OUR TAKE

How Covid-19 Will Impact Medical Groups

Realizing the promise of large-scale group practice

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The medical group's "we before me" moment

During Covid-19, physicians rapidly innovated on pre-Covid norms. In many cases, this meant uniting around medical group goals that previously received tepid support.

As we head into the next phase of Covid-19, medical group leaders will need to continue to unify the goals of their groups. To do so, leaders must define new norms for telehealth, align compensation to group performance, reward flexibility, and standardize APP deployment.

Advisory Board

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The pre-Covid-19 reality

The primary disruptive force reshaping the medical group landscape leading up to Covid-19 was physician aggregation. According to 2018 American Medical Association benchmarks, there were more employed physicians than independent practice owners for the first time. Additionally, the number of solo practices continued to fall, and the lion's share of medical school graduates favored employment.

But unlocking the value of larger medical groups proved tricky, no matter the aggregator. While private equity firms, health plans, large physician groups, and health systems all tried, no one really achieved outsized improvement to quality, cost, patient experience, or physician engagement through a large-scale medical group.

Universally, groups faced the same challenge: threading the needle between individual physician autonomy and group goals.

To win talent, some groups promised more autonomy and hamstrung their care transformation ambition. Others set expectations around shared goals, but the looming threat of physician burnout plus compensation tied to individual productivity created barriers to change.

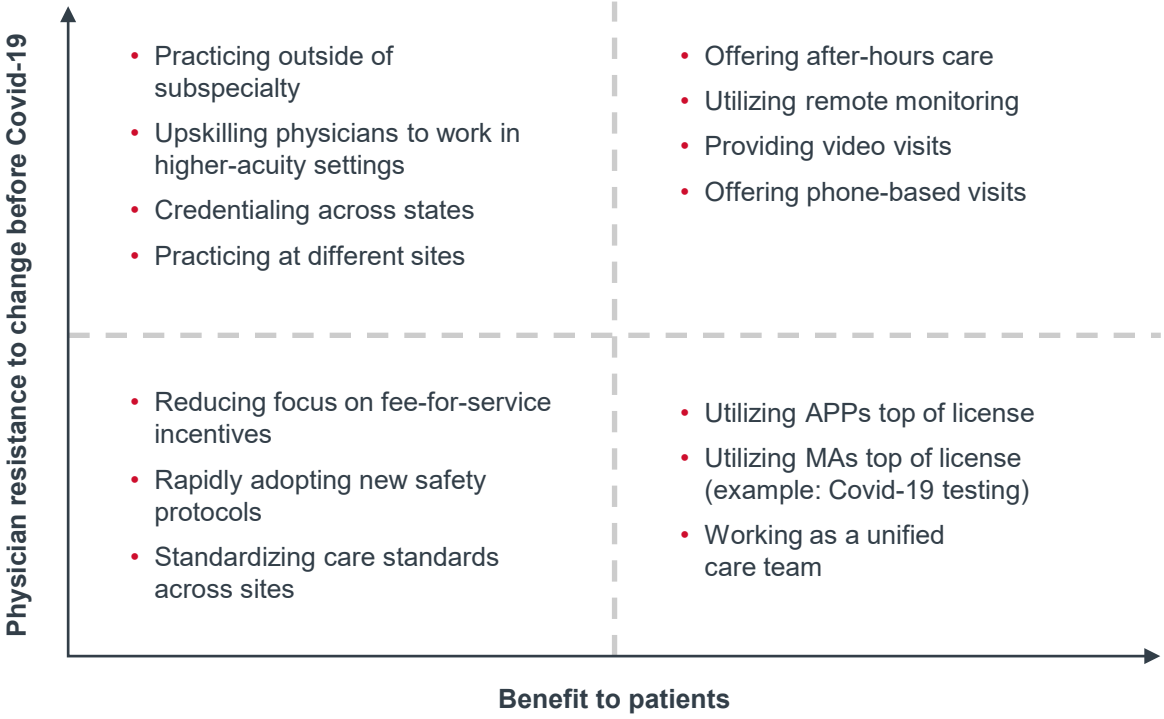
Source: Physician Practice Benchmark Survey, American Medical Association, April 30, 2019. https://www.ama-assn.org/about/research/physician-practice-benchmark-survey#:~:text=2018%20Benchmark%20Survey&text=53.8%25%20of%20physicians%20reported%20participation,up%20from%2025.7%25%20in%202016.

Our take

Not surprisingly, Covid-19 will accelerate physician consolidation. New groups may be willing to partner, and aggregators will be even pickier about talent. Still, we will largely see the existing affiliation strategy at a faster pace, not a wholly new direction in aggregation.

