An HFMA Value Project Report

Strategies for Physician Engagement and Alignment

hfma
healthcare financial management association

ABOUT THIS REPORT

This report on physician strategies is the second of five reports planned for HFMA's current phase of Value Project research. Other topics addressed in this phase of research include:

- Acquisition and affiliation strategies (released June 2014; available at hfma.org/valueaffiliations)
- Reconfiguring cost structure (forthcoming)
- Measuring and communicating value (forthcoming)
- Societal benefit and cost structure (forthcoming)

All HFMA Value Project resources, including reports and online toolkits, are available at hfma.org/valueproject. The findings in this report are based on:

- Responses (118 total) to an HFMA survey sent to a random selection of senior financial executive HFMA members in March 2014. Of the respondents, 55 percent represented stand-alone hospitals and 45 percent represented systems (19 percent at the system headquarters level and 26 percent at the system facility level).
- Site visits and interviews with the following hospitals, health systems, and medical groups:
  - DuPage Medical Group (Chicago metropolitan area)
  - Floyd Memorial Hospital and Health Services (Louisville, Ky., metropolitan area)
  - HealthONE/HCA Continental Division (Denver metropolitan area)
  - Hill Physicians Medical Group (Northern California)
  - OSF HealthCare (multiple locations throughout Illinois and in upper Michigan)
- Interviews with strategic consultants, finance executives, and legal subject matter experts quoted in this report.

INTRODUCTION

"What's wrong with medicine today? You can't make money seeing patients."

This sentiment, expressed during one of the interviews HFMA conducted in researching this report, gets to the heart of a profound transformation in the business of health care that is reshaping the role of physicians. Put simply, revenues generated under the traditional fee-for-service model, whether in a physician's office or a hospital operating room, are flat or falling. New payment models are rewarding providers that can keep patients healthy and reduce their need for more expensive healthcare services. More broadly, this transformation is prompting healthcare organizations—health systems and medical groups alike—to ask many questions (some old and some new) about their physician strategies: Should health systems be acquiring physician practices and directly employing physicians? Should medical groups be asking their members to give up some of their independence in favor of team-based care delivery models? How should physician compensation be adjusted to account for factors such as quality and cost efficiency? What is the right blend of primary care and specialty physicians to meet current and future demand? And when is the right time to answer these questions and move forward?

One of the great difficulties in answering these questions is the fact that physicians are practicing in an environment

PHYSICIAN STRATEGIES: HIGHLIGHTS FROM HFMA'S VALUE PROJECT RESEARCH

Regarding strategies for physician engagement and alignment, a number of themes emerged in our conversations with leaders at the organizations visited during the course of our research.

The gap between what is possible and what is paid for today. The dilemma of "one foot on the dock, one foot in the canoe" is commonly cited in discussions of the transition to value, but it seemed particularly acute in our research on physician strategies. This dilemma is reflected in part in the description of today's ideal physician recruit: one who balances independence and entrepreneurial drive with a willingness to help evolve new team-based models of care delivery.

A continuing focus on multiple approaches to physician alignment. The right alignment model is the product of market dynamics and health system and physician group organizational needs and preferences, and can vary significantly across physician specialties. Moreover, no model guarantees alignment—physician employment, for example, will not bring alignment absent a culture that respects physician input and leadership.

The need to better understand and quantify the contributions and expenses related to physician employment. The continuing use of "loss per physician" as a metric in hospital and health system finance departments can obscure the value that employed physicians bring to the organization and call into question the goals of a physician employment strategy. A clearer understanding, quantification, and description of the relationship between financial support of employed physicians and the contributions they make to the system can provide a more objective view of physician employment and help organizations define and manage to an appropriate and sustainable level of financial support.

The relationship between physician strategy and consumer needs. The consumer marketplace in health care is changing rapidly. A significant focus of physician strategy should be on how consumer needs can best be met by improving convenience and accessibility to physician services. What are the locations and hours of primary care clinics? Are specialists grouped together in ways that can best serve the needs of important patient populations? What investments in physician engagement strategies and tools might be required to support improved physician effectiveness in meeting consumer needs?

The need to achieve scale in the physician enterprise. Greater scale in the physician enterprise is important in many areas. Sufficient scale in the primary care physician network helps to ensure the referrals needed to support specialty services. Greater scale can help spread the costs of physician practice management and support across the enterprise. Scale of the physician network and the patient population it supports is also an important element of population management and access to data on population health.

that is part fee-for-service and part something else that falls beneath the broad umbrella of value-based payment and care delivery (e.g., bundled payment, shared savings, population health management). What precisely the "something else" will look like is still taking shape, but the fee-for-service part almost certainly will continue to diminish. Michael Kasper, CEO of the DuPage Medical Group, describes the issue as a question of pacing: "Move too quickly, and you can lose the confidence of your physicians. Move too slowly, and you will be lapped by the competition."

The pace of change and the opportunities available to physicians, health systems, and medical groups differ dramatically from market to market, as was evident in the survey results, site visits, and interviews HFMA conducted for this report. It is clear, however, that standing still is not a viable option.

This report will focus on how the transition to value affects physician strategy in the following areas:

- Alignment and employment options
- Compensation and incentives
- Financial support of physicians
- Leadership and governance
- Population health management capabilities

ALIGNMENT AND EMPLOYMENT OPTIONS

Issues of physician engagement and alignment have been a topic of conversation for many years, but these issues have grown in significance as the demands of healthcare reform and value-based payment intensify the need for a better-coordinated, more cost-effective approach to care delivery.

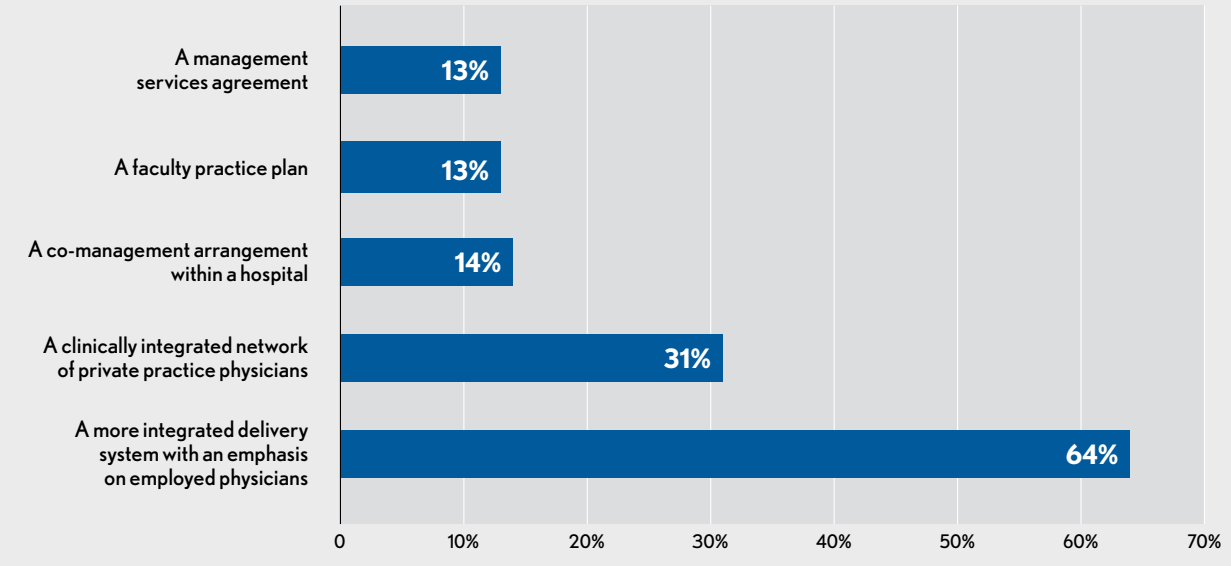
Demands to decrease utilization of specialty and acute care services by focusing on preventive care, to avoid readmissions following inpatient hospitalizations, and to increase the quality and cost efficiency of services across settings can be met only with the close cooperation of clinicians across primary, specialty, inpatient, and post-acute settings. New health plan products for both employer-sponsored insurance and for individuals purchasing health plans in the state and federal exchanges are offering "narrow" or "preferred" networks; their appeal to consumers is driven in part by their ability to offer convenient access to a full range of primary, specialty, and acute care services within the network. Hospitals, health systems, and multi-specialty practices need access to a sufficient referral base to maintain service lines, even as utilization rates for many services are declining. Physicians are facing new economic pressures, from flat or declining payment rates to the need for investments in electronic health records (EHRs) and IT infrastructure.

In response to these new dynamics, individual physicians, independent medical groups, and hospitals and health systems are taking a fresh look at alignment opportunities. From a hospital and health system perspective, direct employment of physicians is back on the agenda. Nearly two-thirds of respondents to an HFMA survey of senior financial executive members indicated that they have been pursuing a more integrated delivery system with an emphasis on employed physicians (see the exhibit below).

Organizations that are pursuing an employment model are trying to avoid mistakes made during the 1990s by ensuring that compensation agreements encourage sustained productivity and by creating forums that give physicians a meaningful voice in organizational decisions that affect clinical practice. They are also trying to be strategic in their

MOST RESPONDENTS REPORT PURSUING A MORE INTEGRATED DELIVERY SYSTEM WITH AN EMPHASIS ON EMPLOYED PHYSICIANS

Which of the following arrangements most closely resembles the model you have been pursuing recently with physicians? Exclude emergency department, pathology, and radiology specialists. Please check all that apply.



Source: HFMA Value Project Survey, March 2014.

approach to physician employment, based on anticipated needs for primary care and specialty services.

At the same time, there is an impression in some markets of a physician "land grab" mentality that may not best serve the interests of either health systems or physicians in the long run. One interviewee noted that there are three primary motivators for physician employment: community need, playing offense, or playing defense. Community need is, of course, the soundest basis for a physician employment strategy, but competitive forces require organizations to play offense or defense in many markets.

