The High-Performance Medical Group

*From Aggregations of Employed Practices to an Integrated Clinical Enterprise*

- In Search of Full Value
- An Integrated Identity
- Infrastructure for Shared Success
- Individual Behavior Aligned with Strategy
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Available Within Your Health Care Advisory Board Membership

Over the past several years, the Health Care Advisory Board has developed numerous resources to assist members in addressing physician strategy. The most relevant resources are outlined on the right. All of these resources are available in unlimited quantities through the Health Care Advisory Board membership.

Strategic Guidance for Physician Alignment in an Era of Reform

- The High-Performance Medical Group Toolkit (24104)
  Resources for Building Physician Integration

- The Accountable Physician Enterprise (21109)
  Partnering with Physicians to Transform Care Delivery

- Building the High-Performance Physician Network (20921)
  Roadmap for Assessing and Implementing a Clinical Integration Strategy

- Transforming Primary Care (21164)
  Building a Sustainable Network for Comprehensive Care Delivery

- Strategy-Aligned Physician Compensation Plans (17985)
  Utilizing the Right Incentives to Improve Physician Alignment and Increase Doctor Satisfaction

Tools to Support Delivery System Redesign

- Accountable Care Readiness Diagnostic
  This turnkey strategic planning tool assesses your organization’s ability to prosper under emerging accountable payment models.

- Medical Home Health Coach Practice Impact Calculator
  This Excel-based tool calculates the return on investment from adding a dedicated diabetes health coach to primary care practices transitioning to a medical home model.

- Clinical Integration Investment Calculator
  This Excel-based tool is intended to aid organizations in assessing whether to pursue a CI strategy by calculating expected baseline investment costs in four key areas: information technology, program staffing, project development, and administrative expenses.

To Order Via Advisory.com
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To Access Data and Analytic Tools
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In addition to the resources available through the Health Care Advisory Board membership, the Advisory Board Company offers two programs focused on physician practice performance: the Medical Group Strategy Council and Crimson Practice Management.

Crimson Practice Management arms practice leadership with the information needed to collaborate with providers to improve practice performance and increase demonstrable contribution to the health system.

The Medical Group Strategy Council offers concrete, replicable best practice research on employed medical group management.

**Elevate Medical Group Performance through Proven Best Practice Solutions**

With physician employment on the rise, hospitals face no shortage of complex challenges. The Medical Group Strategy Council aims to be every practice management executive's one-stop shop for targeted direction and support against the critical challenges confronting physician practices—offering detailed best-practice profiles and implementation guides, opportunity assessments, analytical tools, and more.

### Imperatives for Medical Group Success

<table>
<thead>
<tr>
<th>Imperative</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>How can we develop an engaged and strategically aligned physician culture?</td>
<td></td>
</tr>
<tr>
<td>Are we recruiting and retaining the correct providers?</td>
<td></td>
</tr>
<tr>
<td>In light of our strategic priorities, how should we design our compensation plan?</td>
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<tr>
<td>How can we effectively communicate the value of the medical group to the broader organization?</td>
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<tr>
<td>How should we structure practice governance and encourage physician leadership?</td>
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</tbody>
</table>

**Collaborate with Physicians to Optimize Practice Performance**

Building on the success of the Crimson platform, Crimson Practice Management leverages best-in-class analytics to deploy physician-centric methodology for sharing performance data in order to improve the direct performance of owned physician practices and to elevate their total contribution to the health system.

**Focus on Opportunities with Maximum Impact**

- **Maximize Practice Capacity**
  - Increase practice capacity with a comprehensive look across provider productivity, practice operations, patient access, mid-level provider utilization, and patient panel management. Improvements will yield mutual returns in physician compensation, practice bottom line, and health system contribution
  - Research indicates that each additional practice visit generates approximately $480 in total health system revenue. Adding just one encounter per week per physician in a 50-provider practice quickly exceeds $1.2M

- **Prevent Revenue Leakage**
  - Alleviate physician anxiety stemming from a rise in the visibility of auditors by employing comprehensive coding reviews and benchmarks across E&M, procedural, and drug charges
  - Appropriate coding can often yield more than $15,000 per physician annually without increasing audit risk

- **Increase Billing Office Performance**
  - Identify root causes of collections inefficiencies to accelerate and increase cash collections.
  - Improve performance across all revenue cycle functions, including bad debt, A/R days and charge lag
  - Adhering to point-of-service collections alone can yield more than $10,000 per physician annually

---

**Beyond the Health Care Advisory Board**

**Crimson Practice Management and Medical Group Strategy Council**

**Contact Us**


For additional information on Crimson Practice Management please visit our website [http://www.advisory.com/Technology/Crimson-Practice-Management](http://www.advisory.com/Technology/Crimson-Practice-Management)
Advisors to Our Work

The Membership would like to express its deep gratitude to the individuals and organizations that shared their insights, analysis, and time with us. The research team would especially like to recognize the following individuals for being particularly generous with their time and expertise.

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Executive Summary

The High-Performance Medical Group

Study in 10 Conclusions

Seeking Full Value from the Employment Investment

1 As Physician Employment Grows, Hands-Off Management Approach Falling Short
Many hospitals and health systems are reaching a critical mass of employed physicians, but in continuing to manage practices as autonomous, loosely integrated units, are missing opportunities to realize full value from greater scale.

2 “High-Performance Medical Groups” Capitalize on Cohesion
Organizations that have fostered integration between physician practices offer an alternate model, leveraging the coordinated employed enterprise to achieve strong operational and clinical results.

3 Group Success Due to Strategic, Not Structural, Factors
Successful groups vary in structural factors such as size, market, or history, but share three defining characteristics: identity as a unified, physician-led network; infrastructure to enhance group performance; and incentives designed to engage individual physicians against group goals.

4 Imperative to Begin the Integration Journey Now
Although many medical groups have had decades to organize, systems today must accelerate integration to avoid falling behind amid rapid market changes; even those with just a few employed physicians can begin laying groundwork for group creation.

Attributes of the High-Performance Medical Group

5 Common Physician Culture Undergirds All Group Activities
A formal, physician-led commitment to common values drives group strategy and physician actions; while culture varies, all groups treat care as a team-based sport and assess physician value more broadly than the practice-level bottom line.

6 Integrated Physician Team Key to Referral Retention, Care Coordination
Culture-linked hiring and onboarding, combined with partnership-building activities, perpetuate group identity and foster an environment in which coordinated care and in-network referrals are the norm.

7 Meaningful Decision-Making Authority Placed in Physician Hands
Recognizing physician leadership as crucial to engagement of the rank-and-file, groups build comprehensive physician governance structures, invest in leadership development, and involve medical group leaders in system-level strategy-setting.

8 Infrastructure Supports Collaborative Performance Improvement
Full and open information transfer—via an enterprise-wide information network—promotes care coordination, enhances patient access, and drives formal improvement processes; additional tools deployed at scale allow physicians to optimize practice operations and clinical delivery.

9 Transparency a Primary Tool for Motivating Physician Behavior
Respecting physicians' natural skepticism, groups use open, two-way communication to win buy-in for strategic decisions, while also capitalizing on physicians' competitive tendencies by sharing (often unblinded) individual performance data to drive behavior change.

10 Compensation Change Utilized Sparingly and Strategically
Unlike hospitals that view compensation as the primary means of influencing physician behavior, high-performance groups turn to financial incentives only when other motivational levers fail—altering compensation primarily when the existing model becomes a legitimate barrier to change.
Failing to Capture Full Value from Rising Physician Employment

Thwarted by Fragmentation, Unable to Make Bigger Mean Better

Confluence of Forces Sparking Sharp Employment Growth…

<table>
<thead>
<tr>
<th>Performance Metric</th>
<th>Potential Improvement with Larger Scale</th>
<th>Reason for Current Performance Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Finances</td>
<td>Achieve economies of scale, eliminate operational variation</td>
<td>Protection of practice firewalls inhibits consolidation, cost-sharing; considerable process variability remains</td>
</tr>
<tr>
<td>Referral Volumes</td>
<td>Capture more patients within loyal referral network</td>
<td>Inhibited by weak relationships between practices; many physicians do not know who else is employed</td>
</tr>
<tr>
<td>Patient Access</td>
<td>Leverage broad network to expand appointment availability</td>
<td>Few levers to win physician buy-in for disruptive access redesign; practice silos prevent sharing of mid-level providers</td>
</tr>
<tr>
<td>Care Reliability</td>
<td>Engage broad physician base against clinical quality and cost goals</td>
<td>Emphasis on individual productivity, lack of system affinity provide little incentive to focus on quality</td>
</tr>
<tr>
<td>System Efficiency</td>
<td>Provide full scope of services and coordinate care across provider types</td>
<td>Thwarted by emphasis on individual performance, weak peer relationships, lack of infrastructure</td>
</tr>
</tbody>
</table>

…But Practice Silos Thwarting the Potential Benefits of Scale

Fueled by demographic shifts within the physician workforce, declining reimbursement, and new imperatives for care delivery redesign, physician employment by hospitals and health systems is on a sharp upswing. Across the country, organizations report that their employed ranks have grown significantly as market forces push hospitals and physicians toward tighter alignment. As a result, many hospitals are rapidly approaching a critical mass of employed physicians across many specialties.

Yet even as the employed ranks swell, many hospitals continue to manage practices as standalone units. Still cognizant of practice losses in the 1990s, they have focused primarily on stabilizing practice solvency, mimicking the structure and incentives of private practice. In addition, hospitals have taken a hands-off approach to practice management in a belief that autonomy is attractive to physicians wary of hospital control.

In protecting practice silos, however, hospitals are failing to capture the potential benefits of growth in the employed ranks—an expanded referral network, enhanced patient access, operational economies of scale, opportunities to improve quality, and enhanced care coordination. As a result, many are seeking a new approach to practice management, one that enables them to leverage the employed enterprise as an integrated medical group.

Source: Health Care Advisory Board interviews and analysis.
A subset of organizations have taken an alternative approach to practice management, successfully managing employed physicians at scale. By fostering cohesion among practices, these “high-performance medical groups” have historically generated strong financial, clinical, and operational results.

Yet little guidance exists on what specific organizational attributes and practices make high-performance medical groups successful. To answer that question, the Health Care Advisory Board launched the High-Performance Medical Group Initiative.

Through this Initiative, we identified more than 25 medical groups that excelled on financial, clinical, and other strategic indicators and conducted in-depth conversations and site visits with these organizations in order to understand the sources of strong performance. This publication details the key findings from that research effort.

The groups profiled in this publication differ significantly on structural factors such as size, composition, or history. Yet all have something deeper in common, sharing the 15 core attributes listed on this page. These attributes, explored further in this publication, are the foundation of the groups’ strong performance results.

### Areas of Variability Between High-Performing Groups

<table>
<thead>
<tr>
<th>Size</th>
<th>History</th>
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<tbody>
<tr>
<td>Range from 200</td>
<td>Age range from a few years to more than a century</td>
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<td>physicians to 1,400</td>
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<table>
<thead>
<tr>
<th>Ownership</th>
<th>Market Type</th>
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<tbody>
<tr>
<td>Mix of hospital-owned subsidiaries, independent groups, integrated delivery systems</td>
<td>Mix of urban, suburban, semi-rural and rural</td>
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<thead>
<tr>
<th>Payment Model</th>
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<tr>
<td>Range from pure fee-for-service to capitation</td>
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<th>15 Attributes in Common</th>
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#### Defining the High-Performance Medical Group

#### Wide Variety on Surface Factors, But Set of Shared Strategies at Root

<table>
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<th>An Integrated Identity</th>
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<td>7. Investment in Broad-Based Physician Leadership</td>
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<table>
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<tr>
<th>9</th>
<th>Staged Adoption of New Compensation Plans</th>
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Source: Health Care Advisory Board interviews and analysis.
This publication profiles mature medical groups, painting an aspirational picture of what a successful employed physician network may become. For many hospitals, building a similar high-performance group will require a significant investment of time and resources. The timeline here, which shows the typical progression of medical group development, describes the journey ahead.

While building an integrated medical group requires investment, the decision to forego or delay this journey may be equally costly. As the ranks of employed physicians grow, so do the risks of failing to capture full value from that investment. In the near term, those risks include missed opportunities for quality and cost improvement, revenue lost to out-of-network referrals, or strategically inappropriate acquisition offers. In the long term, failure to build an integrated partnership with employed physicians jeopardizes hospitals’ ability to meet emerging standards for care coordination and management.

Although many successful medical groups have organized over decades, hospitals today must accelerate integration to avoid falling behind amid rapid market changes. Even those with just a few employed physicians can begin to build common culture and invest in network infrastructure. Ultimately, these steps lay the groundwork to create not just a high-performance medical group, but a high-performance health system.
Essay: In Search of Full Value
Across the country, hospital employment of physicians is rising rapidly. From large health systems to small community hospitals, organizations are making significant investments in practice acquisitions. Even hospitals that divested practices in the 1990s are now actively re-engaged in employment strategy. As a result, a large number of hospitals and health systems have seen dramatic growth in their employed physician networks, with many doubling or tripling in size across just a few short years.

Across the Country, Practice Acquisitions on a Clear Upswing

- Five-hospital system
  - 80 physicians employed by foundation, up from zero in 2008

- Two-hospital system
  - 230 employed physicians, up from 25 in 2005

- Two-hospital system
  - 800 employed physicians, up from 50 in 2008

- Three-hospital system
  - 311 employed physicians, up from 70 in 2008

- 210-bed hospital
  - 100 employed physicians by 2012, up from 21 in 2009

- 260 employed physicians, up from 70 in 2008

Everything Old Is New Again

“We had a bad experience with employment in the 1990s and didn’t think we’d do it again. But things change, and now employment’s our primary alignment strategy. At this point, we’re employing far more than we ever thought we would.”

Chief Medical Officer
Four-hospital health system in the Northwest

Source: Health Care Advisory Board interviews and analysis.
A confluence of forces is driving rapid employment growth today. First, hospitals are seeking to protect market share and secure coverage for critical service needs. These evergreen goals are largely responsible for a modest rise in employment activity across the last several years.

Two more recent forces, however, are now accelerating the employment trend. First is instability within the physician workforce, as demographic shifts, declining reimbursement, and uncertainty about the impact of health care reform lead independent practices to seek refuge with hospital partners.

At the same time, hospitals are increasingly recognizing that closer physician relationships will be critical as emerging payment models tie a greater portion of reimbursement to cost and quality improvement. As a result, many hospitals that may have once preferred less intensive alignment models are now opting for practice acquisition in preparation for meeting these new market imperatives.

The following pages look at these two forces in greater detail.
For physicians, several factors are creating a “perfect storm” of instability, leading them to question the viability of independent practice.

The first of these factors is the changing demographics of the physician workforce, as an aging, individualistic physician base is replaced by a new generation that highly values work-life balance and collaborative care. Younger physicians are thus seeking larger groups, leading to recruitment difficulties for many independent practices.

Second, many physicians are finding it increasingly difficult to maintain a solvent independent practice. Practice costs are rising rapidly, while reimbursement has stagnated or, in some cases, declined.

Finally, like hospitals, physicians are also recognizing that emerging payment models will require connection to a broader care network and large investments in care management and information technology infrastructure. To prepare for these changes, physicians are seeking to align with better-resourced partners.

As a result, a majority of hospital leaders report increased interest in employment among physicians across specialties. Notably, the highest employment interest is among cardiologists, who not coincidentally have seen recent threats to reimbursement for key sources of practice revenue, such as ancillary services.

### Changes in the Physician Marketplace

#### Demographic Shifts
- Large number of older physicians approaching retirement
- New generation placing greater premium on work-life balance, team-based care

#### Worsening Financials
- Key specialties (e.g. cardiology, oncology) confronting new reality of reimbursement cuts
- Practice costs rising faster than revenue

#### Reform Uncertainty
- Primary care physicians seeking well-capitalized partners to support investment in care coordination resources
- Specialists seeking tight network alignment to assuage fears of losing referral streams

### Driving Increased Employment Interest

Hospital Leaders Reporting Increase in Employment Requests from Physicians

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Interest in Hospital Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>63%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>50%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>49%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>48%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>48%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>48%</td>
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</tbody>
</table>

With payment reform on the horizon, hospitals and health systems are also recognizing that tighter alignment with physicians will be critical to success for any reimbursement model that places providers at greater risk for patient outcomes. Deep physician alignment is imperative for emerging reimbursement structures such as bundled payments or shared-savings models, which require systems to maximize quality while reducing unnecessary utilization and closely managing expenses.

Only a handful of hospitals are proactively acquiring physicians for the express purpose of taking on population risk or competing as an accountable care organization. But for many more, even the looming possibility of a shift toward greater reimbursement risk seems to be influencing employment decisions. Hospitals that might previously have sought out less intensive alignment options now seem more willing to consider practice acquisition, if only for the option value of having physicians in place to build the care management enterprise when it is needed.

### Physician Contributions to Care Management Imperatives

#### Utilization
- Prevent unnecessary inpatient admissions
- Minimize inappropriate or duplicative care delivery
- Refer patients to most appropriate and efficient specialists, sites of care

#### Expense Management
- Follow evidence-based care pathways
- Streamline costs through adherence to care standards
- Develop economies of scale across continuum for all growth service lines

#### Clinical Outcomes
- Minimize preventable readmissions
- Proactively manage chronic illness to prevent low-margin inpatient utilization
- Promote community wellness for at-risk populations

Source: Health Care Advisory Board interviews and analysis.
Markets Ripe for Tipping as Independent Providers Pick Sides

In many markets, the forces driving employment—physician instability, shifting reimbursement, and the desire to protect market share—are combining to create combustible situations, where a single employment offer can start a chain reaction.

Consider pseudonymed Ramsdell Memorial Hospital, which received an employment request from a cardiology practice struggling to recruit physicians to replace two retiring partners. Seeking to protect the stability of its cardiovascular service line, Ramsdell made an acquisition offer. Shortly thereafter, the town’s other four cardiology practices also requested similar offers. When Ramsdell’s competitor responded with a more attractive acquisition package, Ramsdell was forced to increase its own offer or risk losing business. After an 18-month bidding war, all cardiologists in the market were employed.

Ramsdell’s CEO noted that the sense of a “feeding frenzy” seems familiar to those who had a similar experience in the 1990s. Many hospitals feel they have no choice but to accelerate employment activity in order to protect their core business.

### Case in Brief: Ramsdell Memorial Hospital

- 400-bed hospital, located in the Southeast
- Located in a two-hospital town
- Minimal employment experience prior to cardiology bidding war

### A Feeding Frenzy

- Number of independent cardiologists in market before bidding war: 28
- Number of independent cardiologists after bidding war: 0

Source: Health Care Advisory Board interviews and analysis.
Reaching a Critical Mass—and Bringing Old Fears to the Fore

In the wake of rising acquisition activity, many hospitals today are employing large numbers of physicians across multiple specialties and service areas. Employed physicians represent a critical mass within the medical staff, in contrast to past years when employment was used more sparingly.

Rising employment has the potential to bring a greater number of physicians into strategic alignment with the hospital. Yet for many organizations, the rapid increase in practice acquisition mainly serves to magnify long-held concerns about employed physicians: that practice subsidies are too high, that the hospital is getting little additional downstream return for its investment, and that employed physicians are disconnected from system performance goals.

Growth Magnifies Longstanding Hospital Concerns About Employment

Yesterday’s Model: Employing Sporadically

• Employment driven by one-off reactive decisions, such as need to fill coverage gaps, grow service lines
• Employed physicians represent small portion of medical staff, only a handful of specialties or geographic service areas

Today’s Reality: Acquiring to Scale

• Employment increasingly broad-based and far-reaching, driven by larger strategic goals
• Employed physicians represent growing portion of medical staff, cover multiple specialties and geographic service areas

Common Hospital Concerns About Physician Employment

“A Drag on the Bottom Line”
Employed physicians perceived as a money-losing proposition, requiring considerable financial subsidy

“Paying for What We Already Get”
Hospitals failing to capture additional downstream revenue as physicians maintain old referral patterns even after acquisition

“Not Equal to Integration”
Physicians seen as uninterested in and unwilling to support system goals for care reliability, efficiency despite direct financial ties

Source: Health Care Advisory Board interviews and analysis.
Despite concerns about physician employment, most hospitals have in fact succeeded at managing employed practices against the goals that, until recently, have seemed most important.

