadership teams, there is often a struggle with how to build and manage these relationships effectively. The creation of leadership dyads is one approach being used to create equity and co-accountability between physician and administrative leaders. By pairing clinical and administrative leaders with complementary expertise, systems can force collaborative conversations and joint decisions. Another approach is recruiting experienced and capable physicians for traditionally nonphysician roles, such as COO. In either approach, the concept is to provide meaningful physician inclusion into the organization's leadership team.

Great physician and executive leaders are actively involved and exert influence in improving the health care enterprise. More important, they view their role as system partners who seek the best outcome for patients and the system, rather than their individual interests.

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Financial pressures on physician practices, combined with the challenges of health care reform, are driving the continued integration of physicians with hospitals and health systems. Almost all physicians completing their residency training are seeking employment. This is a huge opportunity for all health care leaders — physicians and nonphysicians — to rethink the relationship with a strong patient-centered focus. Those organizations that can be early adopters of this cultural transformation stand to reap considerable rewards.

There is value in beginning a conversation around the multitude of issues surrounding physician-hospital integration in light of growing physician employment trends. The five priorities listed here were culled from a list of more than a dozen important issues the panel identified. This group comprised only leaders of large employed medical groups.

Current professional organizations tend to confine participants to either physician or administrative perspectives. Many societies are hampered by their own politics, making it difficult for medical societies and hospital societies to come together

in a meaningful way. The necessary national conversation requires all parties at the table — exactly what's required for meaningful clinical integration.

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