From a hospital or health system perspective, physician employment offers the tightest alignment model but may not always be the best strategic option. Accordingly, alternative alignment options—including co-management agreements, management services agreements, and clinically integrated networks of independent physicians—are also being pursued. A critical factor in the success of these options is the ability to identify sufficient economic linkages between the parties to ensure that everyone involved is pursuing the same objectives. Technology is becoming an increasingly significant factor in these alternative arrangements as well, as parties combine to pursue risk-based contracting that requires sophisticated tracking and understanding of patient data across settings of care.

Physician alignment is, of course, a two-way street. From the physician's point of view, a decision on whether to seek employment at a hospital or health system (either through direct employment or employment by a system-owned medical group), join an independent medical group, or pursue other alignment opportunities involves careful consideration of personal and professional goals. Although health systems and independent medical groups have many similar goals, they are not always the same (see the exhibit at left). Some options may offer greater independence, others greater financial and administrative support. This report aims to account for both organizational and individual physician perspectives in discussing employment and alignment options.

A COMPARISON OF PERSPECTIVES

Health System Goals	Medical Group Goals
• Growing/sustaining the primary care base	• Maintaining/enhancing quality of care
• Right-sized specialists	• Meeting/exceeding physician financial goals
• Team-based culture	• Maintaining/enhancing quality of practice
• Evidence-based practices	• Maintaining/enhancing physician practice governance and management
• Shifting from fee-for-service to value-based payments as a group	• Reducing unproductive costs and efforts
• Reaching a sustainable benefit/cost ratio over time	

Source: HFMA Physician Strategies Toolkit, hfma.org/valuephysiciantoolkit.

PHYSICIAN EMPLOYMENT

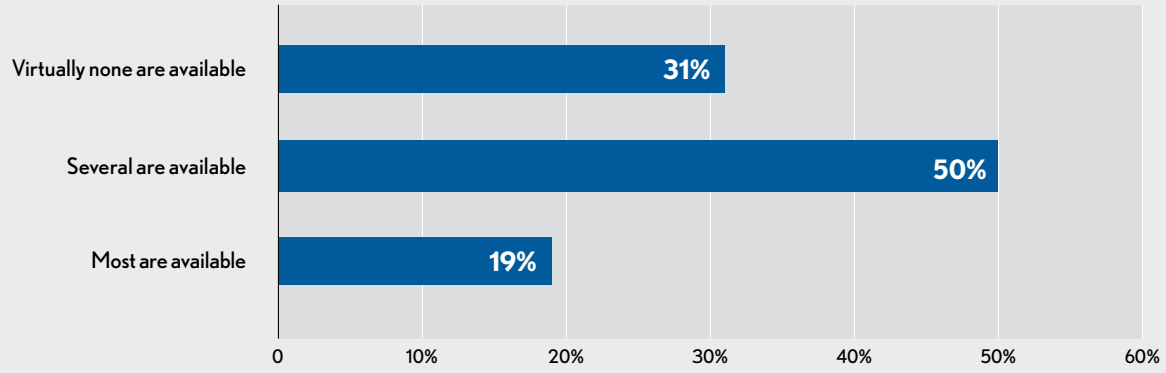
There has been a clear trend toward physician employment in recent years, although there is significant variation in employment trends across specialties and by physician age and gender. A 2012 survey of physicians by the American Medical Association (AMA) found that "while there has been a shift toward hospital employment, 53.2 percent of physicians were self-employed and a full 60 percent worked in practices that were wholly owned by physicians."[a] Looking at single-specialty groups, the AMA survey found that over 45 percent of internal medicine single-specialty groups had at least some hospital ownership, compared with less than 8 percent of surgical subspecialty, radiology, and anesthesiology groups. Of physicians younger than 40, 43.3 percent had an ownership stake in a practice, compared with 60 percent of physicians ages 55 and up. Less than 39 percent of female physicians had an ownership stake, compared with just under 60 percent of male physicians.

Data from HFMA's 2014 survey of senior financial executives also found wide variation among markets in the availability of physician practices for acquisition or alignment. While 50 percent of the respondents indicated that several independent practices or medical groups remained available in their markets, nearly a third indicated that "virtually none" were available; less than 20 percent indicated that "most are available" (see the exhibit on page 5).

With respect to the current mix of employed and non-employed physicians, the HFMA survey respondents indicated a wide range of situations. Just under a third of the respondents indicated that most (i.e., more than 75 percent) of their physicians are employed. At the other end of the

AVAILABILITY OF INDEPENDENT PHYSICIAN PRACTICES/GROUPS FOR ACQUISITION OR ALIGNMENT

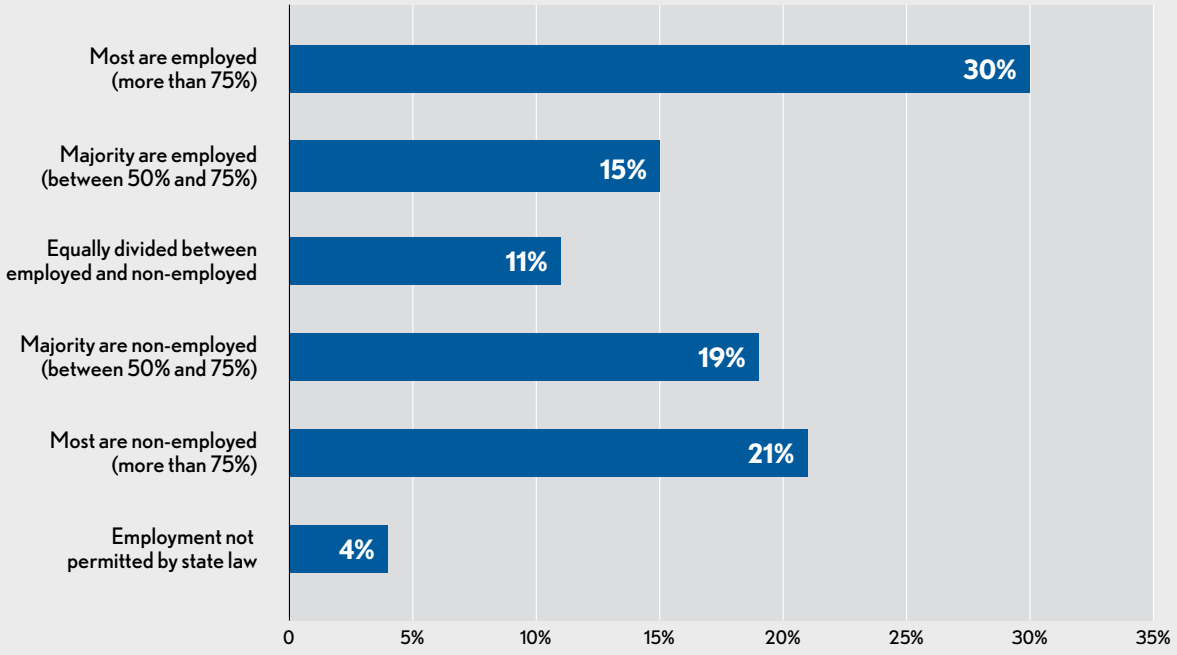
Please describe the extent to which independent physicians or medical groups are available within your community for acquisition or alignment.



Source: HFMA Value Project Survey, March 2014.

MIX OF EMPLOYED AND NON-EMPLOYED PHYSICIANS IN HOSPITAL AND HEALTH SYSTEM NETWORKS

Which of the following options most closely approximates the composition of your network, in terms of the mix of employed and non-employed physicians?



Source: HFMA Value Project Survey, March 2014.

scale, a little more than 20 percent of the respondents indicated that most (again, more than 75 percent) are non-employed (see the exhibit on page 5).

Almost 80 percent of the HFMA survey respondents are looking to expand primary care, while just over 40 percent are looking to expand specialty services (see the exhibit on page 7). More than 50 percent of smaller (i.e., fewer than 200 beds) and stand-alone facilities are interested in expanding specialty services, but fewer than a third of multihospital systems and larger facilities (more than 1,000 beds) wish to do so. Indeed, about a third of multihospital systems and larger facilities are seeking to reduce or control utilization of specialty services; virtually no smaller facilities or stand-alone facilities are seeking to do so. Orthopedics is the specialty that organizations are most likely to seek to expand (chosen by 60 percent of respondents), followed by cardiology (48 percent), oncology (41 percent), and neurology (34 percent). Neonatology ranked lowest, at 7 percent.

Matt Ullum of Healthcare Strategy Group, a Louisville, Ky.-based consulting group focused on physician alignment strategy, confirms that primary care is the biggest focus among clients as they work to lay the foundations of population health management. "We're also seeing fewer management services organizations and professional services agreements and more employment and co-management agreements, particularly for such specialties as orthopedics and general surgery, but the emphasis is clearly on primary care and employment," Ullum says.

Most of the hospitals and health systems interviewed for this report have traditionally been conservative in their approach to physician employment, but have expanded the number of physicians they employ in recent years. At the Denver-based HealthONE healthcare system, part of HCA's Continental Division, a disciplined approach to physician employment has its roots in the fact that "physician investment is expensive," according to a hospital finance executive. "As a for-profit company with accountability to shareholders, this is an issue of key concern." Another HealthONE leader noted that although employment might create a stronger economic bond between hospital and physician, "it is not equivalent to alignment." Part of HealthONE's physician employment strategy is driven by market dynamics.

Michelle Conger, chief strategy officer for Peoria, Ill.-based OSF HealthCare, notes that "The focus of OSF right now is development of the primary care physician base in all of its markets, combined with a strategy to partner with particular specialties." Dan Baker, OSF HealthCare CFO, dates employment of physicians, beginning with primary care, back to the 1990s, but adds, "OSF has not traditionally placed a heavy emphasis on employment of specialty physicians. The physicians we do employ have typically had a relationship with OSF for a number of years." As OSF HealthCare has begun to develop accountable care organizations (ACOs)—it is participating in Medicare's Pioneer ACO program—Illinois state insurance law,

LESSONS LEARNED FROM PHYSICIAN EMPLOYMENT

Respondents to HFMA's member survey on physician strategies were asked to share their experiences with physician employment. The most important—and frequently cited—lessons were the following.