Across the past decade, hospitals’ main objectives for physician employment have been two-fold: first, to minimize losses on individual practice financial performance, and second, to avoid antagonizing physicians wary of hospital control. Hospitals have successfully built management models to meet those objectives, improving the bottom line by mimicking the financial incentives of private practice and assuaging physician concerns by protecting individual physician autonomy and practice silos.

However, hospitals’ success against these objectives may inhibit the realization of broader aims for the employed enterprise, such as growing market share and in-network referrals, recruiting a new generation of physicians interested in team-based care, or building processes to meet new imperatives for care reliability and efficiency.

Changing Market Demands Heightening Risk of Lost Opportunities

### Traditional Employment Approach Maximizes Practice Autonomy...

<table>
<thead>
<tr>
<th>Practice Management Tenet</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>High premium on maintaining physician autonomy from larger system</td>
<td>Perceived as recruiting lever</td>
</tr>
<tr>
<td>Incentives to maximize individual productivity</td>
<td>Minimizes practice subsidy</td>
</tr>
<tr>
<td>Limited standardization of practice operations, clinical decisions, referral patterns</td>
<td>“Keeps the peace”—avoids antagonizing physicians wary of hospital control</td>
</tr>
</tbody>
</table>

...But Fails to Meet Evolving Goals for the Employed Enterprise

- Secure practice finances
- Secure patient access
- Secure referral volumes
- Secure care reliability
- Secure health system efficiency

New efforts likely to flounder

Efforts that have traditionally disappointed

Value vs. Time

Source: Health Care Advisory Board interviews and analysis.
As the employed network grows in size, the potential disadvantages of managing employed physicians within silos become more pronounced. In theory, a larger employed network could provide hospitals with an opportunity to capture many benefits of scale, including enhanced inter-network referrals, improved patient access, and cross-continuum care coordination. However, in focusing on employed physicians as autonomous units, rather than leveraging the network as a coordinated whole, many hospitals are falling short of realizing these gains.

As a result, many hospitals are seeking a new approach to practice management, one that shifts from viewing employed practices as autonomous entities to instead treating them as members of a larger, integrated “medical group.”

### Prioritizing Practice Autonomy Thwarts Achievement of Broader Goals

#### Thwarted by Fragmentation, Unable to Make Bigger Mean Better

#### Goals for the Employed Physician Enterprise

<table>
<thead>
<tr>
<th>Performance Metric</th>
<th>Potential Improvement with Larger Scale</th>
<th>Status Quo</th>
<th>Reason for Current Performance Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Finances</td>
<td>Achieve economies of scale, eliminate variation in practice operations</td>
<td></td>
<td>Protection of practice firewall inhibits consolidation and cost-sharing; considerable process variability remains</td>
</tr>
<tr>
<td>Referral Volumes</td>
<td>Capture more patients within loyal referral network</td>
<td></td>
<td>Inhibited by weak relationships between practices; many physicians do not know who else is employed</td>
</tr>
<tr>
<td>Patient Access</td>
<td>Leverage broad network to expand appointment availability</td>
<td></td>
<td>Few levers to win physician buy-in for disruptive access redesign; practice silos prevent sharing of mid-level providers</td>
</tr>
<tr>
<td>Care Reliability</td>
<td>Engage broad physician base against clinical quality and cost goals</td>
<td></td>
<td>Emphasis on individual productivity, lack of system affinity provide little incentive to focus on quality</td>
</tr>
<tr>
<td>System Efficiency</td>
<td>Provide full scope of services and coordinate care across provider types</td>
<td></td>
<td>Thwarted by emphasis on individual performance, weak peer relationships, and lack of infrastructure for care coordination</td>
</tr>
</tbody>
</table>
A number of medical groups do have a history of successfully managing employed physicians at scale. These organizations work to foster cohesion among physicians rather than promoting autonomy, a practice management approach that appears to result in strong financial, clinical, and operational performance. As such, these high-performance medical groups represent a model for hospitals that hope to realize greater value from the growing employed base.

Yet little guidance exists on what specific organizational attributes and practices make high-performance medical groups successful. To answer that question, the Health Care Advisory Board launched the High-Performance Medical Group Initiative.

Through this Initiative, we identified more than 25 medical groups that excelled on financial, clinical, and other strategic indicators, and conducted in-depth conversations and site visits with these organizations in order to understand the sources of strong performance. This publication details the key findings from that research effort.

Handful of Organizations Effectively Leveraging Scale, Integration

Identifying the High-Performance Medical Group

- Stable group-level financial indicators
- Strong group- or system-level quality outcomes
- Low physician turnover rates compared to market average
- Wide utilization of sophisticated clinical information technology
- Robust market share or evidence of recent growth
- Emphasis on care coordination and disease management

A Representative Sample of Research Participants

- 25+ medical groups with demonstrated high performance on financial and quality indicators
- Minimum size of 200 physicians, typically representing full range of specialties
- All early adopters of processes and systems for care redesign and risk management

Source: Health Care Advisory Board interviews and analysis.
Strong Medical Group Performance Not Linked to Structural Factors

Immediately clear from the research is that strong group outcomes are not due to structural factors. High-performance medical groups vary widely in size, history, ownership model, or market type. The lack of connection between surface characteristics and strong performance is also validated by the few studies evaluating medical group performance published in the academic literature.

On the Surface, Successful Employed Networks Show Wide Variety

Areas of Variability Between High-Performance Groups

- **Size**: Range from 200 physicians to 1,400
- **Ownership**: Mix of hospital-owned subsidiaries, independent groups, integrated delivery systems
- **Payment Model**: Range from pure fee-for-service to capitation
- **History**: Age range from a few years to more than a century
- **Market Type**: Mix of urban, suburban, semi-rural and rural

Something More Ephemeral at Work

“Although research suggests a link between group practice organizational attributes and quality or efficiency, researchers don’t know exactly why these links exist, nor the direction of causality. Most likely, the attributes of cohesion, scale, and affiliation are proxies for other, more difficult to study, characteristics.”

*Laura Tollen*

*Author, “Physician Organization in Relation to Quality and Efficiency of Care”*

Instead, three deeper defining characteristics set high-performance medical groups apart from other employed practices. These characteristics are consistent among all of the groups profiled within this publication, regardless of group structure.

First, groups maintain an identity as a unified, integrated, self-governing network. Their physicians have made a foundational commitment to common values, to care for patients as a team, and to work together to run their practices.

Second, groups build an infrastructure to support this commitment. This infrastructure includes platforms for information sharing, dedicated efforts to eliminate unwarranted variability, and resources to help physicians implement best-practice standards.

Third, groups deploy levers designed to engage individual physicians against strategic goals, recognizing that even the greatest commitment to a team must also be supported by personal rewards.

Each of these areas is described in more depth across the next several pages.
Common Culture Lays Groundwork for All Group Activities

An integrated identity provides the foundation of high-performance medical groups. Physicians within the group view themselves as part of a larger whole and understand that their own success is linked to strong performance by the broader team.

At the base of this identity is a common culture—an intangible attitude that has practical impact in driving group strategy. To make culture tactical, groups first bring physicians together to define values and expectations. While culture varies between organizations, high-performance medical groups tend to share certain tenets, such as collegiality and transparency.

Once physicians have coalesced behind a shared vision, groups then take steps to translate values into tangible elements of group practice and management, making culture enforceable on a day-to-day basis.

Setting Group Vision and Codifying Values the First Stage of Integration

Two Steps in Creating an Integrated Identity

1. Defining Group Values and Norms
   - Physician-led discussion
   - Sample questions: What are typical cultural hallmarks of an integrated medical group? Which of these are right for us?
   - Resulting principles shared with, embraced by all employed physicians and practice staff

2. Transforming Values into Everyday Practice
   - Physician compact that translates values into clear responsibilities and enforceable expectations
   - Adoption of shared brand to communicate integrated identity to both physicians and patients
   - Holistic assessment of employed physician value by parent system in setting budgetary expectations

Common Hallmarks of Group Culture

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Source: Health Care Advisory Board interviews and analysis.
Strong Partnership Between Physicians Essential to Referrals, Coordination

Also central to capturing the benefits of integration is building a team that works well together. High-performance groups recognize the many ways that collegiality and cultural fit pay off, fostering interpersonal connections that facilitate in-group referrals, create a more coordinated patient care experience, and minimize physician turnover.

These efforts begin at hiring: through careful recruiting and selection, groups take pains to ensure that any physician brought on board is a good fit, often walking away from candidates who—while attractive on paper—will not represent a strong cultural match.

On an ongoing basis, groups also take steps to build cohesion among physicians. Peer mentoring programs create connections between new and experienced physician partners within practice areas, while regular all-group forums provide an opportunity to build connections across specialties and practice sites.
While a common culture and a strong partnership provide the bedrock for group creation, fully realizing an integrated identity also requires that physicians have a direct stake in medical group strategic decision making. This tenet represents an ideological shift for many hospitals, which often grant physicians an advisory role but reserve decision-making power for non-physician administrators.

By contrast, high-performance medical groups provide comprehensive governance authority for physicians. Effective medical group governance has three core tenets: a governance structure that centralizes decision making across all physicians and penetrates deep into practice front lines; strong support for physician leadership development; and processes to align physician governance with broader health system strategy.

**Physician-Led Governance Structure**

- Effective practice management infrastructure
- Physician-led, professionally managed
- Integration with health system (e.g., understanding the revenue cycle from both sides)

**Deep Physician Leadership Bench**

- Appropriate tools, training resources available for effective leadership preparation, development
- Adequate administrative, management support for physicians in leadership roles
- Incentive structure in place to reward, create value for leadership roles

**Alignment with System Strategy**

- Medical group impacts, informs health system strategy
- Medical group decisions in lock step with health system goals
- Health system strategy clearly articulated to medical group
- Medical group accountable for performance on goals set by organization

*Recognizing the Need to Let Go of Control*

“Physicians are some of the most loyal people on the planet. They want their hospital to succeed. If you allow them to help in a real way, they’ll solve problems. If you control them, they’ll fight you every step of the way.”

*Administrator*

250-physician medical group

Source: Health Care Advisory Board interviews and analysis.
Providing “Arms and Legs” for Group Success

Core Components of the High-Performance Medical Group Infrastructure

Enterprise-Wide Information Network
- Seamless information exchange across physician practices
- Investment in single-vendor electronic medical record for all group members
- Additional IT systems to elevate performance (e.g., disease registry, clinical decision support, practice management)
- Physician engagement in protocol development, data capture process, adherence to clinical decision algorithms

Data-Driven Performance Improvement Processes
- Comprehensive dashboard providing multi-faceted, system-level view of employed network performance
- Formal process to prioritize and select improvement initiatives
- Physician-led development of best-practice solutions
- Iterative, data-driven approach to implement new standards and protocols

Scaled Resources to Support Care Delivery
- Recognition of key barriers to implementation of improvement initiatives (e.g., lack of physician time or tools)
- Economies of scale captured within administrative functions (e.g., revenue cycle, human resources)
- Extension of next-generation group-level support to facilitate clinical transformation (e.g., disease management staff, centralized referral scheduling)

Construction of an infrastructure that allows physicians to function as a team is the second key strategy used by high-performance medical groups.

Core to this infrastructure is an enterprise-wide information network that enables seamless data flow between physicians, supporting improved clinical care while sending important cultural signals that information is a group asset. Data also fuels formal performance improvement processes, another tactic used by medical groups to generate strong outcomes.

Finally, successful medical groups provide physicians with tools to put performance improvement into action, deploying resources at scale to optimize both operational and clinical performance.
Finally, high-performance medical groups recognize that, no matter how effective group culture and infrastructure, personal rewards and recognition still play an important role in driving physician behavior. Successful groups carefully align these physician motivators with group needs.

The performance levers deployed by successful employed networks capitalize on common physician traits. Responding to physicians’ natural tendency toward skepticism, groups ensure complete transparency in communication. They also leverage physicians’ innate sense of ambition by sharing individual performance data, often unblinded, to utilize this competitive dynamic to drive performance.

In addition, high-performance groups use financial incentives to align physician behavior, but do so sparingly, turning to compensation change only when other motivational levers fail. This practice stands in sharp contrast to many hospital employers, who tend to look at compensation as a primary means of influencing physician behavior.

**Performance Levers Linked to Typical Physician Traits**

**The “Three C’s” of Physician Motivation**

**Typical Physician Trait**

- Skeptical
  - Concerned about being marginalized, undervalued

- Ambitious
  - Constantly striving for “straight A’s,” hate to be outperformed

- Risk Averse
  - Wary of change, particularly when own income at risk

**Resulting Performance Lever**

- Communication
  - Transparent downward communication of rationale for group strategy
  - Structured forums to capture upward feedback from line physicians

- Competition
  - Opportunities for physicians to access holistic data on own performance
  - Sharing of unblinded data to foster peer pressure

- Compensation
  - Use of compensation as motivational tool only as a last resort, primarily when existing model serves as legitimate barriers to behavior change
  - Staged adoption of new compensation plans

**Order of Deployment**

Source: Health Care Advisory Board interviews and analysis.
Looking Beyond Increased “Subsidy” to Identify Broader Returns

A Significant Investment

- Clinical and administrative support staff (e.g., health coaches, data analysts)
- Enterprise-wide information network (e.g., EMR, disease registry, physician performance monitoring platform)
- Non-productivity compensation incentives not supported by external reimbursement (e.g., patient satisfaction metrics)
- Physician leadership training, incentive support
- Physical space for shared services (e.g., centralized referral scheduling center)
- Re-branding following practice name change

Yet Also High Costs to Integration Delay

Decisions to Undo
- Employment contracts structured around individual interests
- Acquisition of physicians who are a poor organizational fit
- Non-standard infrastructure investments by individual practices

Missed Opportunities
- Failure to win recruiting battles for physicians seeking collegial, coordinated environment
- Loss of referral business, market share to out-of-network providers
- Poor engagement of employed physicians around system quality, efficiency goals

Red Flags for Independents
- Indication that hospital is a poor partner for non-employment alignment relationship (e.g., clinical integration) due to underinvestment in medical group resources, lack of employed physician engagement

Source: Health Care Advisory Board interviews and analysis.
Ample Opportunities to Accelerate the Integration Process

Creating a coordinated, cohesive medical group will not happen overnight, but it is an attainable goal. Although many high-performance medical groups have had decades to organize, hospitals today can find ways to accelerate integration. Even those with just a few employed physicians can begin to build common culture and invest in network infrastructure. Such practices can strengthen the small employed network while also positioning the organization well for further growth in the physician ranks.

Timeline for Constructing the High-Performance Medical Group

Laying the Foundation for Coordination
- Define and codify common culture
- Create communication protocols
- Build physician governance
- Invest in leadership training
- Begin to invest in common EMR

Capturing Early Returns from Integration
- Develop group dashboard
- Share individual performance data
- Establish onboarding program
- Design referral scheduling
- Centralize referral scheduling

Leveraging the Enterprise for Care Redesign
- Define clinical pathways
- Reward quality
- Establish access protocols
- Redesign primary care
- Deploy care management resources
- Reward coordination

Time

Source: Health Care Advisory Board interviews and analysis.
Ultimately, hospitals that build a high-performance medical group can position themselves both to capture short-term returns around increasing quality and market share, and to succeed against emerging imperatives for care management and clinical transformation should new payment models take hold. These imperatives will require hospitals to manage quality and coordinate care far more effectively than before, while also continuing to achieve their longstanding central mission of improving the health of the community.

Physicians are crucial partners in that effort. By enhancing coordination among employed physicians, hospitals can use that integrated enterprise as the launching pad for a performance-focused, accountable physician network that engages both employed and independent physicians. In leveraging the employed base to drive improvement across the medical staff, hospitals can begin to build not just a high-performance medical group, but a high-performance health system.

Three Objectives for the Hospital-Physician Enterprise

**Live on Medicare Margins**
- Create and follow clinical protocols and care standards
- Secure referral streams
- Prevent low-margin medical admissions, ED utilization
- Maximize capture of ambulatory and inpatient revenue

**Prepare for Heightened Accountability**
- Treat patients at most appropriate site of care
- Coordinate handoffs across the care continuum
- Proactively manage chronic illness
- Minimize duplicative care delivery

**Advance the Mission**
- Build a patient-centric health care delivery system
- Provide high-quality, high-service, low-cost clinical care
- Improve overall health and wellness of the community

Source: Health Care Advisory Board interviews and analysis.
The High-Performance Medical Group

The remainder of this publication explores in greater detail the 15 key attributes that distinguish high-performance medical groups from other physician employers. As such, they provide a blueprint for building a high-performance medical group. Hospitals hoping to attain similar results with their employed physicians should consider how they will incorporate each of these elements into their own practice management approach.

The attributes profiled are organized into the three core categories discussed earlier: integrated identity, infrastructure for shared success, and strategy-aligned levers to motivate individual behavior. Each of these attributes makes a crucial contribution to the success achieved by high-performance medical groups.

### 15 Attributes of Effective Employed Physician Networks

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>An Integrated Identity</strong></td>
<td><strong>Infrastructure for Shared Success</strong></td>
<td><strong>Individual Behavior Aligned with Strategy</strong></td>
</tr>
<tr>
<td><em>Creating Common Culture</em></td>
<td><em>Extending Performance-Enhancing Tools</em></td>
<td><em>Leveraging Transparency</em></td>
</tr>
<tr>
<td><strong>Fostering the Partnership</strong></td>
<td>11. Scaled Resources to Support Care Delivery</td>
<td><strong>Designing Strategy-Aligned Compensation</strong></td>
</tr>
<tr>
<td>4. Meaningful Interpersonal Relationships Between Physicians</td>
<td></td>
<td>15. Staged Adoption of New Compensation Plans</td>
</tr>
<tr>
<td><strong>Formalizing Physician Control</strong></td>
<td></td>
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<td>5. Centralized Physician-Led Governance Model</td>
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<tr>
<td>6. Frontline Physicians Active in Leadership</td>
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<tr>
<td>7. Investment in Broad-Based Physician Leadership</td>
<td></td>
<td></td>
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<tr>
<td>8. Strategic Alignment Between Health System and Group</td>
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</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
I. An Integrated Identity

- Creating Common Culture
- Fostering the Partnership
- Formalizing Physician Control
At High-Performance Medical Groups, Patient Care Viewed as a “Team Sport”

Perhaps the most fundamental difference between a high-performance medical group and traditional hospital employment is how physicians perceive their role within the organization.

When acquiring practices, hospitals have traditionally protected a private-practice mindset that views care as an "individual sport." Physicians see their success as dictated almost entirely by their own activities, with little perceived value derived from association with a larger system. By fostering this mentality, hospital employers have perpetuated an independent and individualistic identity among employed physicians.

By contrast, physicians who are members of a high-functioning medical group unilaterally perceive value in being part of a larger organization. In the group setting, care is a "team sport." Physicians understand that their activities drive group success, and that organizational success in turn drives the physician’s own personal rewards. This integrated sense of physician identity rests at the core of every high-performance medical group.

### Integrated Physicians See Link Between Individual, Group Outcomes

#### Mindset of the Traditional Employed Physician

*My Success Depends on My Individual Behavior*

- My individual activities lead to my personal financial and clinical success
- Strong financial and clinical performance of my parent organization and physician colleagues has little impact on my personal success

#### Mindset of the Integrated Employed Physician

*My Success Is Enhanced by Collaboration*

- My individual activities lead to the financial and clinical success of my parent organization and physician colleagues
- Strong financial and clinical performance of my parent organization and physician colleagues enhances my personal success

Source: Health Care Advisory Board interviews and analysis.
Three Major Strategies Build Commitment to Mutual Success

High-performance medical groups use three major strategies to build an integrated identity and a commitment to mutual success among physician members.

First, they define common culture—an intangible but shared attitude that has practical impact in driving group strategy. To make culture tactical, groups bring physicians together to codify the values and responsibilities shared by all group members.

Second, high-performance groups take steps to build a team that works well together. They perpetuate culture through well-defined hiring and onboarding processes, and foster interpersonal relationships among physicians to build collegiality.

Finally, high-performance groups put key decisions directly in the hands of physician leaders. True physician governance is seen as crucial to building a sense of physician engagement and commitment.

Each of these strategic categories contains a subset of specific attributes shared by high-performance medical groups. The rest of this section examines these attributes in more detail.