The most important opportunity for physician leaders is harnessing the tremendous innovation from physicians and care teams during Covid-19. The gravity of the crisis, combined with stay-at-home orders and reimbursement changes, brought physicians into alignment with medical group goals. They transformed care delivery in a matter of weeks.

Clinician-led changes amid Covid-19, by impact and resistance



OUR TAKE

With patient volumes slowly returning, the risk of backsliding to old practice patterns is high. Individual autonomy and productivity may re-fracture groups into loose affiliations instead of continuing alignment to shared goals.

Driving new momentum toward cohesive medical groups requires four actions:

Define episodes of care that blend in-person and virtual visits. Telehealth is here to stay, but groups will naturally recede from the record highs when there were limits on in-person care. Securing volumes and patient loyalty in this new market for care requires a consistent and easy telehealth approach. Marshall physicians to set the group standard: what is in person, what is always virtual, and what fluctuates based on market conditions and patient preferences.

Pay physicians for group performance over individual productivity. Covid-19 shattered the illusion of control that productivity-based models previously offered individual physicians. This is a rare moment where leaders shouldn't need to spend large amounts of political capital to rally physicians to redesign compensation. Design compensation for the realities of care in group practice—volumes based on a team approach, telehealth, and succeeding at group priorities such as access, total cost of care, and patient experience.

Set expectations for group flexibility. Large medical groups responded to Covid-19 by flexing talent and leveraging their larger footprint to offer patients more options for care. For example, groups designated Covid-19 and non-Covid-19 sites to the advantage of both patients and staff. That flexibility was always possible but hard to realize. While future Covid-19 surges may be a helpful starting place, set a new baseline for when physicians are expected to flex.

Deploy advanced practice providers (APPs) autonomously. Covid-19 demonstrated the utility of APPs and should spur groups to continue to invest in this high-value care team member. Standardize autonomous deployment across the physician enterprise.

Four actions

Physician executives should take four actions to maintain momentum for a cohesive, large-scale medical group:

01

ACTION 1

Define episodes of care that blend in-person and virtual visits

02

ACTION 2

Pay physicians for group performance over individual productivity

03

ACTION 3

Set expectations for group flexibility

04

ACTION 4

Deploy APPs autonomously

01 Define episodes of care that blend in-person and virtual visits

Covid-19 pushed telehealth from one extreme to the other. Pre-Covid, Advisory Board estimates are 1 in 1,000 visits were virtual. But in the height of the crisis, physicians and care teams innovated to provide as much virtual care as possible.

Telehealth visits will naturally recede from this record high but shouldn't drop back to pre-Covid-19 levels. Virtual care will be necessary for navigating a potential second wave alongside flu season. And telehealth is now a baseline expectation of patients, employers, and payers.

Medical group leaders need to navigate toward the right mix of in-person and virtual care. Groups need to define, for each episode of care, what should be in person, what should be virtual, and what should fluctuate based on patient preference and market conditions.

While it's tempting to wait for greater clarity about the reimbursement and regulatory environment, groups risk losing momentum from experimentation during the Covid-19 crisis. Traditional competitors and disruptive innovators also accelerated telehealth adoption and are looking to expand their patient base. To navigate during regulatory uncertainty, groups are already increasing the security of interactions to protect patient information. Groups are anticipating that reimbursement for telehealth will fall below rates for in-person visits (except in a few, rare cases) but likely not back to zero.

Source: "Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the Covid-19 Pandemic," Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, July 28, 2020; FAIRHealth Monthly Regional Telehealth Tracker; Advisory Board interviews and analysis.

1. DEFINE EPISODES OF CARE THAT BLEND IN-PERSON AND VIRTUAL VISITS

Treat the early days of Covid-19 as the pilot phase for high-volume virtual care. Identify what worked and what didn't to create new group-wide standards. This includes both the types of visits but also the telehealth workflow for physicians and the care team.

To win physician buy-in for new telehealth standards:

- Assemble a cross-functional team.
- Limit the time commitment by asking a team to tackle one standard/clinical area and then disband that team and form a new group for the next standard/clinical area.
- Leverage a central team for reviewing exceptions to the standards and making updates along the way.

While Covid-19 accelerated physician buy-in for telehealth, acceptance hasn't been universal. For some physicians, telehealth improved work-life balance. And for physicians with high-risk conditions or those living with people at high-risk, telehealth provided a way to keep practicing. Among the new telehealth champions, groups may designate "virtualists" to help lead telehealth integration with group strategic priorities.

02 Pay physicians for group performance over individual productivity

Altering physician compensation is one of the hardest changes for medical groups to make. Moving to a sizeable performance bonus took years and required significant political capital.