Employment does not equal alignment. Physician employment is not a shortcut around the hard work and investments of time and resources required of both health systems and their physicians to align themselves around common organizational goals.

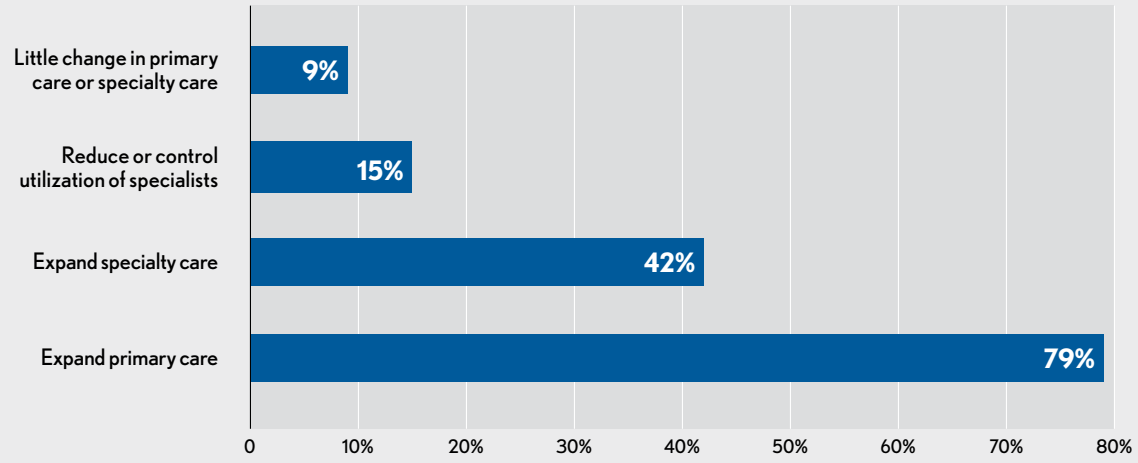
Clear and consistent communication on expectations is critical. "It is extremely important to set expectations from the beginning and then follow up on a regular basis," says one respondent. Another notes, "Standard business practices should be developed prior to any practice acquisitions or employment strategy" to ensure expectations are clear.

Know your organization's needs and have a strategy in place before you start. "It is far better to determine needs, identify positive attributes, and recruit physicians than to simply employ any physician who shows up at your door," a respondent says.

Consider employment needs beyond physicians. If acquiring a practice, consider who beyond the physicians has been important to the practice's success: "It is a good idea to evaluate the staff to determine who else should be included in the employment," according to a survey respondent.

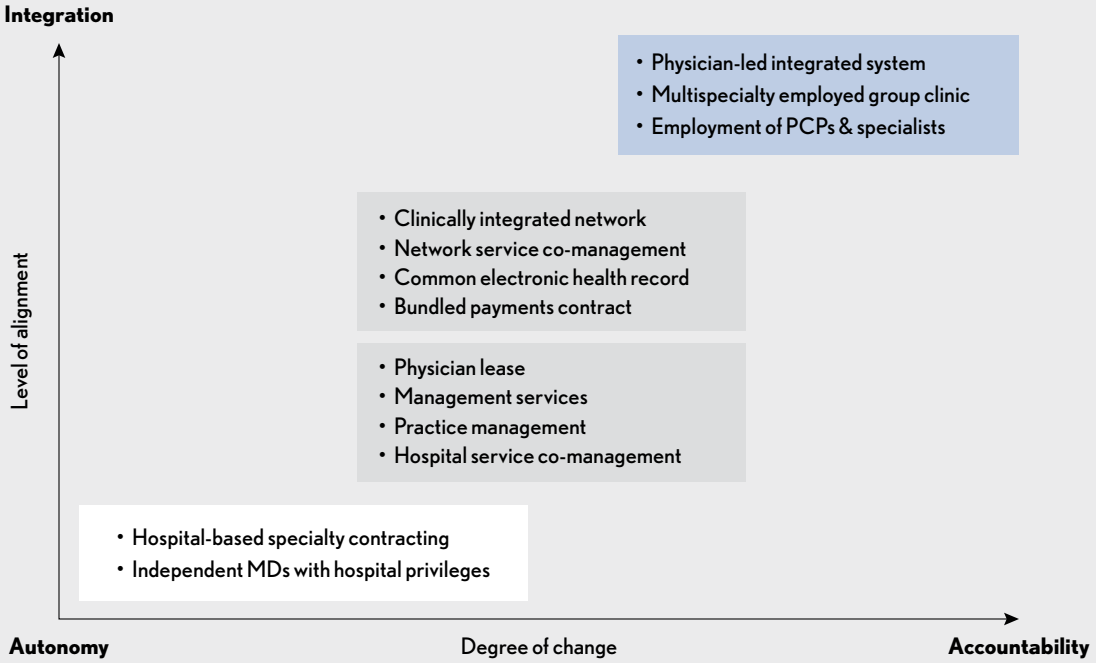
STRATEGY REGARDING PRIMARY CARE AND SPECIALTY PHYSICIANS

Looking forward over the next three years, which of the following best describes your organization's physician affiliation strategy, in terms of emphasis on primary care versus specialty services? Please check all that apply.



Source: HFMA Value Project Survey, March 2014.

PHYSICIAN/HEALTH SYSTEM ALIGNMENT OPTIONS TO BALANCE AUTONOMY, INTEGRATION, AND ACCOUNTABILITY



Source: HFMA Physician Strategies Toolkit, hfma.org/valuephysiciantoolkit.

which prohibits the system from having full-risk contracts with non-employed physicians, has also created incentives to pursue an employment strategy.

At Floyd Memorial Hospital and Health Services, based in New Albany, Ind. (part of the Louisville metropolitan area), growth in physician employment initially was fueled by physician interest. "In 2008, what is now Floyd Memorial Medical Group agreed to employ a group of four primary care physicians who were running a deficit but were important to the hospital," says Joy Whistine, vice president of physician services at Floyd Memorial Hospital and Health Services. "Although we were not intent on employing physicians, other community physicians came forward to inquire about employment possibilities." Floyd Memorial Medical Group has since developed a board-approved structure for assessing practices and determining return value and opportunity for the medical group and hospital, and has implemented standard guidelines for proposing growth in physician employment to the board.

As HFMA's interviews with these organizations suggest, the increase in physician employment by hospitals and health systems is the product of several factors. Systems that are actively pursuing or already engaged in risk-based contracting see a need to build their base of primary care physicians to better manage the health of their patient populations. Competition for physicians with other health systems can trigger an offense/defense dynamic in a local market. And physicians are increasingly seeing employment by a hospital or health system as a means of gaining the administrative and financial support needed to run a practice today.

Leaders at HealthONE, for example, identified their ability to alleviate the burden of managing a physician practice as a key factor in physicians' decisions to become system employees. As part of HCA, HealthONE uses HCA Physician Services (HCAPS) to manage and support its employed physicians and their practices. HCAPS offers operational and administrative management of the practices, employment of office staff, financial services (including credentialing, billing, and collections), and human resources.

Large, independent multispecialty practices offer an alternative to employment by a hospital or health system. DuPage Medical Group, a multispecialty group of approximately 425 primary care and specialty physicians in west-suburban Chicago, notes that newly hired physicians are typically on a two-year track to shareholder status in the group. Most of the group's physicians are thus both shareholders and employees. DuPage Medical Group is 100 percent physician-owned, with a 10-member governing board that includes five primary care and five specialty physicians. Michael Kasper, CEO of the medical group, sees the physician ownership component as a critical distinction between DuPage Medical Group and hospital employment, enabling physicians to maintain a sense of independence that sometimes comes under strain in a

COMPARING CLINICAL INTEGRATION AND ACCOUNTABLE CARE

Although clinically integrated networks (CINs) and accountable care organizations (ACOs) both seek to improve healthcare quality and efficiency, there are some significant differences between the two.

CINs

- Typically organized by a hospital or health system, which takes on the expense of developing infrastructure for the CIN
- Allow joint contracting with commercial health plans
- First developed in the 1990s; created and operated pursuant to guidance by federal antitrust agencies issued in 1996

ACOs

- May be organized by a hospital, physician group, or integrated delivery system
- May have payment relationships with both government and private payers (public ACO programs include the Medicare Shared Savings Program [MSSP] and the Pioneer ACO program)
- Are rewarded for success in improving quality and efficiency for an attributed population
- Federal antitrust authorities have defined "safe harbors" for ACOs formed pursuant to the MSSP

hospital employment situation. At the same time, DMG employs a management team that alleviates the burdens of practice management that a physician would experience in a solo or small practice setting.

OTHER ALIGNMENT OPTIONS

Despite the trend toward employment, many physicians and medical groups still prefer to remain independent. Possibilities in these cases range from clinically integrated networks (CINs) designed to offer a comprehensive range of medical services to co-management agreements focused on quality and cost-efficiency improvements in a select set of procedures or a specific service line.

CINs and ACOs. These arrangements are both designed to improve the efficiency and quality of health care. Although they share similar goals, there are important distinctions between the two.

CINs are typically organized by a hospital or health system and bring both independent and employed physicians together into an integrated network designed to improve the quality and efficiency of healthcare services. A 1996 statement from the federal antitrust enforcement agencies—the Federal Trade Commission (FTC) and Department of Justice (DOJ)—allowed parties to a CIN to jointly contract with payers, provided that:

- The CIN features clinical integration involving authentic initiatives that require the active participation of all network participants in an ongoing program to evaluate and modify practice patterns
- The program is designed to achieve likely improvements in healthcare quality and efficiency
- Joint contracting with a health plan is reasonably necessary to achieve the efficiencies of the clinical integration program

Contracts with the CIN will typically involve some form of value-based incentive (e.g., pay for performance, shared savings) that rewards the network for success in achieving its efficiency goals.