Common Culture, Physician Governance Lay Groundwork for Group Mentality

Organizational Culture Shift Required

Impact on Integrated Identity

Creating Common Culture
- Attribute #1: Shared Vision and Formalized Cultural Expectations
- Attribute #2: Unified Identity Projected to Non-Physician Stakeholders

Fostering the Partnership
- Attribute #3: Cultural Expectations Hardwired in Recruiting and Onboarding
- Attribute #4: Meaningful Interpersonal Relationships Between Physicians

Formalizing Physician Control
- Attribute #5: Centralized Physician-Led Governance Model
- Attribute #6: Frontline Physicians Active in Leadership
- Attribute #7: Investment in Broad-Based Physician Leadership
- Attribute #8: Strategic Alignment Between Health System and Group

Source: Health Care Advisory Board interviews and analysis.
Creating Common Culture

Shared Culture Drives Strategic Decision Making and Physician Behavior

A common, unified physician culture is universally identified by high-performance medical groups when asked what sets them apart. Although intangible on its own, culture produces practical results, driving all aspects of group strategy and operations.

Every high-performance medical group is slightly different, and culture varies accordingly. Yet most successful employed networks tend to share certain values, such as collegiality, transparency and—where the group is hospital-owned—a belief that employed physicians are an integral part of the larger health system. These values translate directly into common operating standards and behaviors.

Creating Common Culture

Shared Culture Drives Strategic Decision Making and Physician Behavior

An Intangible Attitude, with Many Practical Results

Common Hallmarks of High-Performing Medical Group Culture

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“"We have a collaborative culture. It’s the way we’ve always done business, and it drives everything we do—how we pay our physicians, who we hire, how we make decisions. We don’t have specific structures in place to promote cooperation across departments. Our physicians just know they should walk down the hall and ask a colleague. I can’t imagine the number of ‘sidewalk consultations’ that happen here each day.”

James Hoyle, MD
Medical Director, Kelsey-Seybold Clinic

Source: Health Care Advisory Board interviews and analysis.
Creating Common Culture Requires Defining Values, Codifying Expectations

Longstanding medical groups have often maintained a common culture for so long that they struggle to articulate how it began. For newer medical groups, however, the process of creating a shared group identity typically incorporates two key stages.

The first step is to define the values the group will prioritize and the expectations it will have for members. Once physicians have coalesced behind a shared vision, groups then take steps to codify values and expectations, not just by writing them down, but by finding ways to enforce them on a day-to-day basis.

Two Questions to Consider in Establishing an Integrated Identity

How Will We Define Group Values and Norms?

- What are typical cultural hallmarks of an integrated medical group? Which of these are right for us?
- How will we engage physicians in the process of setting cultural expectations in order to ensure their buy-in?

How Will We Transform Values into Everyday Practice?

- How will we codify and communicate the new expectations and values of our integrated enterprise?
- How will we ensure that we “live our values” and enforce new expectations moving forward?
Letting Physicians Define Own Culture and Values Crucial for Acceptance

Medical group culture cannot be defined and mandated from above by health system administrators. Rather, asking physicians to articulate for themselves what values they will espouse is crucial for acceptance of the new identity.

As an example, consider pseudonymed Macoun Health Network, which has recently taken steps to integrate employed physicians into a single medical group. Macoun’s integration process has been fully driven by physician leaders, who worked across several months to define the vision for an integrated, collaborative group and the process needed to achieve that objective.

After vetting their plans with nearly 50 physicians seen as opinion leaders, the integration team called a meeting of all Macoun’s employed physicians. With the system CEO at their side, they presented the arguments for integration and defined the type of group they proposed to create. Leaders made it clear that the process would not proceed without buy-in from the majority of employed physicians.

At the end of the meeting a large majority of physicians expressed support for the integration concept, and many stepped up to volunteer for leadership roles—an indication of how a clear, physician-driven vision and communication process can streamline the shift to a new culture of collaboration.

Physician Ownership of Vision-Setting Process Leads to Broad Support

Defining Culture for a New Integrated Enterprise

1. Multispecialty physician team selects integration strategy, creates tactical “strawman principles” for new group

2. 15-physician Joint Physician Leadership Committee identifies hallmarks of effective group practice, refines guiding principles, develops work plan

3. Proposed work plan, principles presented individually to 50 physicians seen as opinion leaders for approval

4. At meeting of all employed physicians, health system CEO and physician leaders unveil vision for integrated group, request participation from rank-and-file physicians in further defining and building group structures

Guiding Principles

• All decisions place patient interests first
• Physicians are expected to be team leaders and team players
• Fair decision-making processes
• Systems thinking
• Measurement based
• All work to reduce unexplained variation
• All work to deliver increased value to customers
• Interdependencies and diversity are respected and embraced
• Open to work with all clinicians who are willing to support our patient-first goals, mission, and vision

Out of 350 physicians, number volunteering immediately to serve on three planning committees

Case in Brief: Macoun Health Network1

• Five-hospital system located in the Midwest
• Maintained 400 employed physicians organized in 15 subsidiaries under three management groups
• In 2010, began process of creating single integrated physician group at request of physician leaders seeking to improve coordination

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.
Physician Compact Codifies Mutual Expectations, Makes Culture Tangible

A second key step in building integrated identity is to translate physician-defined values into everyday practice, enabling the medical group to communicate and enforce its expectations for participating physicians. Many high-performance medical groups achieve this aim through a written physician compact.

For example, this page shows the compact used at Gundersen Lutheran Health System in Wisconsin, which employs a significant majority of its medical staff. The compact clearly delineates expectations and responsibilities for both the health system and its physicians, codifying the values and behaviors that the organization views as most vital to its success. More than just a guidepost for physicians, the compact is enforceable: employed physicians must sign it, and health system leaders note they have terminated more physicians for failing to meet these citizenship standards than for providing poor-quality care.

Strong compacts should also be jointly defined by physicians and hospital leaders, specific in the responsibilities outlined, directly related to behaviors within a physician's control, and unambiguous in their expectations.

Translating Values into Everyday Actions

Gundersen Lutheran's Medical Staff Compact

<table>
<thead>
<tr>
<th>Gundersen Lutheran’s Responsibilities</th>
<th>Medical Staff’s Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achieve Excellence</strong></td>
<td><strong>Focus on Superior Patient Care</strong></td>
</tr>
<tr>
<td>Recruit, support outstanding physicians</td>
<td>Practice evidence-based, patient-focused, high-quality medicine</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td><strong>Treat All People with Respect</strong></td>
</tr>
<tr>
<td>Communicate organization priorities, objectives</td>
<td>Listen and communicate clinical and non-clinical information clearly and respectfully</td>
</tr>
<tr>
<td><strong>Educate</strong></td>
<td><strong>Take Ownership</strong></td>
</tr>
<tr>
<td>Facilitate teaching and learning</td>
<td>Work to improve outcomes, service quality, practice efficiency</td>
</tr>
<tr>
<td><strong>Reward</strong></td>
<td><strong>Change</strong></td>
</tr>
<tr>
<td>Compensate fairly and competitively</td>
<td>Embrace innovation to improve patient care</td>
</tr>
<tr>
<td><strong>Change</strong></td>
<td></td>
</tr>
<tr>
<td>Enfranchise physicians in system change</td>
<td></td>
</tr>
</tbody>
</table>

Case in Brief: Gundersen Lutheran Health System

- Three-hospital health system based in LaCrosse, Wisconsin
- Leverages a physician-led governance structure to drive organizational culture
- Codifies hospital, physician expectations and responsibilities through medical staff compact

For the complete Gundersen Lutheran Health System Medical Staff Compact, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

High-Performance Groups Promote Group Over Individual Practice Brands

Traditionally Hiding the Larger Affiliation

Adopting an Integrated Brand Instead

Dr. Apple’s Family Medicine
Part of the Pear County Health System

Pear Medical Group
Family Medicine
Part of the Pear County Health System

Perpetuates sense of autonomy among employed practices

Augments assumption of new integrated identity and culture

What’s in a Name?

“I want our physicians to have an attitude about who they work for. When you ask a Cleveland Clinic doctor who he works for, he sticks out his chest and has an attitude. He’s proud, and so he’s willing to invest in making sure that reputation continues to be meaningful. I want our physicians to have that same kind of pride in this organization.”

Administrator
250-physician medical group

Source: Health Care Advisory Board interviews and analysis.
Illustrate the Benefits of Coherent Branding During the Acquisition Process

Loss of individual brand identity can represent an uncomfortable change for physicians. As a result, high-performance medical groups often work to describe the benefits of a common brand early in the practice acquisition process.

This page shows how the pseudonymed Macoun Health Network approaches this challenge. Macoun involves marketing staff during acquisition negotiations to discuss the benefits of an integrated brand—the appeal to patients, the potential positive impact on referrals, and the carryover from larger system marketing efforts. This effort is designed to help new physicians recognize the value of membership in a larger group, while also providing tools and processes to ease the transition and communicate the value of the affiliation to patients and other stakeholders.

### Easing the Brand Transition for New Practices

#### Making an Upfront Case for Common Branding

**Patient Preferences**
- Present focus group results showing power of system brand
- Discuss patient preference for coordinated care

**Physician Referral Opportunity**
- Emphasize opportunity to strengthen referral relationships
- Highlight number of other employed physicians also using brand

**Lower Marketing Costs**
- Present data on the amount of advertising conducted by health system
- Explain how practices carrying system name will indirectly benefit from group-wide advertising

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**Case in Brief: Macoun Health Network**
- Five-hospital system, located in the Midwest
- Implemented coherent branding strategy for employed practices to foster perception of coordination, better leverage marketing funds
- Discusses marketing with physicians during practice acquisition negotiations

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1) Pseudonym.
Communicating the Benefits of Integration to Other Constituencies

Reposition Medical Group’s Value in Everyone’s Eyes

Shifting Perceptions for Three Key Audiences

The Public
Replacing legacy brands projects coordinated image to patients, eliminates confusion about practice affiliation

Practice Staff
Enfranchising non-physician staff in medical group vision critical for reducing operational variability, enhancing care coordination, creating unified experience for patients

System Leaders
Recognizing value beyond practice breakeven enhances executive and board support for employment, strengthens physician cooperation

While physicians are the most important constituency to consider in developing an integrated identity, other stakeholders also must understand the benefits of a unified medical group in order to fully capture the value of integration. Projection of a common, coordinated identity to these constituencies is a second core attribute of high-performance medical groups.

Three audiences must be considered in this process. First, high-performance groups help patients understand the benefits of care coordination, a strategy that may pay off in enhanced market share. Second, groups work to engage non-physician practice staff, who play an important role in reducing variability and creating a consistent patient experience. Finally, groups ensure that leaders of the larger health system perceive employed physicians as more than just red ink on the balance sheet—a broader view of value that is crucial to making appropriate decisions about employment strategy and strengthening physician cooperation for health system initiatives.

How high-performance medical groups approach each of these constituencies is explored across the following pages.

Source: Health Care Advisory Board interviews and analysis.
Message of Comprehensive, Cohesive Care Resonates with Patients

Fearing Loss of Brand Equity…

• Will patients value my practice less if they know it is part of a larger system?
• Will association with other physicians or the hospital dilute patients’ perception of my practice quality?

…But Failing to Recognize Integration’s Appeal

Winning Hearts, Minds, and Market Share

“We’ve seen a steady increase in market share over the last few years. There are several contributing factors, but I believe it’s partly because all of our advertising emphasizes team-based, coordinated care. The message of integration is definitely starting to catch on with consumers.”

Medical Director
300-physician integrated delivery system

High-performance medical groups also ensure that non-physician practice staff recognize the rationale for and impact of integration, particularly when transitioning from a more autonomous practice management approach. The case of McIntosh Medical Group (a pseudonym) highlights the perils of failing to enfranchise all employees within the practice when setting the vision for a newly integrated network.

McIntosh took steps to build cohesion among employed physicians, who understood and supported the concept of integration. But these efforts did not extend to frontline or back-office practice staff, who were left disengaged and confused. Indeed, during a visit to one practice site, McIntosh’s president realized that some frontline staff had no idea that the larger medical group existed at all. As a result, staff members gave inaccurate messages to patients and resisted adoption of standardized protocols, while employee engagement dropped across the enterprise.

Results of Physician-Only Integration Campaign

**Staff and Patient Confusion**
Frontline staff unaware of group affiliation, provide mixed messages to patients

**Unwarranted Operational Variation**
Practices continue to maintain disparate methods for co-pay collection, lab referrals, other administrative procedures

**Poor Employee Engagement**
System-wide survey finds practice staff feel disconnected, unmotivated

*Who Are We Now?*
“I went to visit one of our member practice sites and introduced myself to the receptionist. She called back to the physician, ‘I have somebody here from McIntosh Medical Group. I have no idea what that is. Should I send him back?’”

*President, McIntosh Healthcare Medical Group*

**Case in Brief: McIntosh Healthcare Medical Group**
1. 350-physician group in the Midwest affiliated with two-hospital system
2. Recent rapid growth in employed base, emphasis on value-based purchasing led to push for integrated medical group
3. Integration efforts involved physicians in defining culture, establishing governance but failed to engage practice staff in similar discussions
Recognizing that staff engagement was vital to realizing full value from the integration investment, McIntosh Medical Group’s leaders launched a multi-faceted education campaign. To start, they held forums to discuss the value of being part of a larger medical group and created networking opportunities for staff members across practices to become acquainted.

McIntosh also worked to make the new culture tangible for staff. Similar to the compact created for physicians, they published a handbook of standards and tied staff compliance to performance reviews. At the same time, McIntosh implemented small rewards for employees who helped practices work toward group goals. Leaders credit these efforts with allowing the group to realize improvements in several key areas of operations.

### McIntosh Medical Group’s Staff Integration Strategy

**Leadership Forums**
- Educate staff on rationale, process for integration
- Provide opportunities for staff feedback

**Team Events**
- Bring staff from different practices together to socialize, discuss practice-level operational issues

**Practice Protocols**
- Define common standards for telephone wait time, other operations
- Monitor staff compliance and outcomes

**System Recognition**
- Provide small incentive to practice staff for meeting system goals
- Publicly commend staff who best represent group values

### Impact of Integration Campaign

- Frontline operating metrics (e.g., phone and office wait times)
- In-network referrals
- Staff satisfaction
- Patient satisfaction

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1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.
Myopic System View of Employment’s Value Inhibits High Performance

Perhaps the most critical audience to consider is senior health system leadership—the executives and board members ultimately responsible for setting employment strategy. In many organizations, executives traditionally adopt a relatively narrow view of employed practice value, concentrating on the size of the “subsidy” paid to employed physicians.

Systems with high-performance medical groups, however, recognize that focusing exclusively on the practice-level bottom line paints an incomplete picture of medical group value, obscuring legitimate reasons for on-paper losses and failing to account for downstream revenue. They also realize that an overly narrow definition of value can translate into real and negative consequences for medical group performance, leading the system to miss important opportunities for performance improvement or to overlook needed strategic investments that could strengthen the group and larger health system.

Perhaps most importantly, focusing only on the practice subsidy can also breed alienation among employed physicians. This mentality risks setting up a contentious relationship between physicians and system leaders, rather than fostering the sense of coordination and collaboration that integration is designed to achieve.

Expanding System Leaders’ Focus Beyond the Practice-Level Bottom Line

Often Focused Only on One (Disappointing) Aspect of Performance

Net Income per Employed Physician, 2010

<table>
<thead>
<tr>
<th>Percentile</th>
<th>75th</th>
<th>50th</th>
<th>25th</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>($81 K)</td>
<td>($190 K)</td>
<td>($282 K)</td>
</tr>
</tbody>
</table>

Missing the Broader Picture—and Potential Opportunities

Problems with Limited Budget Focus

- Fails to distinguish true practice efficiency opportunities from legitimate reasons for negative bottom line (e.g., incorporation of practice ancillaries into hospital service line)
- Does not account for practice’s downstream business or care management impact, potentially leading to underinvestment in less profitable but still crucial specialties
- Encourages “us vs. them” sense of alienation between employed physicians and health system, inhibiting integration efforts

Sending the Wrong Message

“That sense that they’re just a drain on the bottom line is incredibly demoralizing for physicians. How can we expect them to recognize the value of being a part of a larger organization if we don’t in turn recognize the broader value they bring to us?”

Chief Operating Officer
1,000-physician medical group

Source: Medical Group Management Association, Cost Survey for Multispecialty Practices, 2011; Health Care Advisory Board interviews and analysis.
Two Common Options for Assessing Owned Medical Group Finances

<table>
<thead>
<tr>
<th>Description</th>
<th>Budgeting Beyond Break Even</th>
<th>Integrated Service Line Accounting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health system assumes medical group will run at a loss</td>
<td>• Health system evaluates budget for entire service line, including both inpatient and ambulatory performance</td>
<td></td>
</tr>
<tr>
<td>• Financial expectations based on historical performance and market norms, rather than national benchmarks</td>
<td>• Overall service line profitability the most important goal; physician compensation and subsidy subsumed under service line costs</td>
<td></td>
</tr>
</tbody>
</table>

**Key Considerations**

<table>
<thead>
<tr>
<th>Budgeting Beyond Break Even</th>
<th>Integrated Service Line Accounting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Most effective when loss supported by additional metrics to quantify positive practice value (e.g., quality improvement, in-network referrals)</td>
<td>• Most effective when employed physicians comprise significant portion of medical staff</td>
</tr>
<tr>
<td>• May still inhibit achievement of system-level integration when compared to integrated service line accounting method</td>
<td>• Medical group still maintains own infrastructure (e.g., governance)</td>
</tr>
<tr>
<td></td>
<td>• Requires expansion of hospital-focused service line mentality (e.g., creation of primary care service line)</td>
</tr>
</tbody>
</table>

An upcoming whitepaper from the Health Care Advisory Board will examine service line accounting in more detail. This paper will be available in early 2012 at www.advisory.com/HCAB.
Strengthening Interpersonal Relationships Among Physician Peers

For high-performance medical groups, defining and promoting a common group culture is the first step in creating integration among employed physicians. Once this culture is established, successful groups focus on building a team that works well together, establishing a sense of collegiality among physician partners that encourages coordination around patient care, cross-network referrals, and other collaborative behaviors.

To foster a strong physician partnership, medical groups rely on two primary strategies. First, through targeted hiring and careful onboarding, they ensure that all new physicians are a good “fit” with the organization and can adapt quickly to cultural norms. Second, recognizing that coordination is difficult if physicians within the network do not know each other, they institute formal strategies to cultivate interpersonal relationships among physician peers.
The process of fostering a strong physician partnership begins at hiring. High-performance medical groups maintain strict standards for adding a new physician partner or acquiring a practice, considering three essential qualities in assessing a candidate’s fit.

First, they evaluate strategic importance. Will the physician bring in new business from other physicians or add new services to the group? Second, groups assess whether the physician is clinically capable, placing a premium on quality and efficiency.

What truly sets high-performance groups apart from other employers, however, is how strongly they embrace the third tenet, hiring for cultural compatibility. As the group’s collective success hinges on collaboration, hiring only candidates who meet organizational norms—even if that means walking away from physicians who could otherwise bring financial or strategic benefits—is critical. Groups also assert that this strategy is financially advantageous for the practice, as physicians who fit well are more likely to stay with the group, to refer to their in-network peers, and to minimize disruptive behavior.

### Cultural Compatibility Assessment Crucial to Effective Hiring Decisions

Seeking Physician Partners with a Complete Set of Attributes

#### Key Benefits of Selective Hiring

**Increases Physician Retention**
- Reduces recruiting costs, resources
- Minimizes vacancies
- Maintains consistent level of productivity

**Improves Patient Satisfaction**
- Supports consistent patient experience across enterprise
- Reduces discontinuity from turnover, miscommunication

**Minimizes Cost of “Bad Apples”**
- Reduces individual behaviors that disrupt group performance
- Avoids conduct issues that harm overall morale

**Fosters Interpersonal Relationships**
- Builds connections that facilitate in-group referrals
- Encourages team ownership of patient care

---

**Attribute #3: Cultural Expectations Hardwired in Recruiting and Onboarding**

**Culturally Compatible**
- Collaborates with other physicians
- Willing to address strategic priorities
- Shares organizational vision

**Strategically Important**
- Expands primary care access
- Brings needed specialty service to organization or community
- Generates sufficient volumes, referrals from other physicians

**High-Performing**
- Provides high-quality, low-cost patient care
- Standardizes devices, clinical protocols
- Works collaboratively to manage chronic disease

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Source: Health Care Advisory Board interviews and analysis.
Hiring a compatible physician is a two-way process. As the medical group focuses on assessing whether candidates are desirable partners, prospective physicians are in turn evaluating the group’s dynamics and practice environment. Communicating group values from the outset helps candidates make an informed and timely decision about whether to pursue partnership.