CINs first appeared in the 1990s and thus predate ACOs by about two decades. Clinical integration is a necessity for an ACO, but a CIN does not have to become an ACO. There are both "public" and "private" forms of ACOs. Public ACOs include those formed pursuant to provisions in the Affordable Care Act (ACA) that authorized the Medicare Shared Savings Program (MSSP) and the Center for Medicare & Medicaid Innovation's Pioneer ACO Program. On the private side, many commercial health plans are working with physicians, hospitals, and other providers to form ACOs. There is significant overlap between the two; an ACO that was formed to participate in the MSSP may also seek a commercial ACO contract with a health plan, for example.

A key distinction between ACOs and CINs is that ACOs are closer to a population management model in that they are designed to improve the quality and reduce the cost of care for an *attributed population*. They are typically rewarded with a share of the savings if they can reduce the cost of care

ACOs TAKE MANY FORMS

Drawing on a database of more than 600 accountable care organizations (ACOs), Salt Lake City-based healthcare intelligence firm Leavitt Partners has developed a taxonomy that outlines six different types of ACOs.

Full-spectrum integrated ACOs. Directly provide all aspects of health care to their patients and are often dominated by a large integrated delivery network (although other providers may be included)

Independent physician group ACOs. Owned by a single physician group and do not contract with other providers to offer additional services

Physician group alliance ACOs. May have multiple physician group owners (often including multispecialty groups), but do not contract with other providers to offer additional services

Expanded physician group ACOs: Regardless of the number of owners, these ACOs directly offer outpatient services only but contract with other providers to offer hospital or subspecialty services

Independent hospital ACOs: Have a single owner that directly provides inpatient services; outpatient services may also be provided directly by the ACO if the owner is an integrated health system, or they may be offered by a contracted provider

Hospital alliance ACOs: Have multiple owners, with at least one of the owners directly providing inpatient services

Source: Muhlestein, D., et al., *A Taxonomy of Accountable Care Organizations: Different Approaches to Achieve the Triple Aim*. Leavitt Partners, 2014.

for the attributed population below a historical benchmark while maintaining or improving the quality of outcomes for that population. Depending on the payment model, they might also be asked to share in the loss if costs of care exceed the historical benchmark.

To promote the formation of ACOs and the required collaboration among providers, the FTC and DOJ have created "safe harbors" from antitrust scrutiny for ACOs that fall below defined market share percentage thresholds.[b] The ACA authorized waivers of fraud and abuse laws to permit funding of an ACO's development (e.g., investment in a shared IT platform), distribution of shared savings among ACO participants, and the provision of nonmonetary preventive items or services (e.g., heart-rate monitors) to Medicare beneficiaries.

With respect to independent physician practices, both CINs and ACOs give hospitals and health systems a means of tightening their alignment with these practices while avoiding some of the potential financial costs of full employment. As the organizer of a CIN, the hospital or health system will still face significant costs to develop the necessary infrastructure for the network, including a common IT platform and care managers. Physicians in the market also have to be ready to integrate, which will typically include acceptance of quality metrics and care protocols designed to improve quality and efficiency.

Co-management agreements. These offer a means for hospitals to align with specialty practices that wish to remain independent. They are typically structured around a service line, such as orthopedics, with physicians receiving a base fee for managing the service line plus incentives if specified quality or operational targets are achieved.

To better align with independent physicians, OSF HealthCare has developed "accountable clinical management" models (ACMs), a twist on the classic co-management agreements that, in the system's experience, typically had a lifespan of three to five years. The ACMs have a formalized, physician-led governance structure focused on operational efficiency and clinical outcomes. Agendas and metrics are established in advance, and physicians receive training on the importance of the operational and clinical metrics that are being pursued. Predefined bonuses, tied to outcomes and fair-market-value parameters, are available to physicians who achieve their metrics. If metrics are not being met, system representatives and physicians hold in-depth conversations about the work needed to meet the metrics. Kathleen Forbes, MD, chief clinical officer for OSF HealthCare, notes that "the structure and training that bring physicians into the ACM's governance structure provide more 'glue' than with traditional co-management agreements."

Management service agreements. A precondition for a hospital or health system interested in pursuing management service agreements with physician practices is a proven track record in effectively managing practices. In this respect, large multispecialty medical groups focused on physician practice management may have an advantage over hospitals and health systems. For example, DuPage Medical Group has formed Midwest Physician Administrative Services as part of its revenue diversification efforts. The new entity provides back-office and billing and collection support to hospital-owned medical groups.

COMPENSATION AND INCENTIVES

Physician compensation and incentives are at a crossroads. Although fee-for-service payment remains the dominant means by which most providers in most markets are paid, new value-based payment methodologies that reward quality and cost efficiency are gaining traction. Compensation and incentives remain subject to federal and state fraud and abuse laws that are premised on a volume-based market for healthcare services, even as the industry increasingly focuses on population management and improved care coordination to reduce utilization of high-cost specialty and acute-care services. Physicians want some sense of certainty regarding what their income will be, even as the system asks them—or their hospital employers—to assume greater risk.

Given the uneven pace of transition across markets, the organizations HFMA interviewed for this report are at different places in their approaches to physician compensation and incentives. But they shared common issues and concerns:

- Productivity is and for the foreseeable future will remain part of compensation for employed physicians.
- Quality and efficiency metrics will be increasingly important. The challenge will be defining metrics that are sufficiently valid to support decisions affecting physician incomes.
- Efforts to develop team-based approaches to care may require compensation and incentives tied to organizational as well as individual goals.
- Financial incentives are not sufficient to ensure physician commitment to changes in practice patterns and care delivery.

Although this discussion will not go into detail on the Stark and related fraud and abuse laws that affect physician compensation and incentives, basic guidelines under the existing legal and regulatory framework require that, in all circumstances, volume or value of referrals should not be considered when developing a compensation and incentive framework.

PRODUCTIVITY

Physician productivity is a concern in any practice setting, but it is of particular importance to hospitals and health systems that are bringing formerly independent physicians into an employed setting. HFMA's survey of senior financial executive members in a hospital or health system setting found that a strong majority (85 percent) reported slight to substantial decreases in productivity when physicians moved into an employed setting; only 5 percent indicated that productivity improved, while 10 percent reported that productivity stayed the same (see the exhibit on page 12).

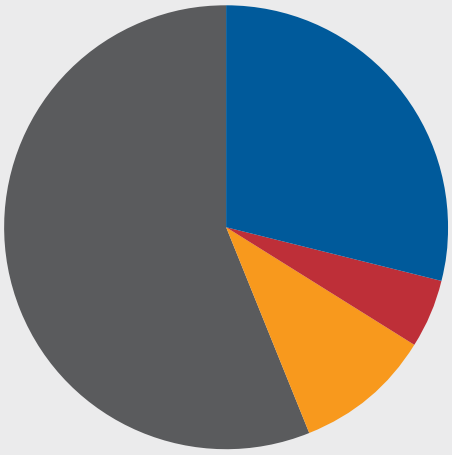
Productivity changes are by no means inevitable, however. Due diligence in negotiations leading to employment can establish benchmarks that promote sustained levels of productivity in an employed setting.

"Before employing a physician, Floyd Memorial Medical Group requests a three-year look back at the physician's billing records as well as his or her tax and income records," says Whistine, the vice president of physician services for Floyd Memorial Hospital and Health Services. "The average over this three-year history is then benchmarked against Floyd Memorial Medical Group's current experience with employed physicians in the same specialty to determine if the physician prospect meets the group's expectations. Base compensation plus the productivity incentive for the newly employed physician are then structured on the premise that compensation should match productivity (determined by work relative value units [RVUs]). If, for example, expected productivity for the employed physician is in the 73rd percentile, the physician will earn in the 73rd percentile of salary (based on Medical Group Management Association [MGMA] medians and other sources) if he or she achieves expected productivity levels." Only eight of 80 physicians who have been employed by the medical group experienced decreases in productivity, and they are no longer with the group.

For most specialties, HealthONE provides physicians with a productivity-based compensation plan along with a base-income guarantee for the first year. HealthONE also uses MGMA data to benchmark its physicians' productivity, establishing a threshold benchmark at a certain percentage of the MGMA scale that physicians are expected to achieve. Practice managers regularly review reports to see how their physicians are performing relative to the benchmark

CHANGES IN PRODUCTIVITY FOLLOWING PHYSICIAN EMPLOYMENT

What has been your experience, in terms of productivity, when physicians move from private practice to hospital or health system employment?



29%
Physician productivity decreases substantially once employed

5%
Physician productivity improves once employed

10%
Physician productivity stays the same whether in private practice or employed

56%
Physician productivity decreases slightly once employed

Those answering "Not applicable" excluded from the analysis

Source: HFMA Value Project Survey, 2014.

threshold and meet on a quarterly basis with physicians who are falling below the threshold.

The organizations interviewed for this report strongly favor RVU-based productivity measures over compensation agreements linked to percentage of revenue. "I don't believe that it is fair to use a system based on charges or revenue," Whistine says. "Charges are meaningless and collection of revenue is not in the physician's control."

VALUE-BASED COMPENSATION INCENTIVES

Both OSF HealthCare and DuPage Medical Group have significant percentages of revenue tied to risk-based contracts: OSF HealthCare participates in the Pioneer ACO Program and DuPage Medical Group is a co-founder (with Edward Hospital and Health Services) of Illinois Health Partners, which has a commercial ACO arrangement with Blue Cross and Blue Shield of Illinois and, as of January 2014, became a participant in an MSSP ACO. Although both systems still use productivity as a significant factor in their compensation agreements, they have added incentives tied to quality, cost efficiency, and patient satisfaction to their physician compensation contracts.

Two years ago, OSF HealthCare began moving toward what it describes as a "transitional" compensation model, with 80 percent of compensation tied to productivity and 20 percent tied to incentive metrics. Incentive metrics are divided into four categories: access, quality, resource utilization, and system performance. Physicians under the transitional compensation model—currently about 40 percent of the system's employed physicians—will typically have metrics in all four categories, each worth 5 percent of their compensation. The system has also aligned physician incentives with team financial awards for staff in the physician offices to ensure that everyone in the office is aligned to drive desired outcomes.

The most significant issue OSF HealthCare has faced with its new model is complexity. "There are many metrics involved, and ensuring that they are all meaningful, accurate, and valid (especially from the perspective of the physicians), is a challenge," says Chuck Dennis, MD, vice president of the OSF Medical Group, Central Region. "Appropriate measures may not be readily available for all specialties. Also, as we move toward more team-based care delivery models, it can be difficult to attribute outcomes to any one physician. A big part of gaining physician acceptance of the new model is communication. We need to connect the dots with a simple message so physicians understand how the terms of their compensation agreements tie back to the key value equation factors of quality, patient experience, and cost."

The compensation model has been developed with the oversight of a physician compensation committee that includes four administration appointees and six physicians selected by the system's executive team based on their expertise and interest. Other individuals are brought in as needed—by specialty, for example—to help identify appropriate metrics. The physician compensation committee will be reviewing the new compensation model over the coming year and hopes to reduce the number of metrics involved. The system also is interested in adding a bonus component tied to the system's success in meeting its overall goals.

About 15 percent of physician compensation for primary care physicians at DuPage Medical Group is outside of productivity (the percentage is slightly lower for specialists). This percentage is tied to quality metrics, including team and organizational goals as well as individual goals hinging on factors such as utilization of generics or measures of asthma or diabetes control. Some efficiency dollars also are at stake in the care of professionally capitated lives among DuPage Medical Group's patient population.

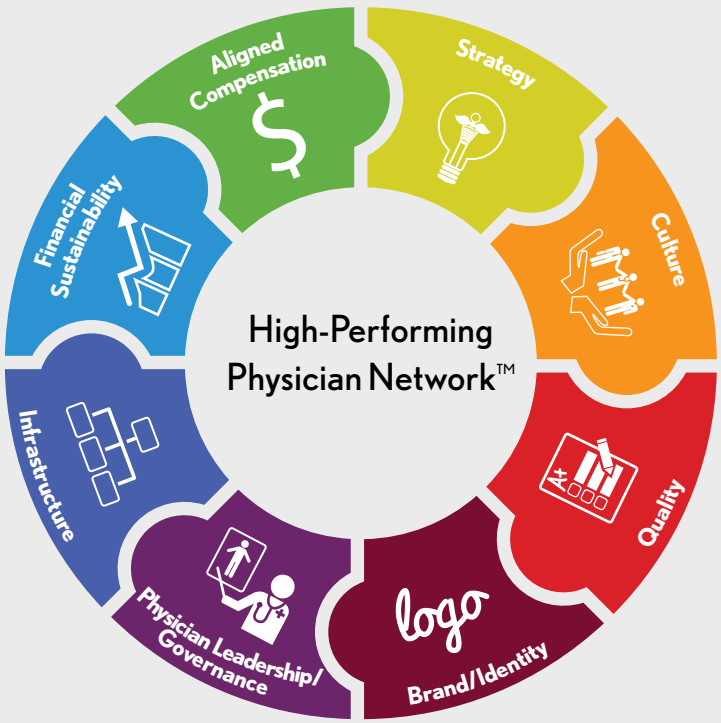
KEY CONSIDERATIONS FOR PHYSICIAN COMPENSATION PLANS

John Hill, a partner in Healthcare Strategy Group, recommends these five key steps when building or changing physician compensation plans:

- Create mechanisms to engage and encourage physician leadership
- Incorporate quality metrics
- Build flexibility to allow for gradual increases in the amount of compensation tied to quality
- Refocus incentives to include group pools or team goals
- Understand the legal parameters of structuring these plans

Although payers in Floyd Memorial Hospital's market have not moved significantly toward value-based payment, the hospital and medical group are actively laying the groundwork for such a payment and care delivery system. They have begun to implement care management to reduce readmissions and recently assembled an employed hospitalist

ESSENTIAL ELEMENTS OF A HIGH-PERFORMING PHYSICIAN NETWORK



Source: Hill, J., and Ullum, M., *67 Tips for Developing a High-Performing Physician Network*, Healthcare Strategy Group, 2014. Available at www.healthcarestrategygroup.com/client-services/network-management-division/

group that has already produced significant drops in length of stay. Floyd Memorial Medical Group is also participating in the Physician Quality Reporting System with the Centers for Medicare & Medicaid Services. Up to 15 percent of compensation for physicians in the medical group is at risk based on performance against a set of quality and other performance indicators. All physicians are held to three standard indicators: patient satisfaction at the 75th percentile or higher, medical record auditing (85 percent or better in coding and documentation accuracy), and submission of complete charge reports and documentation within five days of service. Physicians are also held to two specialty-specific indicators, which may include diabetes control or Healthcare Effectiveness Data and Information Set measures for primary care physicians or on-time status or infection rates for surgeons (Daniel Eichenberger, MD, CMO for Floyd Memorial Hospital, notes that there can be difficulties in getting meaningful, respectable metrics for certain specialties).

ADDITIONAL COMPENSATION CONSIDERATIONS

Although compensation is important, it can be a blunt tool in efforts to drive change in behavior or performance. "Systems won't get physician engagement through financial incentives alone," says Steven Norris, MD, OSF Medical Group regional director, Peoria Primary Care, at OSF HealthCare. "Providers will just learn to play the game well. Instead, you need physician buy-in to your goals and strategy. Once you have that, you don't need to do much to encourage support."

Ullum, of Healthcare Strategy Group, agrees. "Aligned compensation is just one of many factors that help to create a high-performing physician network," he says. "Equally important are a coherent physician strategy, a common culture guided by a shared vision and behavioral norms, a continual focus on process improvement and outcomes, a strong brand identity for the group, physician leadership and governance that understands the need for change and guides physician behavior, an adequate investment in IT and other supporting infrastructure, and ensuring the financial stability of physician practices."

FINANCIAL SUPPORT AND SUSTAINABILITY

The costs of employing physicians go well beyond compensation. The costs of managing an acquired practice, paying salary and benefits for the practice's staff (often at a higher level as part of the hospital compensation plan than when the practice was independent), upgrading IT systems, paying for malpractice insurance, and other expenses add significantly to the financial impact of employment.

On the revenue side, ancillary revenues are often shifted from the practice to the hospital or health system, depriving the practice's business side of an important revenue stream on the ledger sheet. Employed physicians also shift from being essentially a small-business owner in an independent practice to a salaried employee of a large organization. As a result, systems will typically report financial support (often expressed as "loss per physician" on the hospital side or "investment per physician" on the practice management side) well in excess of $100,000 per physician, with potentially significant variations by specialty. Not surprisingly, a survey of HFMA senior financial executive members found that fewer than 25 percent expected to see a positive ROI from physician employment during the first two years of employment (see the exhibit below).

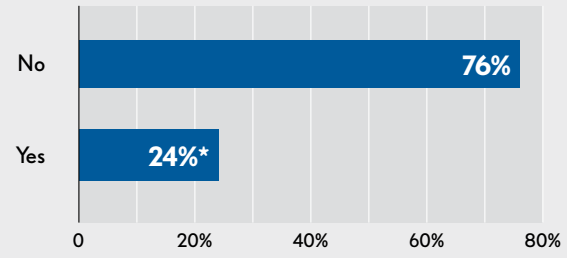
Financial support of physicians is not a fixed cost: Hospitals and health systems can adopt a number of strategies to reduce this figure significantly. A first step, says Ullum of Healthcare Strategy Group, is a focused effort on measurement and benchmarking of practice performance. "Working with the physicians, you need to define the key measures for the practice and manage them relentlessly," Ullum says. "If you are not measuring it, there will be no improvement. Benchmarking practices is also essential, as is close analysis of those that are not performing. For nonperforming practices, it is helpful to bring in an independent resource—whether another manager or a consultant—to help guide the improvement plan." Floyd Memorial Hospital had initially outsourced its practice management, but upon realizing its physician losses were reaching unsustainable levels, it hired an experienced practice manager and brought the function in-house in 2009. It has since reduced those losses by more than 50 percent and is currently holding them below budget.

Physicians also need to be held accountable for costs; they make decisions regarding staff resources, equipment, and supplies that have a major impact on a practice's financial performance. "Cost efficiencies can be created in the back office, but the local decisions that drive RVUs lie in the physicians' offices," says DuPage Medical Group CFO Michael Pacetti. The group computes costs at the organizational and departmental levels, as well as profit-and-loss per physician. Some costs are deemed general, and are spread across the physicians in the group, while others are deemed local. Local costs are those within the control of the individual physician or practice, and those for which the physicians are held accountable.

Most DuPage Medical Group physicians are, of course, shareholders as well as employees of the group, which provides added incentive to carefully manage costs. But effective cost management also will be a critical capability for hospitals and health systems as exposure to risk-based contracts grows, and as noted in the previous section, several of the systems interviewed are considering or actively implementing metrics tied to resource utilization in their physician compensation agreements. It is important for hospital administrators to work closely with physicians in defining appropriate resource utilization measures to help ensure that cost management decisions do not negatively affect the quality of patient care and to secure physician acceptance of the measures.

ROI EXPECTATION FOR PHYSICIAN EMPLOYMENT

Do you believe your organization will achieve a positive ROI after two years of physician employment?



* Further breakdown shows 21% of hospitals with >100 beds; 29% of hospitals with 500+ beds

Source: HFMA Executive Survey on Hospital and Physician Affiliation Strategies, 2013.

A smooth onboarding and credentialing process for newly hired physicians is also critical. "Many hospital executives don't understand this issue," Ullum says. "If the providers are not credentialed, you cannot collect from payers and face months of losses and cash flow challenges. Start the credentialing process the day you agree to hire the physician. No exceptions!"