Braeburn Medical Group (a pseudonym) recognized the need to better communicate organizational values during recruiting after the group embraced a principle of reducing care variability several years ago. Several physicians had trouble with the shift to greater standardization, and Braeburn saw turnover rise, particularly among newly hired physicians.

As a result, Braeburn chose to redesign its hiring process around transparent communication of its culture and group practice style. Key to this process was describing the benefits of the group’s practice style in a comprehensive recruitment packet. With this information in hand, informed recruits asked more pointed questions, shortening the recruitment process. Four years later, Braeburn’s turnover is half the national average.

**Early Focus on Values Streamlines Recruitment, Maximizes Retention**

**Detailed Recruiting Packet Tells the Whole Story**

- Informs candidates of practice culture
- Defines organizational strategy, dedication to eliminating unnecessary variability in clinical and operational processes
- Provides detailed history of the organization, recent achievements in quality improvement and physician satisfaction
- Focuses on differentiating organization from its competitors
- Provides contact information for candidates with outstanding questions

**Appealing to the Right Physicians**

“Previous recruiting efforts did not reflect our commitment to care standardization. Our recruiting now showcases what is exceptional about Braeburn. The physician recruitment packet sends a signal into the market to all physicians looking for the unique practice environment we provide. Our turnover rate is on a downward trend.”

Director, Office of Physician Recruitment
Braeburn Medical Center

**Case in Brief: Braeburn Medical Center**

- Multispecialty group practice with over 350 physicians affiliated with a 250-bed acute care hospital located in the South
- Culturally based engagement efforts redefine recruitment as system implements care standards
- Recruiting packet sent to every candidate prior to interview; includes annual report, organization facts and figures, organizational history, current strategy, recent achievements, and guide to living in the area
Physicians should play a central role in defining cultural standards for new physician hires. Consider the case of NorthShore University HealthSystem Medical Group, a 700-physician employed network in Evanston, Illinois. NorthShore established a rigorous, three-step process for evaluating candidates for employment. Before even scheduling an interview, NorthShore assesses whether the candidate fills a strategic need and evaluates the physician’s past performance, looking at quality metrics and reputation.

But the most effective part of candidate selection is NorthShore’s “Hiring for Fit” process, a behavioral interview designed from the ground up to evaluate cultural compatibility with the group.

To hone the interview, leaders surveyed more than 100 physicians in the group, asking them to identify the attributes they would expect in a new colleague. The responses informed an interview guide that covers six core competencies, provides sample questions, and offers guidance on interpreting responses. Using this guide, physician interviewers grade candidates on each competency, compare notes, and then make the hiring decision.

**Behavioral Interview Guide Standardizes Candidate Evaluation**

**Physician Interview Guide**

Physician evaluated on six categories, including:
- Clinical expertise
- Ability to build loyal patient base
- Interpersonal skills
- Work ethic/time management
- Ability to work within a system
- Technological competence

Sample questions provided to aid candidate assessment

Physician responses evaluated on scale of having “Not Met,” “Met,” or “Exceeded” organizational standards, expectations

Competencies clearly defined to ensure understanding of evaluation criteria among interviewers

**Case in Brief: NorthShore University HealthSystem Medical Group**

- 700-physician medical group within NorthShore University HealthSystem, a four-hospital health system, located in Evanston, Illinois
- Created three-step candidate screening process to identify ideal physicians for employment
- Peer-led interview process evaluates strategic importance, performance quality, cultural fit of each candidate

Source: Health Care Advisory Board interviews and analysis.
Ensuring Cultural Fit Encourages Long-Term Stability of Physician Base

NorthShore’s efforts have resulted in a much more selective and stable physician network. For example, administrators report they no longer quickly and automatically extend employment offers to specialists in new growth markets. Rather, they now assess cultural fit even for physicians who previously looked too good on paper to pass up.

This hard line on cultural fit is paying notable returns, especially around retention. The group improved its turnover rate, down from 12 percent historically to just 4 percent now. NorthShore also reports that involving frontline physicians in the hiring process continues to pay dividends down the road. Physicians who are actively involved in candidate selection feel invested in those colleagues once they are hired and work to make sure that they are positioned well for successful practice.

Effective Hiring Stems Physician Turnover

Preempting Problematic Relationships

<table>
<thead>
<tr>
<th>Candidate Evaluation Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Dr. Perry Russet¹</td>
</tr>
<tr>
<td>Specialty: Gastroenterology</td>
</tr>
</tbody>
</table>

- **Strategic Importance**
  - Meets an important community need and will be a valuable source of referrals

- **Performance Record**
  - Strong reputation and historically high performance on quality metrics

- **Cultural Compatibility**
  - Exhibits self-centered attitude, unreasonable expectations, and lack of willingness to work collaboratively

Hired | Not Hired

Employed Physician Annual Turnover Rate

<table>
<thead>
<tr>
<th>NorthShore University HealthSystem Medical Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Historical Rate</strong></td>
</tr>
<tr>
<td>12–15%</td>
</tr>
</tbody>
</table>

¹ Pseudonym.

Source: Health Care Advisory Board interviews and analysis.
Expanding Cultural Assessment to Entire Practice

While hiring for cultural compatibility is relatively straightforward when interviewing a single physician, it becomes more difficult when evaluating a larger practice for acquisition. Even high-performance medical groups sometimes find themselves forced to bring on physicians who are not a good fit as individuals when acquiring a practice that is otherwise a strong strategic match.

In response to this challenge, Fairview Health Services in Minnesota created a “change assessment tool” that helps it quantify how well the practice overall will mesh with the rest of the group. The tool includes more than 50 standardized questions designed to evaluate cultural fit. Fairview generally brings on all physicians within the practice, even those who would not have been hired on their own; however, the tool helps Fairview identify what problem areas it will need to address immediately post-acquisition and allows the group to intervene early, before major issues take root.

Screening Tool Looks Beyond Individual Physicians to Evaluate Practice Fit

Practice Acquisition Requires Group-Level Assessment of Fit, Compatibility

Assessment Tool Identifies Barriers to Smooth Transition Process

- 50+ questions enable objective evaluation of critical items impacting cost, scope, effort of transaction
- Scoring system provides quantified method to assess cultural compatibility of acquired practice
- Standardized tool guarantees consistent feedback across all evaluators, for all practices
- Identification of problematic items allows opportunity to address issues prior to integration
- Completed assessments serve as a communication tool during onboarding process

Key Cultural Indicators

<table>
<thead>
<tr>
<th>Business Strategy</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission, Vision, Values</td>
<td>Environment</td>
</tr>
<tr>
<td>Human Resource Philosophy</td>
<td>Perspective</td>
</tr>
<tr>
<td>Communication</td>
<td>Quality</td>
</tr>
<tr>
<td>Leadership</td>
<td>Organizational Structure</td>
</tr>
</tbody>
</table>

Case in Brief: Fairview Health Services

- 1,647-bed, multi-hospital system with 750 employed physicians located in Minneapolis
- Developed Change Assessment Tool to diagnose cultural similarities, differences of potential practice acquisitions
- Overall findings determine level of resources afforded for transition, cultural integration

Source: Health Care Advisory Board interviews and analysis.
Hiring for fit is critical to get the right new physicians in the door. But high-performance groups also realize that the onboarding process provides a crucial first opportunity to demonstrate their culture in action to new physicians.

HealthTexas Provider Network, a subsidiary of Baylor Health Care System, has designed a comprehensive onboarding program that includes both formal and informal forums intended to teach physicians about culture and build relationships with peers. Courses offered are diverse and in-depth, going well beyond the traditional, basic administrative introduction most employers offer to new physicians.

The HealthTexas courses are structured to communicate the organization’s values at every turn—a campaign to win the hearts and minds of new physicians, disguised as simple orientation. Group leaders feel this robust and standardized process has been especially key to successfully integrating large numbers of physicians across a recent period of rapid acquisition and growth.

### Key Strategies for Engaging New Physicians

<table>
<thead>
<tr>
<th>Standard Onboarding</th>
<th>Introduce new providers to organization, clinical practice, strategic priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Forums</td>
<td>Provide venue for new physicians to develop relationships with peers within their specialty</td>
</tr>
<tr>
<td>Practice Leader Meetings</td>
<td>Provide updates for leaders of newly acquired practices to connect with system leaders and communicate strategy to frontline physicians</td>
</tr>
<tr>
<td>Group-Wide Networking Opportunities</td>
<td>Utilize key meetings, including Baylor Health Care System Orientation, Physician Spring Forum, regional Town Halls to create cross-specialty relationships</td>
</tr>
</tbody>
</table>

### Comprehensive Curriculum Ensures Acclimation

<table>
<thead>
<tr>
<th>Agenda Items from HealthTexas Care Provider Onboarding Training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topic</strong></td>
</tr>
<tr>
<td>Stewardship or Rationing? Prudence, Equanimity, Justice in the Allocation of Medical Resources</td>
</tr>
<tr>
<td>Physician/Patient Communication</td>
</tr>
<tr>
<td>Volunteer Opportunities</td>
</tr>
<tr>
<td>Social Media</td>
</tr>
<tr>
<td>Review of Press Ganey Data</td>
</tr>
</tbody>
</table>

For complete Onboarding Training Curriculum, please see the High-Performance Medical Group Toolkit available at [www.advisory.com/HCAB](http://www.advisory.com/HCAB)

### Case in Brief: HealthTexas Provider Network

- Medical group with 500+ physicians, affiliated with Baylor Health Care System located in Dallas, Texas
- Conducts regular orientations for all new physicians, including standardized two-day onboarding process that assimilates large acquired practices
Making an Investment in Each New Physician

- Each new physician matched with unpaid mentor in his/her own department, specialty
- Formal relationship lasts one year
- Checklist, handbook facilitate regular meetings between mentor, mentee,
  - Contain links to guide physicians to resources, ensure productive sessions

Highlighting the Mutual Benefits of Mentorship

Mentee Feedback
- Feel supported throughout first year
- Provides familiarity with system, practice culture
- Accelerates peer network development
- Appreciate connection to dedicated peer resource, organized process

Mentor Feedback
- Feel invested in the success of new physician recruits
- Reminds of, reinforces organizational culture
- Increases attachment to organization

For complete Mentoring Checklist, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Case in Brief: WellSpan Medical Group
- 500-provider medical group within WellSpan Health, located in York, Pennsylvania
- Formalized once ad-hoc mentoring relationships occurring organically across many clinical departments
- Program evaluation at one-, three-, six-, nine-, and twelve-month intervals reveals mentoring benefits for both mentors and mentees, shows 100 percent satisfaction with the mentoring program to date

Source: Health Care Advisory Board interviews and analysis.
Beyond one-on-one relationship building, high-performance medical groups bring all physicians together on at least a quarterly basis. These all-group sessions provide an important opportunity to share strategy and to build connections across specialties.

At many organizations, all-physician meetings lack focus or allocate too much time to airing grievances. A poorly run meeting can backfire as an integration tool if physicians feel the group is squandering their time. As a result, high-performance groups take steps to ensure that meetings are relevant and productive.

Several years ago, St. John’s Clinic in Missouri eliminated its all-group meetings after sustained poor attendance. Physicians felt the sessions had turned into “complaining sessions.” Needing a forum to engage physicians on key issues, however, St. John’s decided five years ago to revive the meetings, this time with a revamped formula. Leaders adhere to a formal agenda and observe a strict time limit. St. John’s also offers incentives to make meetings worth physicians’ time.

Most importantly, St. John’s holds all comments until after the meeting. Leaders are always available for those who want to continue discussion. But the meetings now align with the interests of the majority. As a result, physician feedback has been overwhelmingly positive, and participation has increased dramatically.

<table>
<thead>
<tr>
<th>Case in Brief: St. John’s Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 470-physician multispecialty group within St. John’s Health System, located in St. Louis</td>
</tr>
<tr>
<td>• Sought to improve historically low attendance at all-physician meetings</td>
</tr>
<tr>
<td>• New meeting format dedicates first hour to dinner and socialization, second hour to speaker content</td>
</tr>
<tr>
<td>• Now hosts four well-attended two-hour meetings per year</td>
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</tbody>
</table>

**Average Physician Attendance**

<table>
<thead>
<tr>
<th>All-Physician Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before Format Change</strong></td>
</tr>
<tr>
<td>50–75</td>
</tr>
<tr>
<td><strong>With New Meeting Format</strong></td>
</tr>
<tr>
<td>250–300</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Formalizing Physician Control

Evolving Beyond Leadership Lip Service

Beyond creating common culture and fostering partnership among physicians, high-performance groups formalize group identity through physician governance. Their experiences suggest that physicians will only be willing to truly engage in working toward group success if they feel peers are in control of key clinical and operational decisions.

True physician-led governance stands in sharp contrast to how many hospitals have traditionally managed employed practices. Physicians may serve in an advisory role, offering opinions, but decisions are made by health system management. Physicians have little opportunity to impact group or system strategy.

By contrast, high-performance medical groups put key decisions directly in the hands of physician leaders. Every group profiled in this publication unilaterally invests physicians with near-complete control over day-to-day clinical and operational decisions affecting practices. While health system leaders retain reserve powers and play a role in setting larger strategy, physicians have primary oversight of general practice operations.

### Traditional Hospital-Based Employment Model

*Influence, But No Real Control*

- Acknowledgement of physician leadership roles, titles, but little actual decision-making power
- Physician leaders removed from vision-setting process
- Little capacity for physician leaders to drive health system strategy

### High-Performance Medical Group Model

*Power Vested in Physicians*

- Recognition that physician leaders have same status as hospital leadership within system
- Full physician control over key decisions affecting clinical, practice operations
- Health system role limited to reserve power retention, broader strategy-setting

### A Critical Concession of Control

"Physicians are some of the most loyal people on the planet. They want their hospital to succeed. If you allow them to help in a real way, they’ll solve problems. If you control them, they’ll fight you every step of the way."

*Administrator*

250-physician medical group

Source: Health Care Advisory Board interviews and analysis.
Seeking to extend physician control across the network and down to the front lines, high-performance medical groups build leadership models with three essential elements.

First, they construct a centralized governance structure that pulls representatives from across the medical group, bringing together physicians from different practice sites and specialties to make strategic decisions for the enterprise as a whole. This governance structure also reaches down to the practice level, where physicians are placed in charge of day-to-day operational activities.

To populate this governance structure, successful groups also invest heavily in developing and supporting physician leaders, providing formal training programs, financial incentives, and other needed resources.

Finally, high-performance groups create processes to ensure that even as physicians assume responsibility for their own decisions, the group remains aligned with larger health system strategy.

Each of these elements is examined in more detail across the following pages.
Building a Unified Governance Structure

To begin, this page examines key elements of an effective physician governance structure. In high-performance medical groups, governance is unified across all physicians, creating a forum for coordination among practices. Many groups note that centralized decision making is more important for building a sense of integration among physicians than structural consolidation of employed practices; physicians may be employed through different subsidiaries, but if unified through shared governance, will operate as an integrated whole.

Within the typical centralized governance structure, the medical group board oversees high-level strategy. Board representation is split between hospital and physician leaders and is kept small—usually only eight to 12 members—to facilitate consensus decision making.

The medical group board typically reports up to the health system board or system CEO. This direct reporting relationship sends an important signal to physicians that they are valued players within the larger system.

Underneath the board typically sit a host of physician-run committees that oversee operational issues such as information technology or quality improvement. This structure works to ensure that physicians have responsibility for all key decisions that impact operations and clinical practice.

Centralized Decision Making Enables Consistency Across Group

Physician Decision-Making Power Across All Levels of the Organization

- **Hospital/System (Parent Board)**
  - Pulls leadership from across the medical group
  - Ensures equal representation across specialties
  - Assumes broad responsibility for clinical, operational aspects of physician practice

- **Medical Group Joint Policy Board**
  - Split between hospital, physician leaders
  - Small enough to effectively reach consensus decisions
  - Sets high-level group strategy
  - Approves major initiatives
  - Hospital may retain reserve powers

- **Physician Operating Committee**
  - Composed of physicians only
  - Tackles areas such as contracting, quality improvement, IT, other key strategy issues

For sample Organizational Charts, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Source: Health Care Advisory Board interviews and analysis.
Recognizing the Need for Frontline Leadership

Complementing effective centralized decision making at the top of the organization, high-performance medical groups also extend leadership to frontline physicians, engaging practice leaders to coordinate on decisions that affect physicians’ day-to-day operations.

Consider the case of NorthShore University HealthSystem Medical Group. NorthShore is a large, rapidly growing group, and its 28 primary care practices are spread across a wide geographic area, with limited communication between them. This fragmentation impeded the group’s efforts to enhance care coordination and in-network referrals and to reduce care variability between member physicians.

**Network Lacks Natural Connections Across Practices**

**Employed PCP Network**

*28 PCP Practices*

**Leadership Challenges**

- Large geographic distance creates fragmentation
- No formal leadership structure among PCPs
- Lack of communication channels between network leaders, frontline physicians

**Case in Brief: NorthShore University HealthSystem Medical Group**

- 700-physician medical group within NorthShore University HealthSystem, a four-hospital health system located in Evanston, Illinois
- 28 PCP practices across medical group lacked clear hierarchy, connection between practices and group leadership
- Lead Physician Committee successfully organizes groups, creates communication link between network leadership and community practices

Source: Health Care Advisory Board interviews and analysis.
To create a vehicle for uniting PCPs, NorthShore created a PCP Lead Physician Committee, containing leaders selected by each of the group’s 28 primary care practices. This committee fosters dialogue both between practices and with NorthShore’s group leadership, and works to advance the medical group’s broader strategic goals.

For example, group leaders tasked the committee with enhancing primary care patient access in the wake of stagnant growth. After exploring various possibilities, the committee proposed a centralized access program for cross coverage and expanded practice hours.

After collaborating to implement the changes, NorthShore’s PCPs increased both patient loyalty scores and office visits, which translated into an increase for PCP income as well.

Key to NorthShore’s success is that physicians affected by the decisions owned the initiatives and so were more willing to pursue solutions. Had administrators, rather than the PCPs themselves, suggested changes such as expanded weekend hours, the proposal could have generated considerable resistance from physicians instead.
Overcoming the “Us versus Them” Mentality

High-performance medical groups also work to extend collaboration between frontline leaders across specialties.

To foster cross-specialty communication, WellSpan Medical Group in Pennsylvania brings all of its practice leaders together in a monthly Site Director Meeting. Originally conceived as a way to enhance top-down communication between medical group leaders and practice sites, these meetings have also evolved into an effective forum to work out problems that cut across specialty lines.

For example, WellSpan recently asked the site directors to develop standards for care handoffs and referrals. The resulting discussion highlighted many misconceptions that existed between PCPs and specialists about why poor referral communication occurred. By airing those grievances, site directors were able to reach a consensus decision on referral communication standards.

Site Director Meetings Help Physicians See Eye to Eye

- Lead physicians at primary care, specialty sites represent each practice’s individual needs
- Open, face-to-face discussion reduces preconceived notions, reveals similar challenges among practices
- Group has effectively identified several opportunities to create standards across practices (e.g., referral process norms)

Finding Common Ground

“A PCP said, ‘Why can’t the specialist just call me on the phone?’ A specialist said ‘I would like all PCPs who have told their nurses not to forward calls during a patient visit to raise their hands.’ All of them raised their hands.”

Thomas McGann, MD
Senior Vice President, WellSpan Health
President, WellSpan Medical Group

Case in Brief: WellSpan Medical Group

- 500-provider medical group within WellSpan Health, located in York, Pennsylvania
- Monthly Site Director Meetings focus on mutually applicable issues, promoting common level of understanding across practices and specialties, propose solutions to cross-specialty issues
- Aim of meetings to communicate strategy, rationale for organization’s decisions back to each practice
Attribute #7: Investment in Broad-Based Physician Leadership

Creating a Heavy Demand for Physician Leaders

Building a governance structure with adequate breadth and depth requires medical groups to bring a considerable number of physicians into the leadership ranks. For many groups, half or more of their physicians serve in some leadership capacity, from committee membership up to senior executive positions.