Mary Passantino, development director for HealthONE Physician Care, agrees. "HealthONE's hospital CEOs are responsible for determining what recruiting efforts are necessary, but once they have identified a potential recruit, leaders from our team quickly get involved," she says. "The process from recruitment to onboarding takes from three to six months, and we have outlined a six-step process that takes the recruit through contractual terms, payer and hospital credentialing, state licensing (if needed), benefit changes, and human resources policies that will take effect upon employment."

Other factors that can help reduce physician financial support include the following.

Balancing employed specialists with an adequate primary care network. As health systems engage in more value-based contracting that seeks to reduce utilization of higher-cost specialist and acute care services, this balance should be regularly reviewed. Expansion of primary care practices and the patient panels they manage may be necessary to adequately support the system's specialists.

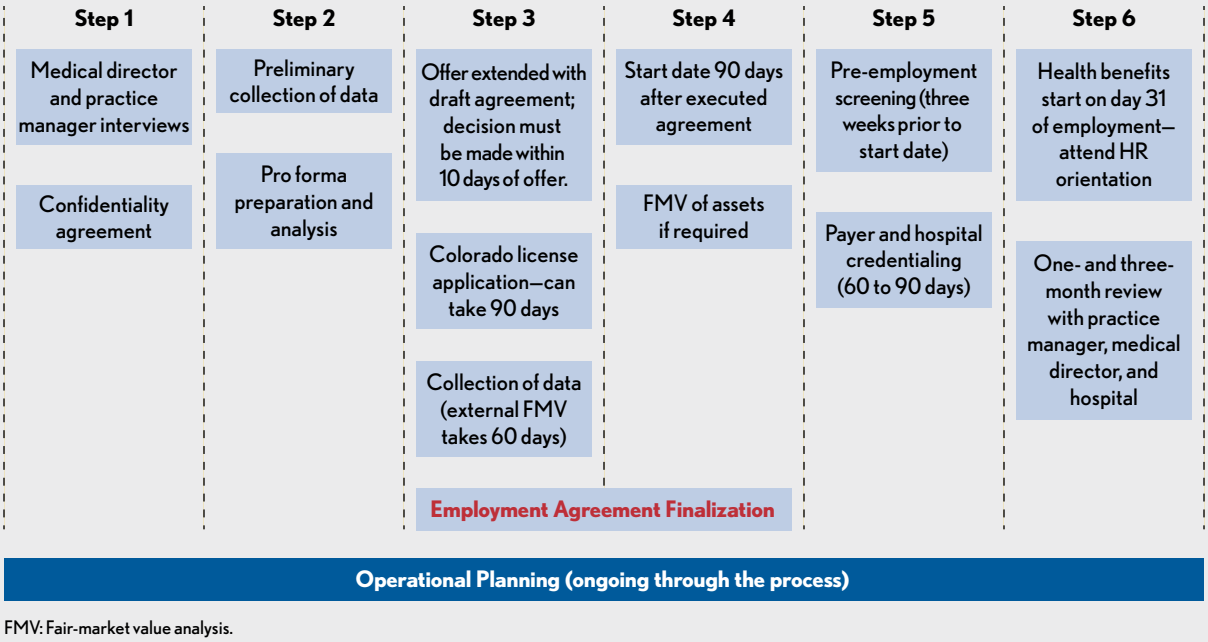
Investing in a physician practice-focused revenue cycle. There are significant differences between hospital and physician practice revenue cycles. Hiring the expertise and implementing the systems needed to manage physician practice revenue cycles is typically worth the investment.

Managing for economies of scale as the number of employed physicians grows. A recent OSF HealthCare cost containment initiative had an $8 million cost reduction goal for the physician enterprise, $5.5 million of which "came from efficiencies captured by capitalizing on the scale of the physician enterprise," says Mark Nafziger, chief administrative officer for OSF Medical Group.

RECOGNIZING VALUE

The health system's finance department should fully account for the value that employed physicians bring to the system. It is worth spending some time thinking about how financial support is described to the board and in conversations with employed physicians. "Loss per

ONBOARDING AN INDEPENDENT PHYSICIAN PRACTICE



FMV: Fair-market value analysis.

Source: HealthONE/HCA Continental Division. Available in the HFMA Physician Strategies Toolkit at hfma.org/valuephysiciantoolkit.

COMPENSATION AND FINANCIAL SUPPORT FOR HOSPITALISTS

The specialty of hospital medicine has grown dramatically in recent years as hospitals seek to better coordinate patient care within acute settings and ease transitions of care into and out of the hospital. Data recently published by the Society of Hospital Medicine (SHM) offer a glimpse into how compensation is changing for this specialty—representative of changes happening across specialties—as well as considerations regarding the financial support of physicians.

HOSPITALIST COMPENSATION

Median hospitalist compensation for 2014 is categorized by adult programs, pediatric programs, and academic programs. For both adult and pediatric program hospitalists, just over 80 percent of compensation is base pay (83 percent for adult programs and 84 percent for pediatric). The remaining percentage is incentive pay, with incentives divided between productivity (approximately two-thirds of incentive pay) and performance (approximately a third of incentive pay). In academic programs, the percentage of base pay is higher, as time spent on patient care is balanced with research and teaching activities.

Several factors are used by hospitalist groups to determine the performance portion of incentive pay. Patient satisfaction is the factor used by the highest percentage of groups with adult programs (79 percent, up from 71 percent in 2012), while good citizenship is the most commonly used factor in pediatric programs (80 percent). Core-measure performance is the second most commonly used factor for both adult and pediatric programs (74 percent of adult programs, 67 percent of pediatric). Both adult and pediatric programs are seeing rapid growth in the use of readmission rates as a factor in performance incentives. In 2014, 46 percent of adult programs and 40 percent of pediatric programs included readmission rates as a factor, up from 30 percent and 18 percent, respectively, in 2012.

FINANCIAL SUPPORT OF HOSPITALIST GROUPS

Median financial support in 2014 was $156,000 per full-time physician in an adult hospitalist program and $106,000 per full-time physician in a pediatric program. Ninety-four percent of adult programs and 87 percent of pediatric programs ran at a deficit.

Joe Miller, senior vice president and chief solutions officer for SHM, identified several factors contributing to the need for financial support of hospitalist groups:

- Many hospitalist groups (57 percent in 2014, up from 44 percent in 2012) are providing 24-7 services, including coverage for overnight admissions.
- Hospitalists are leading hospital initiatives on cost savings, readmission reductions, and quality.
- Additional roles for hospitalists that are not tied to additional patient revenue keep expanding. "Code blue" responsibilities are assumed by 42 percent of hospitalist groups, up from 31 percent in 2012; rapid-response team responsibilities are assumed by 45 percent of groups, also up from 31 percent in 2012; 90 percent of groups are involved in surgical or medical co-management of patients; and 25 percent take on responsibility for seeing patients in skilled nursing facilities and rehabilitation centers following hospital discharge.

As noted in this report's discussion of physician financial support, the value of the many roles assumed by hospitalists must be balanced against financial support to understand the true return on investment for the specialty.

Source: Society of Hospital Medicine, *2014 State of Hospital Medicine Report*. Available at www.hospitalmedicine.org/SurveyHFMA.

physician" is not necessarily the best descriptor. If ancillary services have been removed from the practice, understand—and be able to explain—the impact that has on the practice's margin. And consider the impact that a group of employed hospitalists, for example, are making on hospital readmission rates and the value to the system that avoidance of a financial penalty brings. It is certainly important to understand the costs associated with physician employment, but to some extent those are costs necessary to provide the services that generate the revenue on which the system's financial sustainability depends.

Looking at the system as a whole, the question should be: What is an acceptable level of expense to generate sufficient revenues to maintain the system's financial health? This is the level of physician financial support that the system should be managing.

LEADERSHIP AND GOVERNANCE

Physician leadership is essential to ensure physician alignment with the broader goals of an organization, be it a medical group, a hospital, or a multistate healthcare system.

Physicians have a professional obligation to make decisions that they believe are in the best interests of their patients; accordingly, physicians should have an active role in organizational decisions that will affect their ability to provide care. Not all physicians need be involved in every decision, of course, but they should have trust in the decision-making process because the active participation of all physicians will be needed to implement decisions and achieve corresponding goals. That trust is secured through the involvement of physician leaders.

John Hill, a partner in Healthcare Strategy Group, offers a simple warning about the consequences of failing to engage physicians—or worse, of alienating them: "Physician passivity *predicts* dysfunction. Physician antagonism *guarantees* dysfunction."

GOVERNANCE STRUCTURES AND ADVISORY COUNCILS

Physician leadership takes many forms, as demonstrated by the leadership structures at the organizations interviewed for this report.

HealthONE, as part of HCA's Continental Division, has a physician leadership chain that extends from HCA's national headquarters to the local level. The national organization's CMO also serves as president of its clinical services division. Below corporate are three geographically defined physician service groups, each with its own medical director. And within the Continental Division, medical directors have recently been added to each hospital. Quality is a primary focus of the national organization, which has developed a list of approximately 100 initiatives from which local clinics can choose. Divisions will also define initiatives tied to quality metrics of importance among local markets and hospitals. At the local level, quarterly physician town halls provide a forum to introduce new initiatives and receive physician feedback.

At both OSF HealthCare, a multihospital, multistate system, and Floyd Memorial Hospital and Health Services, a stand-alone hospital system, physician advisory and governance councils help ensure the involvement of physician leadership in defining organizational priorities and initiatives. OSF Medical Group has an 18-member governance council, which includes 11 members elected by the members of the group to provide geographical representation. Although the governance council is advisory, not fiduciary, its members are asked to act in a fiduciary manner during their monthly meetings. Members can serve two consecutive three-year terms, and then must take at least one year off before serving again. Many operational issues are run through the governance council to obtain physician input, and the council also provides a forum for practicing physicians to connect with system CEO Kevin Schoeplein and other members of the executive team. The geographic diversity ensures representation from the four regions of OSF, but the system does not prescribe representation by primary care and specialist physicians. Dennis, the vice president for OSF Medical Group's Central Region, notes that "OSF believes that election by peers will produce the best people, and we have seen a good split between primary care and specialist representation on the council."

Floyd Memorial Hospital and Health Services has both an elected governance council for Floyd Memorial Medical Group and a medical staff advisory council, led by CEO Mark Shugarman, that includes both employed and independent members of the hospital's medical staff. The medical staff advisory council serves as a forum for sharing information on hospital initiatives and addressing physician concerns. Eichenberger, the Floyd Memorial CMO, links the high level of physician engagement with the medical group's governance council to the fact that the group, although owned by the hospital, is run independently; Whistine, the vice president of physician services, manages the group. "It's a very physician-driven group," Eichenberger observes. "Last year, for example, the physicians insisted on streamlining administrative processes with the system as a whole and it was done."

DuPage Medical Group is 100 percent physician-owned and led by a 10-physician board elected by the group's shareholders. The physician board hires the group's management team and has oversight of the group. The board president works closely with the management team in building a sense of trust and confidence with the other physicians.

PHYSICIAN LEADERSHIP DEVELOPMENT

Both OSF HealthCare and DuPage Medical Group have developed or are implementing formal physician leadership development programs. OSF HealthCare has developed a formalized academy that provides training to develop competencies at four levels of physician leader:

- Governing leaders (also described as "system visionaries")
- Executive leaders who serve in executive-level management roles
- Team leaders working on-site in medical group locations
- Foundational leaders, a group that includes all other providers interested in leadership development

An initial cohort has completed the two-year program, which focused primarily on team leaders. OSF HealthCare employs a dyad management model, which pairs physician team leaders with a site administrator, and physicians and administrators went through the training together. Team leader training includes both didactic learning and development of process improvement plans for the participants' individual site locations. "We had 170 providers go through the first team-leader training cohort and they are now operational and delivering on strategy," says Norris, the OSF Medical Group regional director, Peoria Primary Care. "We also identified several promising physician leaders in the first training cohort who might not have been identified without the academy."

DuPage Medical Group will be piloting a "mini-MBA" development program with the Loyola University Quinlan School of Business for physicians interested in board service. The six-month program will emphasize business knowledge and leadership skills, and will incorporate project-focused learning. Professors will come to DuPage Medical Group to make physician participation more convenient.

WHAT DO FINANCE LEADERS WANT FROM PHYSICIAN LEADERS?

HFMA's survey of senior financial executives found that collaborative decision making was the most important skill to develop in physician leaders. Respondents were asked to choose the two most important skills from a total of six, with the following results:

1. **Collaborative decision making (selected by 46 percent)**
2. **Performance measurement (36 percent)**
3. **Quality improvement (35 percent)**
4. **Strategic thinking (31 percent)**
5. **Change management (30 percent)**
6. **Financial management (24 percent)**

POPULATION MANAGEMENT CAPABILITIES

"Now that physicians are no longer being paid 'by the click,'" asks one interviewee, "what needs to change in patient care?" The answer to that question is quite frankly still taking shape, but it is clear that a significant factor will be an organization's ability to manage the health of the patient populations it serves. And that ability will largely be determined by the work of an organization's physicians and the clinicians who support them. Several of the organizations we interviewed have assumed sufficient risk—through the MSSP or Pioneer ACO program, commercial ACO structures, or both—to begin the transition to population management.

The very definition of *population health management* is still being debated. This report uses the Institute for Healthcare Improvement's definition of *population management*: reshaping payment and management of healthcare services for a defined population in pursuit of the Triple Aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.[c]

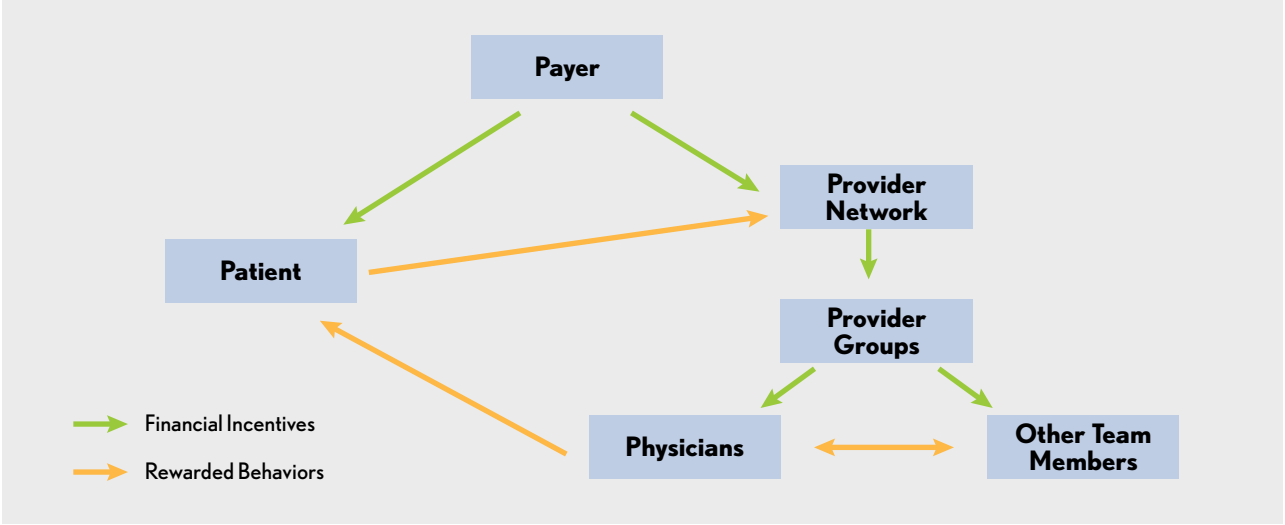
Beyond *population management* is *population health*, which seeks to affect broader determinants of health within a population. Although some organizations are beginning to move in this direction, the more basic concept of developing population management capabilities is still the focus for most organizations and will be the focus of this discussion.

PROVIDER/PAYER PARTNERSHIPS

A precondition for movement toward population management is the realignment of incentives within the healthcare system. Currently, the state of realignment varies significantly from market to market. Without the proper incentives to encourage desired behavior, it is difficult for the healthcare system to advance from fee-for-service payment to population management.

An effective incentive chain requires alignment of payment and incentives across many groups. For the payer, the key relationships are with the contracted provider network and the patient. The provider network should be rewarded for maintaining or improving the quality of patient outcomes at or below a historically benchmarked cost of care for an attributed patient population. At the same time, patients should have financial incentives to seek their care from the provider network that is being held responsible for the quality and cost-effectiveness of their care (e.g., different copayments based on choice of provider).

INCENTIVE AND BEHAVIOR FLOWS FOR POPULATION MANAGEMENT



Internally, the provider network should determine allocation of funds among the provider groups represented in the network, and the provider groups should determine allocation of funds to individual clinicians and other team members within a group. Allocation of funds will typically be based upon multiple factors, including the quality of patient outcomes (e.g., percentage of patients with diabetes under control, incidence of surgical site infections), risk-adjusted size of the patient panel managed by the physician and his or her team, resource utilization and cost-effectiveness of the care delivered, and patient experience (e.g., average waiting time for an appointment, efficiency of scheduling). These factors depend upon both cooperation among physicians and their team members within different provider groups and a focus on the outcomes, efficiency, and patient experience of care.

One of the best examples of an aligned incentives structure is a commercial ACO program initially piloted in 2010 by Blue Shield of California, Hill Physicians Medical Group, and Dignity Health to manage the California Public Employees' Retirement System's (CalPERS's) member population in the Sacramento area (the program has since been extended to employees of the City and County of San Francisco, adding the University of California, San Francisco, as a partner, and to Blue Shield HMO enrollees in San Joaquin County, the majority of whom are CalPERS enrollees). All three partners are jointly at risk for managing to the budgeted cost of care for the population, with a percentage of the capitated payment for the managed population withheld from each partner. Monthly reports compare actual costs against per member per month (PMPM) targets. At the end of the year, if the partners come in at or below budget, they receive payment for the withheld funds and any surplus. In a deficit situation, the withheld payments would be applied to the deficit.

In its first year, the pilot achieved a zero cost increase against historical growth of 8 to 12 percent per year by saving more than $15.5 million (which included a 20 percent reduction in PMPM costs for inpatient admissions). At the same time, patient outcomes improved across a range of metrics, including:

- A 15 percent reduction in 30-day inpatient readmissions
- A 15 percent reduction in inpatient days per 1,000 hospitalized pilot beneficiaries
- A 50 percent reduction in inpatient stays of 20 days or more per 1,000 hospitalized pilot beneficiaries
- A half-day reduction in average patient length of stay[d]

David Joyner, COO of PriMed, which manages Hill Physicians, notes that good population management practices are not radically different from what should always be intended for patient care—for example, smoothly transitioning patients between sites of care or identifying chronically ill patients and keeping them out of the hospital. "But they happen more effectively where there are aligned incentives and parties working closely together, rigorously and consistently," Joyner says.

IT AND DATA ANALYTICS

Effective population management is driven in large part by timely information. Ideally, organizations that are partners in a population management initiative share a common EHR. In many instances, however, such synchronization is not feasible; in those cases, rigorously observed protocols for the timely exchange of relevant information are critical.

When DuPage Medical Group formed Illinois Health Partners (IHP), a joint venture with Edward Hospital & Health Services in west-suburban Chicago, it sought "integration without ownership" and saw clinical integration through IT with its IHP partners as one way to achieve this goal. In addition to Edward Hospital and its medical group, IHP also includes Elmhurst Memorial Hospital (which recently merged with Edward Hospital), the Elmhurst Clinic, and ELMCARE (the Elmhurst physician-hospital organization), as well as Northwest Community Healthcare's Physician Hospital Organization. Most IHP partners are on the same instance of the same EHR, giving physicians in the hospitals and in the practices a complete view of the patient that has contributed to a significant reduction in redundant tests and procedures.