Meeting this leadership demand may seem daunting to the many hospitals that struggle to engage physicians in leadership roles. Prepared only for clinical practice, physicians often lack the leadership training needed to govern and manage effectively.

At the same time, however, a significant number of physicians do possess the personal attributes needed to be an effective leader, such as strong interpersonal skills or a solutions-oriented attitude. The challenge is to first identify these potential leaders and then to deploy appropriate resources to support them.

### Leaders Needed at 200-Physician Medical Group

<table>
<thead>
<tr>
<th>Position</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Physician Executives</td>
<td>5</td>
</tr>
<tr>
<td>Division Chiefs, Medical Directors</td>
<td>12</td>
</tr>
<tr>
<td>Committee Chiefs, Chairs</td>
<td>10</td>
</tr>
<tr>
<td>Physician Practice Managers</td>
<td>30</td>
</tr>
<tr>
<td>Physician Committee Participants, Members</td>
<td>40</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>97</strong></td>
</tr>
</tbody>
</table>

**Filling the Leadership Void**

**Skill Set More Common Than Expected**

- **Strong Interpersonal Skills:** Respected by peers, staff for both clinical, non-clinical skills
- **Elevated Commitment:** Additional time volunteered to support medical staff initiatives
- **System-Oriented Thinking:** Proactive identification of systematic concerns requiring further investigation

Source: Health Care Advisory Board interviews and analysis.
Establishing a Venue for Leaders to Emerge

An Open Invitation
- Regular forum with medical group CEO intended to give all titled leaders a venue to voice concerns
- Attendees include leaders in both formal, informal roles

True Leaders Emerge
- CEO able to identify leaders who are engaged, elevate their role
- Forum an opportunity to transition from leaders in name to leaders in action

Stronger Than Before
- Process resulted in replacement of low-performing leaders with effective, engaged physicians
- New leaders provide valuable review, feedback of work plans, strategic initiatives

Case in Brief: NorthShore University HealthSystem Medical Group
- 700-physician medical group within NorthShore University HealthSystem, a four-hospital health system located in Evanston, Illinois
- High-potential physician leaders informally identified through their regular attendance at physician forums
- Group continues to meet quarterly, providing valuable information, feedback to senior leadership

NorthShore University HealthSystem Medical Group utilized a standing discussion forum with the group’s CEO to identify physicians with strong leadership potential. The forum is open to all physicians with a leadership title—even those serving only in nominal roles—and provides group executives with an opportunity to communicate around strategy with a large number of physicians.

As NorthShore was working to build up its leadership base, the discussion forums also offered an ancillary benefit. By monitoring who participated in and contributed most meaningfully to the forums, NorthShore was able to identify strong candidates for more senior leadership roles. These physicians were then elevated into central governance positions, often replacing low-performing or disengaged peers.

Source: Health Care Advisory Board interviews and analysis.
Once medical groups have identified high-potential leaders, they must also provide them with the support and skills necessary to be effective.

A key challenge for many physicians is having adequate time to devote to leadership duties. Physician leaders are most effective if they remain at least partially active in clinical practice, allowing them to truly understand the challenges faced by their peers. But balancing the demands of clinical work with leadership responsibilities is often difficult.

As a result, many high-performance medical groups support physician leaders through a “dyad” leadership model. In this model, physician leaders are paired with an administrative counterpart. The administrator oversees the operational tasks of management, while physician leaders are free to focus on interfacing with other clinicians. Most high-performing medical groups see this pairing as so crucial that they extend the dyad model to every level of management.

**Leveraging the Physician-Administrator Dyad Model**

**Physician**
- Oversees physician productivity, staffing, recruitment
- Provides physicians with performance feedback and improvement plan
- Provides clinical oversight
- Convenes, leads physician leadership groups

**Skills**
- Displays strong understanding of clinical data, physician practice economics
- Respected by PCPs, specialists

**Administrator**
- Oversees support staff, practice equipment, supply needs
- Manages logistics of payer contracting negotiations
- Monitors, prepares compensation reports
- Assesses, implements quality improvement initiatives

**Skills**
- Displays strong communication, organizational skills
- Engages diverse stakeholders from physicians, office staff to payers, employers

**Administrative Support Helps Physicians Balance Competing Demands**

Source: Health Care Advisory Board interviews and analysis.
Group Sets a High Bar for Physician Commitment, Organizational Support

Group Sets a High Bar for Physician Commitment, Organizational Support

Development of management and leadership skills—not something typically taught in medical school—is another core need for emerging physician leaders. High-performance medical groups therefore invest heavily in leadership training.

HealthTexas Physician Network, part of the Baylor system, views leadership service as an important way to acculturate new physicians. As the group has undergone a period of rapid growth in recent years, it has worked to quickly engage new physicians in committee roles, with the expectation that many of these physicians will subsequently assume more senior leadership responsibilities within the organization.

As part of this commitment, HealthTexas provides formal leadership development training. All new leaders go through a five-month course introducing them to Baylor’s sophisticated quality improvement program and are coached on fundamental business and management skills.

### Requirements for All Physician Leaders

| ✔ | Demonstrated success in quality improvement project |
| ✔ | Completion of ABC Baylor Course |
| ✔ | Meeting thresholds for patient satisfaction |
| ✔ | Exhibition of good citizenship (meeting attendance) |
| ✔ | At least one year spent on committee |
| ✔ | Ability to demonstrate leadership skills |
| ✔ | Acceptance by other physicians as leader |

### Resources for Physician Leaders

- **ABC Baylor**: Five-month, internally developed course with a focus on continuous quality improvement attended by rising physician leaders, practice administrators

- **School of Management**: Year-long course, offered every other year with a focus on acclimating experienced physician leaders to management roles

### Case in Brief: HealthTexas Physician Network

- 500+ physician medical group affiliated with Baylor Health Care System, located in Dallas, Texas
- Group investment in incentive, high premium on leadership bolsters involvement
- Network invests in leadership development through formal training, strict requirements

Source: Health Care Advisory Board interviews and analysis.
Establishing a Sense of Shared Responsibility for Leadership Development

To increase the feasibility and attractiveness of leadership service, HealthTexas Physician Network also compensates its physicians for leadership duties. The group pays physicians at an hourly, fair market value-based rate for leadership duties, helping to defray productivity and revenue lost due to time spent away from clinical practice.

Although many other high-performance medical groups also compensate for leadership service, HealthTexas goes a step further than most. To stress the impact that leaders are making for all physicians, HealthTexas funds its stipends through a so-called “leadership tax”—a fee paid by every physician in the medical group that explicitly goes toward leadership compensation. This strategy communicates that physician leadership is so important to group success that all physicians are expected to make a contribution toward it in some way, whether through time or money.

The net result of these support systems is that HealthTexas has an impressive 30 percent of its physicians serving in leadership roles.

Required Contribution Communicates Importance of Leadership Service

HealthTexas Leadership Incentive Fund

- **Committee Participation**: $150/hour
- **Committee Chair**: $200/hour

**Pooled contribution:** $65 per month per physician required to fund organization’s committee pay structure

**HealthTexas Leadership Incentive Fund**

- **30%**: Estimated percent of physicians in compensated leadership roles
- **$3,300**: Amount earned annually by physician committee member attending all meetings

Source: Health Care Advisory Board interviews and analysis.

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1) Rate applies to hours dedicated to leadership role.
The final core element of effective physician governance is alignment with system strategy. In creating a physician-led medical group, health systems must avoid inadvertently fostering discord between physicians and the rest of the organization.

Akero Health Medical Group is a pseudonymed multispecialty network affiliated with a multi-hospital system. Akero has a thriving medical group governance structure, and the group is operationally and financially successful, with practice losses dropping considerably across the past five years.

However, Akero’s physician leaders typically make decisions with little consideration of how those choices impact, or are impacted by, larger health system strategy. The group is a successful business unit, but not a strategic partner—group-level integration has failed to improve physician attachment to system goals.

**Self-Governance, Group-System Alignment Potentially in Conflict**

**Autonomous but Disconnected**
- Financially stable group not aligned with health system
- Medical group unaware of system strategy due to poor communication
- Physician input not solicited, medical group decisions do not further system strategy

**Missing Out on Benefits of Integration**
- Health system failing to realize value of closely aligned medical group
- Missed opportunities include cross-continuum referral capture, improved care coordination, physician support of clinical, efficiency goals

**Case in Brief: Akero Health Medical Group**
- 380-physician multispecialty group located in the East
- Medical group operationally and financially sound, but operates autonomously with little input from system; frequently makes decisions in conflict with system strategic goals
- Future stability, success of organization jeopardized by failure to realize benefits of physician integration

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.
A more integrated approach is offered by Indiana University (IU) Health Physicians, a large multispecialty medical group in the Midwest. Like many high-performance groups, IU has created system-physician alignment by elevating the medical group’s CEO to a seat at the system’s highest executive table.

In that capacity, the CEO is able to ensure that medical group decision making reflects system needs and concerns. With a direct line between them, the medical group and health system can tailor their strategic plans and performance scorecards to match each other. Individual physician performance is thus linked directly back to system success.

At the same time, the CEO’s role as a senior system executive allows him to influence system decision making, ensuring that larger organizational strategy also reflects physicians’ needs and concerns. For example, the medical group CEO recently encouraged health system leaders to incorporate diabetes-specific metrics into system-level performance scorecards, noting that while diabetes management indicators are most directly applicable on the ambulatory (rather than inpatient) side, their relevance to the system as a whole would grow as the organization took on more reimbursement risk.

**Strengthening the Link Between System and Physician Group Strategy**

**Impact of Placing Medical Group CEO on System Senior Executive Committee**

- **Benefits to Medical Group**
  - Representation in key decisions impacting clinical, practice operations
  - Consideration of physician practice concerns when setting high-level strategy
  - Senior, bidirectional line of communication to facilitate feedback, input between system, group

- **Benefits to Health System**
  - Physician perspective on decisions impacting system-wide care delivery
  - Channel to communicate rationale for system-level strategy decisions, fostering support
  - Safeguard to ensure practice-level activities in sync with system strategy

**Case in Brief: Indiana University Health Physicians**

- 1,100-physician medical group affiliated with Indiana University Health System, located in Indianapolis, Indiana
- Medical group leadership present at health system executive vice president meetings
- Direct line of communication contributes to a more comprehensive view of care delivery in system strategy, aligned performance scorecards

**Source:** Health Care Advisory Board interviews and analysis.
The box on this page provides a brief overview summary of the eight attributes used by high-performance medical groups to develop an integrated identity. These elements involved in creating common culture, fostering partnership between physicians, and formalizing physician control represent the first level of foundational tenets for the high-performance medical group.

### Takeaway Summary for Health System Leaders

<table>
<thead>
<tr>
<th>Attribute #1: Shared Vision and Formalized Cultural Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledge the need for a unified culture across all employed physicians and engage physicians to define and codify the core values of the medical group; link group tenets to enforceable performance standards</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Attribute #2: Unified Identity Projected to Non-Physician Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate value of integration to practice staff and patients through common branding and operations; develop comprehensive system perspective of medical group value beyond bottom-line performance</td>
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</table>

<table>
<thead>
<tr>
<th>Attribute #3: Cultural Expectations Hardwired in Recruiting and Onboarding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design candidate selection and onboarding processes to ensure that physician partners meet strategic and quality goals, fit organizational culture, and are capable of working collaboratively</td>
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</table>

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<tr>
<th>Attribute #4: Meaningful Interpersonal Relationships Between Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster interpersonal relationships between new and tenured physicians through formalized mentoring; perpetuate collegial relationships among physicians through efficient, regular group-wide forums</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Attribute #5: Centralized Physician-Led Governance Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formalize physician control of key operational and strategic decisions through centralized, physician-led governance; aim for governance unifying all physicians across specialties and corporate divisions</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Attribute #6: Frontline Physicians Active in Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create leadership roles that allow frontline physicians to improve practice performance and care delivery; create an organizational structure that maximizes their impact on practice-level decisions</td>
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<table>
<thead>
<tr>
<th>Attribute #7: Investment in Broad-Based Physician Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognize the need for a large number of physicians to serve in medical group leadership roles; actively seek high-potential leadership candidates and provide them with the training and tools needed to succeed</td>
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<table>
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<tr>
<th>Attribute #8: Strategic Alignment Between Health System and Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognize that physician autonomy should not impede hospital-physician integration; elevate medical group leadership to senior executive team to ensure bidirectional communication and strategic alignment</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
An Integrated Identity

The box on this page contains key questions for health system leaders to discuss as they consider their own progress toward creating an integrated identity among employed physicians.

Key Questions for Health System Leaders

- Can system leaders and physicians articulate a common vision for the medical group culture? What are our core values? How do we engage our physicians to formalize these tenets, and integrate them into practice?

- Do our current branding efforts reinforce our integrated identity and the advantages of integration for patients? How do we work with frontline staff to create a consistent experience for patients across the group?

- Does our physician leadership encompass a broad range of physicians across specialties, sites of practice, and tenure? How do we identify high-potential leaders to expand leadership ranks and support them in balancing these duties with care delivery?

- Do we have active, physician-led medical group governance? How do we unify governance to enable common decision making across the group? How do we create robust leadership at the practice level?

- How do we help system leaders and board members embrace a comprehensive view of medical group performance? How do we build processes to ensure the health system and physicians are working toward shared goals?
II. Infrastructure for Shared Success

- Extending Performance-Enhancing Tools
Construction of an infrastructure that allows physicians to function as a team is the second key strategy used by high-performance medical groups. If building an integrated identity is designed to win physicians’ “hearts and minds” for closer collaboration, medical group infrastructure is designed to provide physicians with “arms and legs” for collective performance improvement and shared success.

The high-performance medical group infrastructure includes three key attributes, each of which is explored further across the following pages.

First, groups construct an information technology backbone that enables seamless data flow and supports clinical care. Second, they develop a physician-led, data-driven process to identify performance improvement opportunities and to respond with standardized solutions. Finally, high-performance groups deploy a set of network-level resources that help physicians implement those improvements, capitalizing on group scale to advance clinical care beyond the capabilities of a single provider acting alone.
Seamless Information Exchange a Long-Held Ambition

For high-performance medical groups, free-flowing exchange of patient information has long been a core value. Indeed, more than 100 years ago, one of the nation’s first group practices—the Mayo Clinic—converted to a unified patient record and built a massive pneumatic tube system to move data between clinic sites.

Full and open information transfer allows physicians to provide better clinical care. More importantly, it sends a cultural signal that information is a group asset and that colleagues have nothing to hide. As one group administrator noted, “When everyone in the group knows what is going on elsewhere, medicine can truly be a team sport.”

Today, Mayo’s pneumatic tube system has been replaced by an electronic medical record (EMR). The EMR’s benefits go far beyond data sharing, allowing groups to build in value-added features such as clinical decision support, care pathways, and data analytics. As a result, high-performance medical groups have unilaterally adopted enterprise-wide EMR systems, often far earlier than others in the market.

The Historical Precedent

Technology in Brief: Pneumatic Tube System at the Mayo Clinic

- 3,700-physician health system based in Rochester, Minnesota
- In 1907, created single-unit patient record system and built comprehensive pneumatic tube network for transporting records
- Pneumatic tubes shuttle foot-long containers throughout, across buildings to enable sharing information
- Two pneumatic tube systems span 10 miles, connecting 94 clinic sites

The Modern (and More Effective) Replacement

100% High-performance medical groups using an enterprise-wide EMR

<table>
<thead>
<tr>
<th>EMR Attributes</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard field to enter information</td>
<td>Creates capacity to pull accurate data, analyze quality</td>
</tr>
<tr>
<td>Ability to flag care protocols</td>
<td>Increases ability to standardize care pathways</td>
</tr>
<tr>
<td>Clinical decision support</td>
<td>Allows instant verification of proper course of action</td>
</tr>
<tr>
<td>Information on past care interventions</td>
<td>Averts conflict in care regimen, adverse medication interactions</td>
</tr>
<tr>
<td>Full access to patient information</td>
<td>Prevents unnecessary repeat documentation, provides full medical history</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Designing an Information System with Maximum Functionality

Two considerations are key to high-performance medical groups’ use of EMR technology and the resulting benefits.

First, medical groups invest not just in any EMR, but in a single-vendor, enterprise-wide platform providing the same user interface across all practices. Several groups have even chosen to replace existing functional but disparate EMR systems originally selected by individual practices, citing a common platform as the only way to both ensure transparency and hardwire standard operating protocols.

For example, Gala Health Network (a pseudonym) invested several million dollars to replace its EMR network after spending years trying unsuccessfully to patch together disparate systems. Notably, this change was driven by Gala’s physicians, who were frustrated with the shortcomings of legacy platforms and lobbied for new technology despite the potential negative impact on productivity.

Second, medical groups recognize that even the most advanced EMR lacks all the capabilities needed to drive group performance. As a result, they also invest in complementary platforms, such as disease registry or practice management software. These systems provide services that the EMR cannot, such as the ability to identify care gaps for chronic disease patients or evaluate population-level performance.

Common EMR Platform, Use of Additional Technologies Drive Effectiveness

Investing in a Single-Vendor Platform

Augmenting with Other Systems

Information Needed to Drive Performance

- Disease Registry
- Practice Management Software
- Clinical Decision Support
- ePrescribing
- CPOE²

Advantages of Comprehensive Information System

<table>
<thead>
<tr>
<th>Advantage</th>
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<tbody>
<tr>
<td>Ensures compliance with clinical standards</td>
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<tr>
<td>Fosters sense of integration across all physicians</td>
</tr>
<tr>
<td>Alerts physician of adverse medication interactions</td>
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<tr>
<td>Provides database of results on clinical outcomes</td>
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<tr>
<td>Tracks care site transitions</td>
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<tr>
<td>Reviews test results, referral diagnoses instantly</td>
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Source: Health Care Advisory Board interviews and analysis.

1) Pseudonym.
2) Computerized physician order entry.

Case in Brief: Gala Health Network¹

- 1,500-physician, seven-hospital system located in the Midwest
- Invested in system-wide EMR to support commitment to effective physician integration
The Marshfield Clinic in Wisconsin provides an example of a comprehensive information network at work. Its robust IT infrastructure includes a myriad of data systems. The clinic’s home-grown EMR is the gateway into this infrastructure, which also includes a number of other supporting technologies. The goal of Marshfield’s extensive IT effort is to put as much information as possible at every physician’s fingertips, driving proactive care management for those patients most at risk.

Marshfield was a participant in the Medicare Physician Group Practice (PGP) Demonstration, which tested a shared-savings reimbursement model. Participating organizations were charged with decreasing spending for an assigned group of Medicare beneficiaries by at least 2 percent; once that threshold was reached, PGP sites were eligible to receive 80 percent of any additional savings realized. Out of 10 participants, Marshfield was one of only two organizations to earn bonuses during every year of the demonstration project, a success it credits in part to its comprehensive information backbone.

**Elevating Performance Through a Comprehensive Information Platform**

**With a Myriad of Data at Their Fingertips, Physicians Able to Excel**

**Information-Powered Care Delivery at Marshfield Clinic**

- **Electronic Access to Lab Results**: Delivers lab results in real time, customized by specialty
- **Disease Registries**: Facilitate preventive health prompts, capacity to adjust for chronically ill
- **ePrescribing**: Highlights list of preferred alternates, flags allergies, potential ADEs
- **CDSS**: Provides real-time guidance for key clinical decisions

**Case in Brief: Marshfield Clinic**

- 800-physician, not-for-profit multispecialty group practice located in Marshfield, Wisconsin
- Developed a custom electronic health record, telemedicine network
- Electronic network supports care delivery in 33 rural communities in northern, central, and western Wisconsin

Physician Input Key to Maximizing IT Effectiveness

Physician support is another critical consideration for IT effectiveness. Physicians play a key role in developing system protocols, ensuring that data is properly entered, and using the system to its fullest capability on an ongoing basis. As a result, high-performance medical groups are careful to engage and train physicians around IT at every opportunity. This practice begins, as Marshfield’s president notes, during the development phase, when physicians are integrally involved in selecting and testing IT systems. Once the information system is operational, medical groups invest time and energy in training physicians on how to use it properly and constantly reinforce how physicians’ use of the system links back to larger goals for patient safety and quality.