In connection with its participation in the Pioneer ACO program and other at-risk managed care contracts, OSF HealthCare has built decision support tools into its EHR to help with chronic disease management and at-risk patient populations. The system's hospitals and employed physicians are all on the same instance of the EHR, but the system has faced greater connectivity challenges with independent physicians, who may be able to view the EHR only when they are in a system facility. OSF HealthCare is

pursuing system hosting of the EHR for independent groups as one solution.

Hill Physicians Medical Group has invested in technologies that identify gaps in care or data, and offers a subsidized EHR to physician practices, with approximately a third of the practices now on a common platform. But even if all were on the same platform, connectivity issues could still prevent access to hospital-based systems that use a different vendor. The partners in the commercial ACO have worked to identify key data exchanges, including pharmacy data and twice-daily census data from the hospital partners that augment claims data from Blue Shield of California, which is useful but not real-time.

With data systems in place, the focus turns to data analytics and predictive modeling. Stephen Hippler, MD, vice president for quality and clinical programs at OSF HealthCare, defines the challenge as being able to prospectively identify the small percentage of the population that consumes the greatest share of healthcare resources, rather than identifying those patients retrospectively. An initial focus has been on identifying patients at risk of readmission. OSF HealthCare found that 53 percent of its patients have less than a 3 percent risk of readmission, while 2 percent have a 38 percent risk. They are intensively targeting that 2 percent of the patient population at greatest risk, while also providing extra care and attention for patients within the upper two quartiles of risk. Forbes, the system's chief clinical officer, estimates that if classic predictive modeling tools had about a 50 percent success rate in predicting readmissions, OSF HealthCare is now closer to 60 percent and is looking to move to 65 to 70 percent.

Hippler cautions that interventions resulting from predictive modeling cannot be too prescribed. "Sometimes, the medium- or low-risk patient needs more attention than the higher-risk patient," Hippler says. "Our approach is to remain patient-focused—looking at the patient holistically from the patient's perspective, not a disease management perspective. Predictive modeling needs to be paired with an understanding of patient needs to craft solutions that are best for the patient."

NEW CARE MANAGEMENT MODELS

Effective population management also focuses on reducing fragmentation of services and improving coordination of care and access to care for the managed population. Organizations are developing and implementing a wide range of techniques to meet these goals.

PriMed, the group that manages Hill Physicians, recognized that case management activities could be fragmented or duplicative and has created more centralized points of service to work with the physician practices. In particular, it has created a "virtual care" team of case managers, pharmacists, social workers, and advanced practice nurses to support and coordinate case management efforts in the physician practices. The team uses predictive modeling to proactively identify patients for whom an investment in case management makes sense. "We have added resources to do this, but the payoff under our at-risk contracts has been multiples of any incremental resources that have been deployed," says Rick Messman, PriMed's CFO.

At OSF HealthCare, which has many facilities in relatively rural areas, ensuring access to needed services across the system's four regions is one of the biggest challenges. The system has implemented a telehealth program that offers, for example, neurology support from the Central Region to its Northern Region sites, and is developing an e-Pharmacy platform that will spread pharmacy services more evenly across the system, including the ability to perform pre-discharge medication reconciliations for every patient. An e-ICU program also has been implemented across the entire system, reducing lengths of stay in the intensive care unit.

OSF HealthCare also is analyzing the possibility of virtual e-visits for primary care patients, especially its young and relatively healthy patients, so time in the clinics can be devoted to sicker patients. Additionally, the health system has piloted PromptCare clinics to supplement and support primary care offices. The PromptCare clinics are walk-in, open on evenings and weekends, and are staffed with both physicians and advanced practitioners.

DuPage Medical Group is also experimenting with the idea of virtual visits for younger, healthier patients, which Kasper, the group's CEO, sees as the next step in convenient access for patients. Already implemented are two examples of "niche care" programs—BreakThrough Care Centers and herDMG—designed to effectively address the needs of specific patient groups.

BreakThrough Care Centers focus on seniors with chronic diseases, with referrals coming from IHP

THINKING THROUGH VIRTUAL VISITS

Virtual visits offer a promising approach to meeting the needs of patients who want a quick medical consult without scheduling a live clinical visit. Such visits cannot meet all patient needs, however. Health systems, medical groups, and physician practices should think through some basic questions when establishing the parameters for when virtual visits are appropriate and when they are not. James Stamos, a Chicago-based attorney specializing in medical malpractice, describes some key points to consider.

Is the program patient-focused or system-focused? Virtual-visit programs that are designed to meet a clear patient demand for access and convenience are on a stronger footing than those that are driven by a desire to reduce health system costs.

Will physicians involved in the program be able to say that the program meets an appropriate standard of care? Physicians are responsible for making an independent medical judgment for the individual patient. They should have the ability to independently determine the practicalities of a virtual visit that will allow them to address the patient's needs within the standard of care.

Would patients be comfortable that they are receiving the appropriate level of care through a virtual visit? A patient's perspective on what happened during a virtual visit might differ from the physician's perspective. There should be clear communication to the patient throughout the virtual visit of what the visit is intended to accomplish (as well as what issues the visit may not be able to address).

Would the care rendered in a program visit be defensible in front of a jury? The parameters for a virtual visit should clearly delineate conditions that can be discussed and diagnosed remotely versus those for which a physical visit would be more appropriate. The more the program moves away from what people might have expected to happen in a personal visit, the more difficult the care might be to defend.

physicians. The centers are a joint venture between the medical group and Humana and are designed to care for the 5 to 10 percent of the patient population that drives the majority of healthcare costs. The centers offer care teams that include a physician, nurse practitioners, health coach, pharmacist, physical therapist, dietitian, licensed social worker, and licensed behavioral health specialist. The centers have on-site labs and diagnostic imaging, as well as a fitness center. DuPage Medical Group is managing approximately 1,000 patients through three centers in west-suburban Chicago and is seeing encouraging early results.

The medical group's second niche care program, herDMG, addresses the often-fragmented delivery of women's health services as well as women's need for convenience as they balance families and careers. The program segments women by age bracket, with all needed services available through one appointment. Women in the over-40 age bracket, for example, are able to get a screening mammogram during a visit, and other services include breast and pelvic exams, pap smears, blood work, and referral to specialists as needed. The program was introduced in April 2014, with plans to make it available at more than 20 sites within the medical group.

Several common themes run through these new care management models:

- The need to ensure that a managed population has access to a full range of services
- The need to better understand specific population segments and their care requirements, and then bundle services or implement new services to make meeting those requirements more convenient
- The need to alleviate pressures on primary care physicians by deploying care teams and technologies that can free up time to care for patients most in need of the physician's attention

CONCLUSION

The reconfigurations of care delivery by organizations in markets where the transition to value-based payment is well underway are indicative of changes that most healthcare organizations across the country are anticipating, even in markets that have not moved as quickly toward value-based models. Demands for improved outcomes, more convenient access to care, and greater cost efficiency will be impossible to meet without the active participation of physicians and the appropriate alignment of incentives across the system.

Although the realignment of incentives is only beginning in many markets, most organizations understand the need for a renewed focus on their physician strategies and are actively moving forward. Many strategies will be market-specific, but certain fundamental elements of a physician strategy pertain to all organizations.

Determining the best alignment opportunities for physician practices in the market. For hospitals and health systems, the trend is clearly toward employment of physicians, but this is not always appropriate for, or desired by, every specialty. Physician practices are experiencing pressures to achieve scale, but large, independent medical groups offer an alternative to alignment with a hospital or health system. CINs and ACOs offer opportunities for alignment and collaboration among hospitals and health systems, independent medical groups and physician practices, and other provider organizations.

Building a sufficient primary care base to support specialty services. The proper balance between primary care and specialty services is, and for some time will remain, a moving target, especially as new population management techniques intended to reduce utilization of specialty and acute care services take hold. A solid primary care base nevertheless will help to ensure adequate referrals to specialists today while laying the foundation for population management.

Communicating the need for flexibility and change in physician compensation agreements. As public and private payers introduce new payment models designed to reward improved quality and cost efficiency, physician compensation agreements will need to change accordingly. Many organizations have begun to experiment with new compensation models, but everyone should understand that these new models are a work in progress and will continue to evolve. Communication is essential here, as is collaboration with physicians on the development of new models and metrics.

Developing physician leadership and governance structures. Change in physician culture and practice patterns requires trusted and strong physician leadership. Ensure that physicians have meaningful forums in which to share their ideas and concerns with both clinical and administrative leadership and that mechanisms are in place to identify, cultivate, and promote physician leaders within the organization.

Ensuring that the contributions of physicians are accurately valued and described. Looking at the system as a whole, what is an acceptable level of expense to generate sufficient revenues (or, increasingly, avoid negative financial risk) to maintain the system's financial health? What other services do physicians provide to the organization, and what is the appropriate value of these services?

Recognizing that physicians will be critical to an organization's success in making the transition to value. The success of any physician strategy will depend on its effectiveness in engaging the physicians themselves.

Footnotes

a. Kane, C.K., and Emmons, D.W., *Policy Perspective: New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment*, American Medical Association, 2013.

b. An accountable care organization (ACO) falls within a "safe harbor" if independent ACO participants that provide the same service (a "common service") have a combined share of 30 percent or less of each common service in each participant's primary service area, wherever two or more of the ACO participants provide that service to patients from that primary service area. The statement by the Federal Trade Commission and Department of Justice also offers guidance for ACOs outside the safe harbor, including a summary of conduct to avoid and a process for expedited antitrust review of a proposed ACO ("Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program," *Federal Register*, Oct. 28, 2011.

c. Lewis, N., "Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in U.S. Health Care Today," *IHI Leadership Blog*, March 19, 2014. The IHI distinguishes population management from population health in that the latter focuses on broader determinants of health.

d. Outcomes reported in *An Accountable Care Organization Pilot: Lessons Learned*, Blue Shield of California, 2012.

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