Enfranchising Physicians at Every Step

- **Develop Clinical and Operational Protocols**
  - Involve experts across all specialties in creation of evidence-based care standards
  - Solicit physician feedback prior to rollout
  - Ensure physician review process for updating standards

- **Ensure Accurate Data Capture**
  - Engage physician champions to set example, train colleagues on standardized data entry
  - Ensure physicians understand link between accurate data entry, improved patient care

- **Adhere to Clinical Decision Algorithms**
  - Highlight data indicating that decision support results in higher quality care
  - Deploy physician-led communication strategy linking algorithms to clinical excellence

“If you look at our system, it wasn’t developed by some IT folks in a vacuum. Doctors are on the development team.”

Ken Ulrich, MD
President, Marshfield Clinic

This page summarizes the four necessary capabilities of the high-performance information network—a system that both supports the best possible performance at the moment of care and fuels analysis that engenders additional, ongoing improvement.

The Knowledge-Powered Medical Group

Four Hallmarks of Effective IT Platforms

Establishes Baseline for Performance
- Captures complete picture of clinical, operational performance
- Standardizes physician performance evaluation to increase accuracy

Hardwires Clinical Standards
- Provides clinical decision support to remove unwarranted variation
- Encourages consensus-driven care protocols to increase overall patient safety

Manages Patients Proactively
- Identifies patients most in need of disease management, intense interventions

Enables Cross-Network Visibility
- Builds system for care coordination
- Elevates the patient experience
- Creates virtual format for real-time communication
- Increases visibility to schedule availability across network

Source: Health Care Advisory Board interviews and analysis.
With an enterprise-wide information network in place, the high-performance medical group’s next strategy is to use that data to drive performance improvement.

High-performance medical groups typically follow a four-step process to identify and address opportunities for performance improvement. They begin by developing a comprehensive executive-level dashboard that provides a holistic view of medical group performance across a range of operational, financial, and clinical indicators. Groups then use that dashboard to identify areas of underperformance and prioritize interventions based on an analysis that weighs likely benefits and physician reaction.

Once the group has selected an improvement opportunity, it looks for solutions within its own ranks, pulling together physicians to create “economies of intellect” around best-practice standards. Finally, groups roll those standards out gradually, building on strong initial results to generate enthusiasm and buy-in among physicians.
At the root of the performance improvement process is the executive dashboard, which gives medical group leadership a bird’s-eye view into group activity and outcomes.

This dashboard provides a more comprehensive view of medical group performance than the typical physician practice report cards, which primarily focus on employed physicians’ productivity and financial outcomes. By contrast, the high-performance medical group dashboard incorporates a broader set of indicators, such as clinical outcomes, patient and peer satisfaction, or physician citizenship. This holistic view allows the group to identify a wide range of opportunities for performance improvement.

**Successful Groups Adopt Multi-Faceted View of Network Performance**

**Element #1—Build a Comprehensive Dashboard**

**Expanding Performance Focus Beyond the Financials**

### Status Quo Groups Solely Focused on Practice Financials

**Performance Dashboard for Employed Physicians**

- Profit and Loss Statement: $___
- Bad Debt: $___
- Days in A/R: _____
- Expense per wRVU: $___
- Revenue per wRVU: $___

**Medical Group Income**: $___

### Characteristics of a High-Performance Group Dashboard

- Offers both broad and comprehensive view of practice performance
- Provides system-level perspective on practice value beyond financial transactions
- Identifies critical areas requiring performance improvement

Source: Health Care Advisory Board interviews and analysis.
Aggregating Data from Multiple Sources for Complete Performance Visibility

To populate the comprehensive performance dashboard, medical groups pull information from a range of data sources, including both inpatient and ambulatory clinical and administrative information systems. Additional data, such as peer and patient feedback, may be collected by hand.

Based on conversations with high-performance medical groups, the Health Care Advisory Board has created a "pick list" of commonly used dashboard metrics. This list, which is available through the Advisory.com website, organizes metrics along three dimensions of value.

Monitoring Metrics Across Three Performance Dimensions

### Myriad of Data Sources

#### Clinical Systems
- Disease registry
- EMR

#### Administrative Systems
- Practice management system
- Financial/billing system

#### Other Data Sources
- Patient satisfaction
- Peer feedback

### Comprehensive Group Performance Dashboard

**Sample Metrics**

<table>
<thead>
<tr>
<th>Care Sustainability</th>
<th>Care Outcomes</th>
<th>Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice/Group-Level Expenses</td>
<td>Evidence-Based, Specialty-Specific Metrics</td>
<td>Care Coordination Processes</td>
</tr>
<tr>
<td>Practice-Level Revenue</td>
<td>Care Standard Adherence</td>
<td>Primary Care Transformation</td>
</tr>
<tr>
<td>Downstream Revenue</td>
<td>Readmission Reduction Metrics</td>
<td>Patient Engagement</td>
</tr>
</tbody>
</table>

For complete Medical Group Dashboard Metric Pick List, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Source: Health Care Advisory Board interviews and analysis.
The dashboard’s role is to highlight opportunities where performance is lagging. The next step in the performance improvement process is to decide which of those opportunities are most worth pursuing.

The Marshfield Clinic invests considerable effort into performance management, another crucial factor in its success with the Physician Group Practice Demonstration. As part of this effort, Marshfield conducts a four-step assessment process to determine which potential improvement initiatives will be most feasible.

With physicians involved at every step, Marshfield first determines whether a particular initiative is actionable and feasible given the analytical and human resources available. If so, Marshfield then conducts a cost-benefit analysis of the potential opportunity. Finally, Marshfield considers physician response, rejecting initiatives likely to generate too high a level of resistance. This process results in a prioritized list of physician-championed, actionable initiatives with concrete performance goals.

**Sequence of Questions Allows Clinic to Prioritize Potential Initiatives**

1. **Can we pinpoint the root cause of the problem?**
2. **Do we have a physician who will champion the initiative?**
3. **Will the benefits outweigh the costs?**
4. **Are physicians ready for change?**

**Physician leaders identify multiple potential targets**

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**Case in Brief: Marshfield Clinic**
- 800-physician multispecialty group practice located in Marshfield, Wisconsin
- Developed data-driven system to select performance improvement initiatives
- Operations group, system implementation team jointly identify metrics to determine rollout timeline, measure success

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Source: Health Care Advisory Board interviews and analysis.
Once medical groups have identified a viable improvement opportunity, they next work to develop best-practice solutions. Successful groups look first for those best practices within their own ranks, pulling together physicians from across the organization to create “economies of intellect.”

Atrius Health, a tightly knit network of standalone medical groups in Massachusetts, believes strongly that unnecessary variation leads to inefficiency and poor outcomes. As a result, Atrius works closely to identify the most effective clinical and operational practices in use by member physicians and to spread those practices across the network as standard operating protocols.

To facilitate this process, Atrius created the Quality Improvement Council, staffed by representative physicians from across the network. Using data provided by network administrators, the council identifies the top three and bottom three performing physician practices on a metric of interest. The group next brings those physicians together to discuss what has made them successful or where they have struggled. The committee then uses that information to develop a best-practice standard that can be effectively implemented by other network physicians.

### Case in Brief: Atrius Health
- Alliance of five non-profit, community-based independent physician groups located in Central and Eastern Massachusetts
- Draws on experiences of high-performing practices to resolve common clinical quality challenges
- Expanded model of best practice standardization to pharmacy operations, plans to extend to financial operations in future

Source: Health Care Advisory Board interviews and analysis.
Physician involvement in the development of a best-practice standard, while critical, is no guarantee that the new protocol will be easily accepted by other physicians. Even high-performance medical groups sometimes struggle to overcome physicians’ general resistance to the concept of standardization. As a result, successful groups pay careful attention to how they deploy new standards, implementing changes in a way designed to maximize physician comfort.

One such method is to roll out a new standard gradually. For example, the Marshfield Clinic in Wisconsin pilots all new initiatives first at “maven” sites—practices that are generally receptive to change and will likely implement the initiative successfully. During the pilot process, Marshfield refines the initiative as needed and collects data showing a positive impact. It then uses that information to build enthusiasm for the initiative from other practices.

**“Maven” Sites Pave the Way Before Broad Rollout**

**Creating Momentum for Change**

**Indicators of Ideal Pilot Sites**

- Effective leadership, buy-in from physicians, support staff
- Known for adaptability, willingness to spearhead new programs
- Demonstrated success in “working out the kinks” to prepare for expansion to other sites

**Case in Brief: Marshfield Clinic**

- 800-physician multispecialty group practice located in Marshfield, Wisconsin
- Physicians practice at more than 50 sites, increasing challenge of deploying initiative
- When rolling out performance improvement initiatives, high-performing sites undergo pilot first in order to demonstrate early success, create enthusiasm around the initiative
Another tactic to generate acceptance for new standards is to demonstrate clearly the benefits that will result from the change—particularly those benefits that affect the physician personally.

NorthShore University HealthSystem Medical Group strives to support all change improvement initiatives with comprehensive data to this effect. For example, several years ago, the medical group recognized that its revenue cycle was highly inefficient, with an average days in accounts receivable of 120. In response, physician leaders created a new standardized process to improve cash flow.

To generate physician support for the change, NorthShore demonstrated to physicians exactly how standardized revenue cycle improvements translated into a personal increase in compensation. As a result, physicians were largely willing to embrace the standard. NorthShore was able to reduce days in accounts receivable significantly, while also generating physician goodwill that it has leveraged in subsequent standardization efforts.

### Case in Brief: NorthShore University HealthSystem Medical Group

- 700-physician medical group within NorthShore University HealthSystem, a four-hospital health system located in Evanston, Illinois
- Monitored and shared outcomes data to assure physicians of initiative success, secured physician buy-in for expanded standardization beyond revenue cycle
- Utilized physician feedback to resolve difficulties across expansion

Source: Health Care Advisory Board interviews and analysis.
Designing an Iterative Rollout Process

Iterative implementation of new initiatives is another key element of change management at NorthShore University HealthSystem Medical Group. NorthShore deploys new standards and protocols in incremental steps, pausing after each adjustment to check impact and reassure physicians.

For example, when NorthShore’s primary care practice leaders decided to standardize extended office hours in order to improve patient access, they began by asking physicians to stay open late for just one night a week. Medical group leaders then collected data to show how this single change had positively impacted patient satisfaction, practice revenue, and physician compensation.

Pleased with the results, the physicians themselves suggested additional evening hours. When that too yielded positive results, physicians were willing to consider organizing across practices to open on weekends as well. By implementing the change slowly, backed by data every step of the way, NorthShore was ultimately able to smoothly implement a change that would likely have generated significant resistance had it been forced on physicians all at once.

Ongoing Evaluation of Outcomes

1. Implement Change
2. Collect Data
3. Assess Outcomes
4. Share Outcomes with Physicians

Physicians agree to proposal by primary care practice leaders to extend office hours for one evening per week.

Data demonstrates positive return from initial change; physicians suggest extending additional hours on other evenings.

Data continues to reveal positive impact on patient satisfaction, physician revenue; physicians agree to work weekends.

Source: Health Care Advisory Board interviews and analysis.
Standards that impact only administrative or back-office functions are typically easier for physicians to accept than protocols that influence clinical decisions. But initial success around operational standards can demonstrate to physicians the positive impact of reducing variability and build goodwill for subsequent efforts to implement best-practice protocols affecting clinical work.

As a result, many high-performance medical groups choose to begin by standardizing relatively uncontroversial areas such as revenue cycle or physician onboarding processes, clearly demonstrating to physicians both the group and individual benefits that result. With each successful implementation of a new process or protocol, physician resistance drops. Many high-performance groups report that they are now at a stage where physicians themselves have proposed extending standardization into once-contentious clinical areas.
Physician buy-in for change is necessary but not sufficient to achieve true performance improvement. On their own, most physicians are ill-equipped to implement improvement initiatives and standards, whether due to lack of time, knowledge, or resources. High-performance medical groups respond by providing support at scale—resources are built by the group, then leveraged by all, providing practices with capabilities that none could afford alone.

For many health system employers, the concept of scaling services across practices has been limited to business functions, such as human resources, billing, or information technology support. High-performance groups take scale a step farther, building group-level resources to support physicians in optimizing care delivery as well.

Expanding the Potential for Scale Across the Network

Supporting Clinical as Well as Administrative Functions

Individual Practices Lacking Key Ingredients for Improvement Initiatives

- **Time**
  "Everyone in my practice is busy seeing patients and couldn’t possibly take on another project…"

- **Skill Set**
  "I really don’t even know how to do this. It’s completely outside of my job description…”

- **Resources**
  "I’d love to hire a diabetes care manager, but I don’t have the dollars or patients to support a full-time position…”

Providing Group-Level Resources to Enable Performance Change

- **Traditional Opportunities for Scale**
  - Revenue cycle
  - Human resources
  - Ancillary services
  - Information technology support

- **Next-Generation Opportunities for Scale**
  - Performance management support
  - Patient access
  - Referrals management
  - Care management resources

Source: Health Care Advisory Board interviews and analysis.
Overcoming Barriers to Care Transformation

Centralized care management resources can greatly accelerate care transformation in physician practices that may not be able to afford or justify full-scale resources individually. As a practical example, consider the challenges that primary care physicians face as they implement a medical home model.

Medical homes leverage a team of providers and information technology such as a disease registry to provide comprehensive, coordinated care. To meet this objective, practices must make a significant investment in team staffing, build infrastructure to enhance patient access, strengthen referral relationships, and support the practice through disruptive change. Any one of these changes would be difficult for an individual primary care practice to make on its own.

Without Scaled Resources, Medical Home Adoption an Upward Climb

Common Challenges to Medical Home Implementation

- **Limited Management Capability**
  - Time consuming to design new model, outline transformation
  - New requirements likely for data collection, analysis

- **Insufficient Care Network**
  - Specialists not aligned to similar quality goals
  - Poor coordination of ongoing patient information
  - Necessary referral relationships lacking, weak

- **Inadequate Staffing for Comprehensive Care Delivery**
  - Multiple levels of staff required to provide top-of-license care
  - Individual practices may struggle with flexing providers to meet patient needs

- **Poor PCP Practice Economics**
  - Practices operating at a loss
  - Financially unable to take on major restructuring or additional staff members

Source: Health Care Advisory Board interviews and analysis.
Facilitating the Transition to Team-Based Care

Scaled resources provided by the medical group can support PCPs through the medical home transition. This page describes two models for resource deployment: providing in-practice care teams that PCPs can access within their own office or establishing an external practice resource, such as an outpatient chronic care center. The most appropriate model for each organization depends on physician needs and hospital resources, but both provide PCPs with access to resources that would be too costly for any single practice to develop on its own.

Details on each model for care management support are provided on the following pages.

Providing Medical Home Resources at a Network Level

Models of Team-Based Care

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<thead>
<tr>
<th>Characteristics</th>
<th>In-Practice Care Team</th>
<th>External Practice Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Hospital provides support that practices are able to access within their practice, at their discretion</td>
<td>Hospital provides external support for group of practices; may be network-wide outpatient center</td>
</tr>
<tr>
<td><strong>Type of Resource</strong></td>
<td>Could include registered nurse (RN), dietitian, and/or chronic disease educator</td>
<td>Typically comprises RNs, nurse practitioners; may also include dietitians, trained educators, mental health providers</td>
</tr>
<tr>
<td><strong>Applicability</strong></td>
<td>Resource may be permanently placed within practice</td>
<td>May be utilized by both employed and independent physicians</td>
</tr>
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Source: Health Care Advisory Board interviews and analysis.
Deploying a Single Care Team to Benefit Multiple Practices

Carondelet Health Network in Tucson offers an example of an organization that provides a scalable in-practice resource to support team-based care. The system leases a diabetes care management team to its employed physicians. (Independent practices may lease the team as well.) This model allows Carondelet to build scale by distributing the costs of the care team across several practices.

Physicians have the ability to determine how frequently to host the care team based on the needs of their patient panel. For some practices, the team comes to the practice one full day each week. For others, the team may be leased for only one afternoon each month. To finance the care team, the practice bills out for the appropriate level of care provided by team members. This new revenue usually covers the cost of the team, making the program a break-even opportunity.

Distributing Resource Costs Across Sites

Care Team Lease

- Hired and trained by system
- Leased out to practices at hourly rate
- Includes RN, registered dietitian, diabetes navigator
- Elevates quality of diabetes care

Diabetes Care Team

Physician Practices

Case in Brief: Carondelet Health Network

- Four-hospital system located in Tucson, Arizona
- Growing diabetes population prompts comprehensive outpatient diabetes strategy
- Physician practice bills to the payer, compensates care team with hourly rate; diabetes navigator, community health outreach worker covered by grant funding

Source: Health Care Advisory Board interviews and analysis.
Middlesex Hospital in Connecticut offers an example of the second model for deploying care management support: a centralized, external care team resource. Under this model, PCPs refer patients to Middlesex’s Center for Chronic Care Management, an outpatient facility where care managers provide patient education and self-management support. The center proactively communicates with practices regarding treatment plans and patient compliance, ensuring that PCPs remain informed and building a seamless experience for patients. This bidirectional exchange of information is critical for patient and physician satisfaction.

Middlesex originally developed the Center for Chronic Care Management more than 10 years ago in preparation for capitation. Although risk contracts never materialized, strong physician support and improved patient outcomes encouraged the hospital to continue operating the center.

### Practices Share Access to Advanced Care Management Program

#### Center for Chronic Care Management

- Members of Medical Group

#### Knowledge of Disease Symptoms

- **Percentage of CHF Patients**
  - Before: 80%
  - After: 100%

- **Annual HbA1c Testing**
  - Before: 74%
  - After: 84%

#### Case in Brief: Middlesex Hospital

- 150-bed hospital located in Middletown, Connecticut
- Through physician-hospital organization (PHO), created Center for Chronic Care Management to assist PCPs in managing patients with chronic disease, history of tobacco use
- Created 10 years ago in anticipation of capitation; continued because of improved outcomes

Source: Health Care Advisory Board interviews and analysis.
Successful Medical Groups Frequently Provide a Range of Resources

Centralized Appointment Scheduling
- Coordinates in-network referrals, post-referral communication
- Facilitates practice cross-coverage to enhance patient access

Floating Physician Extenders
- Deployed as needed to support practice sites with inadequate patient volumes to fund full-time mid-level or nurse

Physician Performance Improvement Assistance
- Includes coaches, proctors, and training programs
- Designed to support physicians struggling to meet group’s performance expectations

Dedicated Human Resources Staff
- Oversee culture-linked medical group hiring and onboarding programs
- Respond to questions about compensation, other physician-specific concerns

Beyond care transformation, high-performance medical groups deploy a number of other shared resources to aid physicians in optimizing care delivery, both in the practice and at a central level.

For example, in an effort to improve patient access, medical groups may maintain a pool of physician extenders who can float between sites. This allows practices that do not, on their own, have adequate patient volumes to support a full-time mid-level to secure additional coverage as needed, rather than turning patients away. At the same time, many high-performance groups also maintain a centralized scheduling service that helps patients make timely appointments with another in-group provider when their own physician is unavailable, preventing leakage outside the network.

When combined with administrative support, these resources have an additive effect, ultimately improving both clinical and financial performance.

Source: Health Care Advisory Board interviews and analysis.
Infrastructure for Shared Success

The box on this page provides a brief overview summary of the three attributes used by high-performance medical groups to develop an infrastructure for shared success. These performance-enhancing tools represent the second level of core elements maintained by the high-performance medical group.

Takeaway Summary for Health System Leaders

Attribute #9: Enterprise-Wide Information Network
Recognize the importance of seamless information exchange in building transparency and driving high-value care; build a common information management platform capable of not just data integration, but also identifying performance gaps, hardwiring care standards and advancing population health

Attribute #10: Formal Processes for Data-Driven Performance Improvement
Create a robust data-driven performance improvement process across the medical group; engage physician leaders to prioritize initiatives, define standards and accelerate roll-out across practices

Attribute #11: Scaled Resources to Support Care Delivery
Create economies of scale across practices to support practice-level operational and financial success; organize centralized medical group resources to enable practices to deliver comprehensive, coordinated care

Source: Health Care Advisory Board interviews and analysis.
Infrastructure for Shared Success

The box on this page contains key questions for health system leaders to discuss as they consider progress toward building infrastructure among their own employed practices.

Key Questions for Health System Leaders

- Do our information systems support seamless information exchange across all practices? Can our IT systems support clinicians in complying with care standards and making the best clinical decisions?

- How do we build a performance dashboard that provides a comprehensive view of employed practice performance? Do we have the systems to provide the information necessary to populate that dashboard? How do we choose metrics that are specific and actionable?

- Do we have the capabilities to not only exchange and aggregate data, but also analyze that information to identify care gaps and performance shortfalls? How will we act to elevate performance and engage physicians in change?

- How receptive are our physicians to standardizing elements of practice operations and care delivery?

- What avenues exist for physicians to share their ideas for improvement?

- What resources do our physicians need to improve care delivery? How can we leverage economies of scale across practices to accelerate new care model development?

Source: Health Care Advisory Board interviews and analysis.
III. Individual Behavior Aligned with Strategy

- Leveraging Transparency
- Designing Strategy-Aligned Compensation
No matter how effective group culture and infrastructure, personal rewards and recognition still play an important role in driving physician behavior. As a result, high-performance medical groups put careful thought into the design of individual incentives that can engage physicians against group goals.

The performance levers deployed by successful employed networks capitalize on common physician traits, as shown on this page. Responding to physicians’ natural tendency toward skepticism, they ensure complete transparency in communication, building systems for both downward and upward feedback. They also leverage physicians’ innate sense of ambition by sharing individual performance data, often in unblinded fashion, to maximize the competitive effect.

In addition, groups turn to compensation to motivate physician behavior. However, most high-performance groups deploy financial incentives sparingly, mindful of physicians’ tendency toward risk aversion. Rather, they alter compensation primarily when other motivational levers fail or when compensation itself serves as a barrier to change. This practice stands in contrast to many hospital employers, who tend to look at compensation as the primary means of influencing physician behavior.

These performance levers are each linked to specific attributes explored across the following pages.
Leaders of High-Performance Groups Hold No Secrets

**Elements of a Successful Downward Communication Strategy**

- **Available and Accessible**
  - Delivered at regular, frequent intervals
  - Requires minimal physician effort to participate in dialogue
  - Employs range of communication modes

- **Comprehensive Coverage**
  - Reports on new initiatives, status of current projects, group quality, and financial performance
  - Explains rationale behind key decisions

- **Personally Relevant**
  - Constantly links group actions, initiatives back to shared strategy, vision
  - Connects organizational change to individual physician benefits, concerns

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**No Secrets**

"I tell physicians that they should know everything I know. There is nothing I can’t tell them about the reasons behind the decisions we make. Trust correlates directly with level of communication from the top."

Craig Samitt, MD
CEO, Dean Clinic

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In high-performance medical groups, transparency is a core cultural tenet. Full and open communication is seen as crucial to building trust, reassuring physicians that leaders and colleagues are not hiding anything that might affect their practice or patients.

Effective downward communication requires medical group leaders to provide frequent, proactive updates to rank-and-file physicians, employing a variety of communication vehicles (written, in-person, and electronic) to account for physicians’ different preferences and schedules. Leaders should communicate around all group activities and initiatives, no matter how small. Communication should also clearly explain the rationale for new decisions or process changes, linking initiatives back to group strategy and, where possible, identifying the group and individual benefits that will result.
Erring Toward Over-Communication

A Comprehensive Communication Strategy at Dean Clinic

Dean Clinic in Wisconsin offers a good example of a comprehensive communication strategy in practice. A large independent physician group, Dean has actively embraced care transformation and is often cited as a model for organizations seeking to assume greater responsibility for population management and accountable care. As a result, Dean has implemented a significant number of changes across the past few years, making open communication particularly important.

Dean’s leaders have created multiple forums to distribute information throughout the group. They hold regular meetings with both frontline leaders and rank-and-file physicians. The clinic also produces a written newsletter for physicians, and Dean’s CEO provides regular electronic updates via a widely read executive blog. In all, Dean errs toward over-communication, with leaders believing that having some physicians feel inundated with information is preferable to having others feel left in the dark.

Case in Brief: Dean Clinic

- Integrated system composed of 500 physicians and a 300,000-member health plan located in Madison, Wisconsin
- Redesigned care model as part of long-standing vision to deliver value-based care
- To enhance physician support for redesign, strengthened downward and upward communication channels
- Communication strategy generates physician support for strategic initiatives

In Person

- Frequent in-person meetings between board, frontline physician leaders, rank-and-file physicians to convey strategy
- Facilitated meetings between representatives of physician practices to discuss ongoing initiatives, resolve concerns

In Print and Online

- Newsletter produced by communications staff updates physicians on ongoing projects, announces new initiatives
- Executive blog provides forum for CEO to communicate organizational strategy, vision
- Materials delivered regularly over e-mail

Source: Health Care Advisory Board interviews and analysis.
Establishing Robust Opportunities for Upward Feedback

Effective communication requires more than top-down messaging. Physicians also need an opportunity to share their thoughts with leaders, making communication a two-way process.

To address the need for upward feedback, Dean Clinic has created online forums in which group leaders begin conversations about key initiatives, then step back to allow individual physicians to discuss and debate. Dean uses the online forums for many new initiatives, such as a recent successful effort to win approval for a new physician compact.

The online forums run through open listservs housed on the clinic’s Intranet site, enabling physicians across Dean’s expansive market to log in at their own convenience. Given the high premium that the clinic’s culture places on transparency, the forums are not confidential, but the lack of anonymity has not been a barrier to physician use. In fact, Dean’s leaders note that many physicians seem more willing to comment online than in person, and that discussion is often more balanced and civil as a result.

Dean Uses Online Forums to Engage the “Silent Majority”

Dean Online Physician Forums

- Intranet-linked tool used to gather input on key initiatives, such as new physician compact
- Listserv model allows physicians and leadership to post in an ongoing conversation
- CEO and executive leadership begin online conversations to solicit physician feedback, prompt discussion
- Leadership responds to all comments, questions
- Users may not remain anonymous

Key Benefits

- Allows physicians to offer feedback without attending meetings
- Enables CEO to provide direct feedback to frontline physician input
- Avoids monopoly of conversation by a vocal minority
- Creates conversation among all physicians across broad market

Online, “Squeaky Wheels” Get No Grease

“A vocal minority tends to dominate face-to-face meetings, but online the ‘silent majority’ is much more likely to speak its mind.”

Craig Samitt, MD
CEO, Dean Clinic

Source: Health Care Advisory Board interviews and analysis.
Data Sharing a Mandatory First Step in Performance Improvement

**Hallmarks of an Effective Data-Sharing Process**

- Reported regularly and frequently
- Organized in an intuitive, easy-to-understand format
- Places performance comparisons in statistical context
- Meets reasonable standards for data integrity (e.g., statistically valid, timely, focused on outcomes within physician's individual control)
- Supplemented with additional information as needed (e.g., access to patient-level details for further analysis)

**Key Impacts on Physician Behavior**

1. Establishes Clear Targets
   - Access to individual data allows physicians to identify specific areas of underperformance

2. Generates Peer Pressure
   - Comparison to other physicians in group spurs (often rapid) behavior change

**Transparency About Individual Physician Performance No Longer Optional**

While open, bidirectional communication provides the platform to engage physicians and present the rationale for change, sharing individual physician performance data is also critical to drive behavior change.

In an effective data-sharing process, physicians have regular access to clear, comprehensive, and accurate information about their individual performance against key strategic metrics, as well as information that compares their performance to others within the group. This transparency allows physicians to recognize specific opportunities for performance improvement. Even more important, transparency also can generate peer pressure that plays off physicians' desire to avoid being seen as an outlier.

High-performance medical groups are distinguished from other employers by how extensively they use data to leverage physicians' natural ambitious tendencies. The groups profiled in this publication all monitor a wide range of physician performance indicators and frequently share that information not just with the individual physician, but with his or her peers as well.
Medical Group Measurements Go Beyond the Basics

WellSpan Medical Group in Pennsylvania provides an example of how high-performance organizations monitor an extensive range of physician performance indicators. WellSpan’s physician report card not only includes basic financial and clinical quality metrics, but also measures how well the physician supports system growth initiatives and operates within a larger team. The report card depicts performance relative to peers and to group averages, allowing physicians and group leaders to identify opportunities for improvement.

Notably, many of the citizenship and professionalism metrics included in WellSpan’s physician report card are similar to the responsibilities outlined in the physician compacts profiled on page 41 of this publication. Along with identifying areas for individual improvement, WellSpan’s report card serves as an enforcement mechanism for the group’s cultural values.

WellSpan Medical Group Physician Dashboard

<table>
<thead>
<tr>
<th>Finance</th>
<th>Quality</th>
<th>Growth</th>
<th>Citizenship</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Work RVUs or other productivity measures</td>
<td>• Specialty-specific clinical quality indicators</td>
<td>• PCP panel size</td>
<td>• Meeting attendance</td>
</tr>
<tr>
<td>• Practice expenses in relation to budget</td>
<td></td>
<td>• Specialist responsiveness, discharge planning (as measured by PCP survey)</td>
<td>• Community involvement (self-reported; only visible to administrative staff)</td>
</tr>
</tbody>
</table>

Case in Brief: WellSpan Medical Group

- 500-provider medical group within WellSpan Health, located in York, Pennsylvania
- Combined data from across health system to create comprehensive physician scorecard
- Leveraged scorecard for physician performance review

Source: Health Care Advisory Board interviews and analysis.
Allowing individual physicians to see their performance relative to the rest of the group as a whole is, in and of itself, a powerful means to motivate behavior change. But many high-performance groups are taking transparency to the next level with fully unblinded data sharing, calling public attention to physicians’ standing against their peers.

This page shows data from a study at ThedaCare, a Wisconsin health system that wanted to reduce the rate of elective inductions performed before 39 weeks gestation. The system first presented data to each obstetrician that compared individual performance to the department mean.

Although this initial information led to some improvement, the group’s goals were not reached until the system began sharing each physician’s induction rate by name. Following this change, the number of unnecessary elective inductions performed before 39 weeks dropped to 0 as physicians moved quickly to avoid being seen as an outlier.

Naturally Competitive

“Data is…more powerful when it can be personalized, such as enabling physicians to see their own performance compared to that of their peers. Most powerful of all is unblinded data.”

John Toussaint, MD
CEO Emeritus, ThedaCare

Case in Brief: ThedaCare

- Four-hospital health system located in Appleton, Wisconsin
- After finding that 35 percent of electively induced deliveries took place before 39 weeks, took steps to reduce early induction rate
- Blinded performance data encouraged initial but limited improvement
- Release of unblinded data motivated full physician compliance with standard

Adherence to Elective Induction Guidelines¹

May 2007–April 2008

<table>
<thead>
<tr>
<th>Month</th>
<th>Performance</th>
<th>Unblinded performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

¹) Apart from clinical necessity, prohibition on elective induction before 39 weeks of gestation.
Gradual Shift to Unblinded Data Sharing Designed to Ease Physician Concerns

Concerned about how physicians will react to unblinded data sharing, many high-performance medical groups have chosen to transition toward full performance transparency gradually, increasing the exposure levels in stages. However, as they go through this process groups report that physicians are often more receptive to the idea of unblinded data sharing than they had anticipated.

Consider the case of Covenant Health Partners (CHP), a clinically integrated physician network in Texas. CHP has signed payer contracts that reward the group under a shared-savings model, giving physicians a vested interest in quality and cost management. After several years spent reviewing blinded performance data, the physicians themselves approached network leaders to unblind the information, arguing that they needed greater visibility across the network to find new performance opportunities.

CHP surveyed the entire physician group and found that 70 percent supported greater data transparency. As a result, the network recently unblinded data within specialty divisions, with plans to unblind data across the entire network in the near future.

Loss of Anonymity Often an Anti-Climactic Event

Positioning Unblinded Data Sharing as a Longer-Term Goal

Guidance on Unblinding Data
- Begin with less competitive specialties
- Select less controversial metrics, such as operational indicators (on-time starts) or documentation metrics (incomplete records)
- Avoid sensitive peer review data (e.g., complications, infections)

Generating Surprising Physician Support for Full Transparency

Case in Brief: Covenant Health Partners
- 300+ physician clinically integrated network affiliated with Covenant Health System located in Lubbock, Texas
- Physicians pushed for greater data transparency to spur competition, change referral patterns
- Backed by physician support, recently shifted from blinded to unblinded data among peers in same specialty
- Currently considering sharing data across specialties

Survey of Physicians in Covenant Health Partners’ Clinical Integration Program

Opposed 30% Supportive 70%
Beyond communication and competition, financial incentives provide the medical group’s final lever to motivate employed physicians. As noted earlier, however, high-performance groups turn to compensation change sparingly, in contrast to many hospital employers who view compensation as a primary means of motivating physician behavior.

Compensation is not something that medical groups ignore—indeed, most strive to ensure that their physicians maintain market-competitive rates of pay. But successful groups use compensation as a lever for behavioral change only in three select circumstances.

First, groups turn to compensation when other levers, such as communication, have failed. In that case, compensation incentives are seen as the last resort to win physician engagement for change. Second, groups occasionally deploy financial incentives to signal the importance attached to a particular initiative, shifting compensation as a way to “put their money where their mouth is.” Finally, high-performance groups alter compensation if the existing model is itself a barrier to change and if reworking financial incentives to eliminate legitimate obstacles is critical for goal achievement.

### High-Performance Groups Use Monetary Incentives Sparingly, Strategically

#### Reasons for Turning to Compensation as a Performance Lever

1. **Replacing Other, Failed Mechanisms**
   
   “We tried to get physicians to use proper documentation by setting explicit expectations. It didn’t work. We will now also use an incentive or a withhold.”
   
   **CEO**  
   Physician-owned health system

2. **Communicating an Initiative’s Importance**
   
   “Our culture enables us to drive change. But in some instances, we think it’s important to show physicians that we’re putting our money where our mouth is.”
   
   **Vice President**  
   Large employed medical group

3. **Removing Legitimate Barriers to Change**
   
   “As primary care demand grows and reimbursement rates decline, our PCPs won’t be able to make ends meet if we continue to pay them on productivity.”
   
   **Medical Director**  
   Large independent physician group

Source: Health Care Advisory Board interviews and analysis.
No Single Compensation Model Dominates in High-Performance Medical Groups

Unlike many of the other medical group attributes profiled in this publication, there is no “model” compensation plan used by high-performance medical groups. As shown by the examples on this page, compensation structures vary considerably between successful employed networks.

Instead, what groups have in common is not the specific method in which they pay physicians, but the fact that compensation models are carefully designed to reflect and further the group’s larger strategic goals. Only if these objectives change do most groups consider altering their compensation model or deploying new financial incentives.

A Range of Incentive Structures in Use

- **At Risk for Productivity**
  - **Edith Smith Medical Group**: Compensation tied to productivity measured in RVUs with small quality bonus

- **At Risk for Population Health**
  - **Dean Clinic**: More than 50 percent of primary care physician income at risk for quality, service, and panel size

- **A Blended Approach**
  - **Falstaff Clinic**: Physicians paid on RVU basis, but responsible for any overhead not deemed to improve quality; ancillary income is divided equally

- **Revenue Minus Expenses**
  - **St. John’s Clinic**: All physicians paid on net income model, with some incentive based on performance

- **Rejecting Uniformity**
  - **Beacon Medical Group**: Each of 26 specialty departments designs its own compensation model, which must include quality and patient satisfaction incentives

- **Salary with Bonus**
  - **Kelsey-Seybold Clinic**: Tiered salary model with productivity bonus based on both RVUs and patient visits

Source: Health Care Advisory Board interviews and analysis.
Productivity-Based Models Increasingly Seen as Barrier to New Strategic Aims

Mastering Yesterday’s Goals, But Preventing Success on Emerging Objectives

Building on Private Practice Incentives

- Typical compensation plan designed to maximize visit-based productivity and/or minimize practice expenses
- Common models include revenue minus expenses, percentage of collections, pay based on wRVUs or other productivity measure
- Through focus on individual visits or financial outcomes, pay structure primarily promotes physician autonomy, productivity

Undermining Other Priorities

- IT Adoption
  - New technologies temporarily slow physicians down, breeding resistance
- Quality Improvement
  - Focus on productivity leaves little time for other improvement initiatives
- Primary Care Redesign
  - New models call for longer visits, greater care team leverage
- Utilization Reduction
  - Lower specialist visit volumes may challenge productivity expectations

For many high-performance groups, a fairly significant shift in strategic objectives is occurring today, as value-based purchasing and other payment reforms take root. In reaction to these changes, many medical groups are evolving their strategic objectives to incorporate broader aims around quality, cost, and coordination. Traditional compensation models designed solely to optimize individual practice financial performance are increasingly viewed as barriers to meeting these new objectives.

Even a relatively basic priority such as EMR adoption becomes difficult if the resulting slowdown in productivity negatively impacts physician income. Further, as groups prepare to assume increased payment risk, they find that existing compensation incentives are at direct odds with the type of transformed care that physicians will be asked to provide.

Source: Health Care Advisory Board interviews and analysis.
As market imperatives evolve, many high-performance medical groups are focused on designing compensation models compatible with new objectives for the delivery of high-quality, low-cost, coordinated care. The focus here is on revising discrete aspects of the existing compensation model that serve as explicit barriers to meeting the organization’s changing goals.

At the same time, groups also work to ensure that compensation redesign is not overly disruptive to physicians, many of whom may be wary about the impact of change on their personal income or practice style. To do so, groups couple compensation change with strategies designed to mitigate physician concerns.

These final two attributes of the high-performance medical group are explored further across the following pages.
Failure of Existing Model Spurs Shift to Something New

Compensation model change often occurs in reaction to past challenges or failures of incentive design. After salary-based compensation models led to heavy losses in the 1990s, many employers responded by implementing incentive plans focused on individual productivity or income performance. These models proved effective for several years to meet the imperatives of a purely fee-for-service market, but are increasingly seen as preventing the achievement of broader group goals.

As a result, many high-performance medical groups today are scaling back the proportion of physician compensation at risk for productivity alone. While productivity is and will remain an important component of compensation design, groups are supplementing it with incentives for quality improvement, care coordination, and clinical transformation. This shift away from pure production is most significant for primary care physicians, who play a large role in care management, although compensation redesign impacts specialists as well.
Legacy Compensation Models Inadvertently Preventing Care Redesign

For PCPs, compensation models based on pure productivity are often in direct conflict with emerging imperatives for enhanced coordination and team-based care.

Tracy Health System (a pseudonym) is an 11-hospital system in the South with 600 employed physicians, many of them PCPs. Tracy’s original primary care compensation model was a fairly simple calculation of multiplying work Relative Value Units (wRVUs) by a conversion rate linked directly to practice cost control—dollars per wRVU. As a result, when system leaders suggested that PCP practices add new care team staff as part of a transition to the medical home model, physicians quickly realized the negative financial consequences for compensation and balked at the change.

When Tracy realized its legacy primary care compensation model was impeding the system’s strategic objective to develop medical homes, it overhauled the model to incentivize PCPs against new goals. The details of the new model are outlined on the following page.

Incentive Structure Linked to Cost Control Discourages Investment in Practice

PCP Compensation Formula

<table>
<thead>
<tr>
<th>Work Relative Value Units: _______</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conversion Rate $:</strong> _______</td>
<td></td>
</tr>
<tr>
<td><strong>Total Compensation:</strong> _______</td>
<td></td>
</tr>
</tbody>
</table>

Conversion Rate Calculation

Zeroed in on Practice Cost Control

Cost control-linked conversion rate hinders transformation to medical home

Practice Costs

Case in Brief: Tracy Health System¹

• 11-hospital system located in the South
• Initial compensation model focused on increasing wRVU productivity, controlling costs
• Increased costs of medical home implementation drove down physician compensation
• No commercial payer reimbursement for additional costs of medical home activity, certification
• New model focuses on panel size, mid-level staff efficiency, and PCP performance metrics

Source: Health Care Advisory Board interviews and analysis.
In Tracy’s new compensation model, productivity remains a core component, accounting for roughly 70 percent of total income. However, Tracy has redefined productivity to include both traditional measures of production and overall patient panel size per physician, recognizing the need to expand the base of managed lives within the medical home. Initially, active panel size accounted for 10 percent of base salary. As PCPs gained familiarity with medical home practice, Tracy increased the proportion of compensation at risk for panel size. PCPs are now incented on production and panel size equally.

The rest of the new compensation model also supports Tracy’s medical home objectives. Approximately 15 percent of physician income is tied to the profitability of mid-level providers in order to encourage team-based care and enable panel expansion. The final 15 percent is tied to success against PCP scorecard metrics, which provides Tracy with flexibility to incentivize additional objectives in the future without needing to fundamentally rewrite the compensation model each time.

### Tracy Health System Revised PCP Compensation Model

<table>
<thead>
<tr>
<th>Base Salary Composition</th>
<th>Mid-Level Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010: 90% Active Panel Size, 10% Productivity</td>
<td>2010: 70% Productivity, 15% Mid-Level Performance, 15% PCP Scorecard</td>
</tr>
<tr>
<td>2011+: 50% Active Panel Size, 50% Productivity</td>
<td>2011+: 50% Active Panel Size, 50% Productivity, 25% Mid-Level Performance, 25% PCP Scorecard</td>
</tr>
</tbody>
</table>

**PCP Scorecard Metrics**
- Access Target: 15%
- Patient Satisfaction: 5%
- Budget Target: 10%
- New Patients: 10%
- Expense per RVU: 10%
- RVU Production: 10%
- Diabetes Management: 15%
- Hypertension: 15%
- Medical Home: 10%

Source: Health Care Advisory Board interviews and analysis.
Motivating Proceduralists to Coordinate Care

Productivity-based compensation creates less of a conflict for specialists, whose practices are not as affected by emerging care models. However, many high-performance medical groups recognize that specialists will play an important role in cross-continuum care management and are designing incentives to encourage them to meet those goals.

Pseudonymed Johnstown Physician Group is part of a four-hospital system that is actively seeking payer contracts with greater risk for population outcomes. In preparation, the medical group is working with physicians to design compensation incentives focused on clinical quality and care coordination. Specialists are integrally involved in this process. For example, one new compensation metric will evaluate how well Johnstown’s cardiac surgeons manage patients on anti-coagulation medication, who are at high risk for bleeding complications during surgery. Initially, proceduralists will be rewarded for participating in the design of an anti-coagulation medication management protocol. Ultimately, a portion of compensation will be at risk based on how effectively proceduralists comply with this protocol and communicate back to referring physicians, with an eye toward avoiding preventable readmissions or other complications.

Incentives Target Communication with PCPs, Avoidable Complications

Incenting Cardiac Surgeons on Anti-Coagulation Medication Management

### Understanding the Clinical Challenge

- Patients on anti-coagulation therapy require management during surgery to avoid bleeding complications, readmissions
- Clear communication between referring physicians, proceduralists key to effective medication-bridging strategy

### Designing a Two-Part Incentive

#### Year One

- Expected to meet with PCPs, cardiologists to develop surgical anti-coagulation management protocol
- Upside-only incentive; no penalty for non-compliance

#### Year Two

- Expected to provide clear discharge summaries to referring physician detailing anti-coagulation management plan
- Both upside and downside risk for compliance

### Case in Brief: Johnstown Physician Group

1) Pseudonym.

- 260-physician medical group associated with four-hospital system located in the East
- System aims to reduce utilization, improve care management in anticipation of risk contracts
- Physician compensation incentives designed to promote collaboration and standards development in the first year, standards-based practice and quality outcomes in subsequent years

Source: Health Care Advisory Board interviews and analysis.
Identify Appropriate Incentives to Support New Physician Roles

Identify Appropriate Incentives to Support New Physician Roles

Evolving Physician Incentives Under Payment Reform

<table>
<thead>
<tr>
<th>Evolution of Compensation Model Under Payment Risk</th>
<th>Primary Care Physicians</th>
<th>Proceduralists</th>
<th>Hospital-Based Specialists¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increasing focus on patient panel expansion</td>
<td>• Incented on team productivity, office efficiency, use of extenders</td>
<td>• Increasingly paid with multi-tier models based on both productivity, strategic alignment with hospital goals</td>
<td>• Compensation becomes divided into flat salary and bonus</td>
</tr>
<tr>
<td>• Increasingly paid with multi-tier models based on both productivity, strategic alignment with hospital goals</td>
<td>• Zeroing in on profitability per case to improve hospital’s overall margin</td>
<td>• Bonus tied to quality, maintenance of productivity levels, non-clinical duties</td>
<td></td>
</tr>
</tbody>
</table>

Potential Performance Metrics

<table>
<thead>
<tr>
<th>Primary Care Physicians</th>
<th>Proceduralists</th>
<th>Hospital-Based Specialists¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chronic disease management</td>
<td>• Quality outcomes</td>
<td>• Inpatient quality outcomes</td>
</tr>
<tr>
<td>• Panel size</td>
<td>• Team-based care</td>
<td>• Inpatient efficiency</td>
</tr>
<tr>
<td>• Medical home development</td>
<td>• Referral communication</td>
<td>• Hospital-based quality improvement leadership</td>
</tr>
<tr>
<td>• Performance of care team</td>
<td>• Consult availability</td>
<td>• Administrative and academic activities</td>
</tr>
<tr>
<td></td>
<td>• Time to appointment</td>
<td>• Readmissions decline</td>
</tr>
<tr>
<td></td>
<td>• Efficiency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discharge planning</td>
<td></td>
</tr>
</tbody>
</table>

Inpatient quality outcomes
Inpatient efficiency
Hospital-based quality improvement leadership
Administrative and academic activities
Readmissions decline

Additional Compensation Resources from the Health Care Advisory Board

<table>
<thead>
<tr>
<th>Compensation Assessment Tool</th>
<th>Next-Generation Physician Compensation</th>
<th>Strategy-Aligned Physician Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnostic questions to gauge effectiveness of existing compensation model, readiness for change</td>
<td>• On-demand webconference examining emerging issues in physician compensation design</td>
<td>• Book-length study dedicated to physician compensation design</td>
</tr>
<tr>
<td>• Available in the Appendix</td>
<td>• Available at <a href="http://www.advisory.com/HCAB">www.advisory.com/HCAB</a></td>
<td>• Published in 2009, available at <a href="http://www.advisory.com/HCAB">www.advisory.com/HCAB</a></td>
</tr>
</tbody>
</table>

¹ Includes radiologists, hospitalists, anesthesiologists, pathologists, and emergency medicine physicians.

Source: Health Care Advisory Board interviews and analysis.
Mitigating Physician Concerns About Compensation Change

Compensation change, while necessary to meet evolving imperatives, can nevertheless be frightening to physicians. Even if physicians understand the larger rationale for payment redesign, they still may feel understandably concerned about whether the new model protects physician interests and what the impact will be on their own income and practice habits.

High-performance medical groups design strategies to address these concerns proactively, as detailed across the following pages.

Payment Model Redesign Raises a Host of (Justifiable) Fears

Who is Making This Decision and Why?
Uncertain that pay redesign adequately reflects physician needs and practice habits

How Quickly Will I Have to Make this Change?
Concerned that rapid shift in practice expectations will strain capabilities and resources

What Will Happen to My Income?
Unclear how new incentives will translate into specific dollar figures, compare to current income

Source: Health Care Advisory Board interviews and analysis.
Empowering Physicians to Revamp Compensation Incentives

In order to ease concerns about whether the new compensation model will adequately reflect the realities of physician practice, successful medical groups ensure that all compensation decisions are physician-driven. Many groups create a physician-run committee to oversee compensation issues and to provide a forum for individual providers to air concerns.

Phoebe Putney Health System reformed employed physician compensation in 2009 as part of a larger overhaul of its 170-physician medical group. Recognizing that physician leadership of the process was essential for achieving buy-in, the system created a cross-specialty physician finance committee that developed a plan for shifting the compensation model from flat salary to RVU-based productivity. The committee worked to persuade rank-and-file physicians that the change was favorable to physician interests, ensuring a smooth transition to the new model. Today, the finance committee is working with the medical group’s quality committee—which is also physician-run—to build new quality incentives into the compensation model.

Physician Leadership Eases Concerns About Intentions

Physician Finance Committee

- Composed of physicians across specialties
- Develops compensation model and proposes to medical group board for approval
- Advocates for compensation model with rank-and-file physicians

Yesterday: Eliminating Salary

- In 2009, proposed shift from salary to productivity compensation model
- Addressed physician concerns about transition

Today: Introducing Quality Metrics

- With physician quality committee, discerning which quality metrics to incorporate into compensation

Letting Physicians Lead the Way

“You have to swallow hard and trust the physicians. It took work for us to trust the finance committee to develop the compensation model and answer directly to the board.”

Bob LeGesse
VP, Physician Division
Phoebe Putney Health System

Case in Brief: Phoebe Putney Health System

- Five-hospital system employing a 170-physician medical group, located in Albany, Georgia
- In 2009, with help of physician champion, undertook reform of group structure and compensation; to win physician support, placed physicians on governing board and created physician committees
- Oversight of compensation model by physician finance committee, as well as physician champion, crucial for mitigating physician discomfort with shift to RVU-based compensation in 2009, addition of quality metrics in 2011

1) The physician finance committee proposes only the compensation model and has no power to suggest the actual amount physicians should receive in compensation.

Source: Health Care Advisory Board interviews and analysis.
Gradually Transitioning to New Payment Model

High-performance medical groups also roll out compensation change gradually, rather than implementing a major change in payment structure overnight. They take slow steps to increase both the amount of compensation at risk for new incentives and the complexity of metrics chosen, allowing physicians to adapt to the change over time.

Dean Clinic in Wisconsin is rapidly redesigning care delivery in anticipation of increased payment risk and evolving its compensation model in tandem with this change. Dean’s ultimate goal is to implement a compensation model based almost entirely on salary, with additional incentives for indicators such as panel size and quality, with only a fraction at risk for productivity. However, Dean also recognizes that this new model will represent a major change from its traditional compensation structure, which was based almost entirely on productivity.

As a result, Dean is transitioning to the new model gradually. It began several years ago simply by measuring—not compensating on—basic quality indicators. A few years later, the clinic began attaching incentives to those metrics, but only placed a small amount of total compensation at risk. Across the next few years, it expects to slowly increase the number of metrics and amount of money at risk, moving gradually to allow physicians the time needed to successfully adjust practice patterns.

Starting with Quality Measurement, Then Slowly Linking to Pay

Incremental Transformation of Physician Compensation Model

Breakdown of Compensation by Component

2007 2009 2010 2011 2012 2013

- Strategic Initiatives
- Flat Salary
- Production

Began measuring non-productivity indicators in 2007, attaching incentives in 2010 once physicians grew comfortable with measures

Case in Brief: Dean Clinic

- Integrated system composed of 500 physicians and a 300,000-member health plan located in Madison, Wisconsin
- Redesigning care model to succeed against value-based contracts
- Gradually transitioning physicians from productivity-based compensation to payment tied to panel size, quality

A third tactic used to mitigate physician concerns about compensation change is shadow compensation, which provides physicians with visibility into how their current performance will reflect under a new payment model. In this strategy, medical group leaders meet with each individual physician before a new compensation model is implemented, comparing the physician’s individual pay under the existing and new models. This conversation is based on the physician’s existing performance, with the intention of communicating either that the physician will likely benefit from the compensation redesign or that the physician needs to improve performance against new goals in order to protect current earning levels.

Shadowing continues for three to six months, allowing physicians to compare their performance under current and proposed models side by side, evaluate the impact of practice changes, and provide feedback to leadership. Beyond reassuring physicians, shadow compensation also has the ancillary benefit of engaging physicians in performance change before a new compensation model even takes effect.

Modeling the Impact of Compensation Redesign on Individual Income

Shadow Compensation Gives Physicians Time to Prepare for Change

Tactic in Brief: Shadow Compensation
- Group leaders devise alternative physician compensation model
- Comparison of current earnings with projected earnings under new model shared with each physician for three to six months prior to new model launch
- Physicians reassured regarding future income or warned to improve performance in order to maintain current earnings under the new model
- Physicians given individual and system-level cost and quality data to facilitate performance improvement

Physicians informed of compensation change
Physicians given monthly shadow compensation reports to compare existing, new models
New compensation model launched

Source: Health Care Advisory Board interviews and analysis.
Finally, high-performance medical groups provide resources to give physicians ongoing transparency into compensation, even long after a change has been implemented. This strategy—consistent with medical groups’ broader embrace of transparency as a core cultural hallmark of effective team-based care—helps to ensure that compensation does not become a source of physician dissatisfaction and keeps physicians focused on the larger strategic goals that compensation is designed to advance.

Kelsey-Seybold Clinic in Texas, for example, employs a full-time, dedicated compensation consultant. The consultant works to keep the medical group’s 370 physicians updated on progress toward productivity and quality goals and serves as a resource to answer physician questions about compensation structure. The consultant also plays a role during hiring and onboarding, meeting with both candidates and new physicians to explain how the clinic’s compensation approach—a salary-based model that, while productivity-linked, is designed to encourage team-based care—supports Kelsey-Seybold’s collegial culture.

Many organizations unable to support a full-time compensation consultant have integrated these duties into the roles of other administrative and support staff within the group.

### Offering Ongoing Transparency into Payment Structure

**Compensation Consultant Supports New and Tenured Physicians Alike**

**Educates Newly Hired Physicians**
- Explains compensation model to new hires
- Stresses importance of quality in organizational culture during interview
- Clarifies that poor quality rather than low productivity can lead to termination

**Ensures Ongoing Transparency and Trust**
- Monitors productivity data
- Regularly reports data to physicians, enabling easy calculation of bonus
- Provides data on demand to resolve concerns or monitor improvement

**Case in Brief: Kelsey-Seybold Clinic**
- 370-provider physician group located in Houston, Texas
- Physicians paid one of four salary tiers tied to productivity percentile, with productivity-based bonus
- Staff member dedicated to managing compensation ensures transparency, clarifies how compensation supports the organization’s culture of high productivity and high quality

For a full job description of the Physician Compensation Consultant, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Source: Health Care Advisory Board interviews and analysis.
Individual Behavior Aligned with Strategy

The box on this page provides a brief overview summary of the four attributes used by high-performance medical groups to design individual incentives that engage physicians against group goals. These elements involved in leveraging transparency and designing strategy-aligned compensation represent the third and final level of core tenets for the high-performance medical group.

Takeaway Summary for Health System Leaders

Attribute #12: Effective Bidirectional Communication Processes
Build multimodal communication systems to keep frontline physicians consistently updated on all group activities and strategic decisions; create regular opportunities for physicians to provide feedback up the chain of command.

Attribute #13: Dissemination of Unblinded Physician Performance Data
Design physician scorecards that provide a comprehensive and holistic picture of individual performance; share unblinded data to maximize the performance-enhancing effect of peer pressure.

Attribute #14: Compensation Narrowly Tailored to Advance Group Objectives
Deploy financial incentives sparingly and only as needed to advance group strategy; redesign productivity-only compensation models to eliminate barriers to delivery of high-quality, low-cost, coordinated care.

Attribute #15: Staged Adoption of New Compensation Plans
Mitigate physician concerns about compensation change by engaging physician leaders in redesign, transitioning gradually to new incentive models and providing ongoing transparency into the impact of payment structure on individual physician income.

Source: Health Care Advisory Board interviews and analysis.
Individual Behavior Aligned with Strategy

The box on this page contains key questions for health system leaders to discuss as they consider their own progress toward individually motivating employed practices against organizational objectives.

Key Questions for Health System Leaders

- Do our physicians feel well-informed around group strategy and the impact of group decisions on their practice? How do we build communication vehicles to engage the “silent majority” who do not readily seek information or provide feedback?

- Do we regularly share individual performance data with our physicians? Can our physicians benchmark their performance relative to peers? How do we build peer-driven processes to remediate underperformance?

- How do we foster a culture of complete transparency around individual performance? What are the barriers to unblinded performance data sharing across the group, and how can we migrate physicians toward acceptance?

- Have we reviewed physician compensation models to ensure they support our current strategic objectives? What barriers exist that could prevent physicians from fully partnering with us to advance care delivery? How do we evolve our compensation models to realign incentives with group and system strategy?

- How do we mitigate physician concerns about compensation change? How do we proactively provide transparency into the impact of model change on physician incomes and work with them to identify needed changes to ensure mutual success?
Appendix

- Compensation Diagnostic Questionnaire
- Compensation Discussion Guide
Compensation Diagnostic Questionnaire

Below are questions for senior executives and physician leaders to ask about physician compensation—a self-assessment of whether the model is appropriate in light of system goals. Each question targets a key consideration in designing compensation. A “no” response to any question suggests an area meriting further attention.

1. Does our compensation model effectively support our employment strategy, i.e., does its design advance our primary overall goals for employing physicians?

2. Do physicians play a leadership role in spearheading compensation model design and selecting appropriate pay incentives?

3. Do we use compensation incentives sparingly and only as needed to affect physician behavior, i.e. when other means of motivation have failed, to communicate an initiative’s importance, or to remove barriers to goal achievement?

4. Is our compensation model flexible enough to incorporate new or different incentives as our strategy or market dynamics change? Are we prepared to redesign compensation plans to eliminate barriers that arise as system goals evolve?

5. Have we identified both the short- and long-term keys to program advancement in each specialty or department, and do our compensation model incentives for physician leaders reflect both those goal types?

6. Do our goals for physicians differ across specialties to reflect specific strategic objectives?

7. Do we regularly raise performance thresholds for physicians as they make progress against the goals we prioritize?

8. Do our existing information systems enable us to easily collect adequate data to monitor all performance metrics linked to compensation?

9. Is our compensation model reflective of and supported by external reimbursement structures (e.g., positions physicians to capture performance-based pay)? If we are shifting compensation to reward activities not supported by current payment models, are we prepared for the increased subsidies that practices may require as a result?

10. Is physicians’ take-home pay competitive with the income they could earn through other practice opportunities in our local market?

11. In cases where we have compromised practice-level financials in pursuit of higher-priority organizational goals, have physicians been protected against any personal downside resulting from those choices?

12. Do we have strategies in place to manage physician concerns about the impact of any compensation model change on their practice patterns or take-home pay?

13. Are adequate compensation incentives in place for physicians engaged in leadership at the practice, medical group, and system levels?

14. Have we audited the amount and type of time employed physicians spend on administrative and leadership duties to ensure adequate administrative compensation?

YES  NO

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Compensation Discussion Guide

Complementing the Compensation Diagnostic Questionnaire, below is a list of open-ended questions intended to aid hospitals and health systems as they consider a redesign of their physician compensation model. Senior executives and physician leaders should use this guide to engage in a discussion about barriers to collaboration in the current incentive structure, short- and long-term goals, and opportunities to enhance the employment relationship.

1. What are our strategic goals for our employed physicians?

2. Specifically, how important are the following issues that might be influenced by the incentives in our compensation model?

   a) Maximizing employed physician productivity and revenue?
   b) Minimizing physician practice costs?
   c) Ensuring access to care for all patients, including the underserved?
   d) Capturing enhanced ambulatory and inpatient market share1?
   e) Increasing the percentage of patients receiving recommended and evidence-based care?
   f) Improving clinical quality and care efficiency outcomes?
   g) Standardizing clinical operations and business processes across sites?
   h) Improving proactive management of chronic illness?
   i) Implementing team-based care within the practice?
   j) Adoption of new clinical care models (e.g., medical home)
   k) Fostering cross-continuum coordination of patient care?
   l) Ensuring provision of care in most appropriate clinical setting1?
   m) Engaging physicians in leadership roles?
   n) Enhancing patient satisfaction, professionalism, or other citizenship measures?

3. What explicit or implicit incentives in our existing compensation model(s) for employed physicians prevent us from reaching the goals outlined in question 2?

4. How will we involve our physicians in selecting appropriate compensation design?

5. What proportion of total physician pay should we allocate to productivity vs. incentives for other strategic goals (e.g., quality improvement, patient satisfaction, leadership service)?

6. When compensating physicians for production, how will we balance rewards for individual vs. group or team productivity?

7. How will use of incentive structures vary between primary care physicians and specialists?

8. What specific metrics will we use to gauge performance against each incentive? Do our existing information systems enable us to easily collect data to monitor these metrics?

9. Are our physician incentives supported by our external reimbursement environment? For those that are not, are we prepared to fund the incentives ourselves through increased subsidies?

10. If we choose to redesign our existing compensation model, how will we manage physician concerns about the impact this change will have to their practice patterns or take-home pay?

11. How will we ensure that our compensation model remains flexible to incorporate new or different incentives as our strategy or market dynamics change?

1) Hospitals should consult legal counsel to ensure relevant financial incentives do not violate fraud and abuse requirements.

Source: Health Care Advisory Board interviews and analysis.