Productivity models seemed to balance medical group growth and maintaining autonomy for physicians around their compensation. However, productivity also created inherit tension between group performance and individual performance. Practice changes that were a drag on productivity created a financial disincentive to change.

As groups matured, the tension increased. Strategic priorities like team-based care, telehealth, and chronic care management often asked physicians to put group performance over individual performance.

Covid-19 upended volume assumptions and the control that productivity offered individual physicians. As groups navigate through this pandemic, there is new momentum to design compensation models that reward physician contribution to group success.

Source: Kane L, "Medscape Physician Compensation Report 2020", Medscape, May 14, 2020.

2. PAY PHYSICIANS FOR GROUP PERFORMANCE OVER INDIVIDUAL PRODUCTIVITY

Executives have an opportunity to move toward performance-based models—and do so with more physician buy-in. This transformation looks different for independent and hospital-employed physicians.

Both types of groups will be making changes in two key areas:

- Resetting metrics of success to account for strategic priorities around telehealth and group flexibility, in addition to previous metrics like patient experience and access
- Increasing the weight of group performance incentives and decreasing the weight of productivity

	Independent physicians	Hospital-employed physicians
Status quo	Compensation tied to individual productivity minus expenses	Majority of compensation tied to individual productivity with bonus tied to group priorities, such as patient access
Emerging models	Majority of compensation tied to individual productivity with bonus tied to group priorities, such as access	Compensation more equally weighted between individual productivity and contribution to group goals; some groups are evaluating a guaranteed floor based on performance threshold
Recommended Advisory Board resource	Transforming Independent Physician Compensation	Report from the Frontier of Physician Compensation

03 Set expectations for group flexibility

Utility players able to flex across site of care or type of care are a coveted resource during the Covid-19 crisis. An advantage of large-scale group practice should be an agile workforce that can quickly pivot to meet changing community needs.

In Covid-19 hot spots, clinician flexibility was critical. Utility players flexed outpatient to inpatient and across critical care areas to help their facilities survive the surge. Even in areas with smaller community spread, flexibility across sties and settings helped rapidly ramp up testing, telehealth, and emergency plans in case of a surge.

Rapidly reshuffling the workforce also exposed how siloed physicians have become. Silos that had to be undone during this crisis ranged from expanding who had privileges at system hospitals to creating workarounds for process and technology differences across sites of care in the same system.

Physician leaders should take steps now to reset the baseline on group flexibility. At a minimum, leaders should recognize clinicians who flexed and celebrate success around patient care and access to the care team. Minor challenges identified in flexing staff—such as privileging—can also be addressed to prevent operational hurdles in anticipation of new surges in Covid-19 cases.

Building on these small steps, leaders should push all clinicians to flex within their specialty, especially to accommodate new patients and acute visits.

3. SET EXPECTATIONS FOR GROUP FLEXIBILITY

Now is also the time to rethink legacy staffing models. Groups should strive for well-rounded care teams. For example, pair providers and nurses with complementary expertise, consider investing in e-consult models to give primary care physicians virtual access to specialist expertise, and leverage APPs.

Cementing these flexibilities as the new normal is a significant change to physician practice. Below, find a list of proven levers to help normalize new flexibilities across the medical group.

Levers to pull to support permanent flexibility

Clinician education:

- Rely on physician "champions" to share their experience
- Train clinicians on new platforms or protocols

Technology investment:

- Integrate technology across sites of care
- Invest in secure vendor solutions

Workflows and protocols:

- Standardize unit or clinic protocols
- Establish guidelines for visit types (such as in-person versus virtual visits)

Recruitment and onboarding:

- Assess new hires for willingness or ability to adopt new care models
- Provide scripting to set practice expectations during hiring conversations
- Revamp onboarding to normalize new flexibilities

Compensation:

- Consider incentives for practicing across sites

04 Deploy APPs autonomously

APPs can perform many of the same tasks as physicians at less than half the cost.[1] Due to their more generalist training, APPs can also more easily flex across specialties and fill in workforce gaps.

These attributes—combined with relaxation in supervision and scope-of-practice regulations—made APPs an indispensable resource in responding to the Covid-19 crisis. Even if some regulatory flexibility goes away, APPs have an equally pivotal role to play in recovery from the first wave, responding to any future surges, and helping address pent-up patient demand.

Long viewed as "physician extenders," APPs must be deployed autonomously for organizations to fully capitalize on their value. While they may co-manage a panel with a physician, APPs should see and treat patients independently, acting as a provider in their own right.

	Conventional wisdom: Physician-dependent APP roles	**Our take: Autonomous APP roles within care team**
		
Visit	Physician determines APP role in the visit	APP sees patient independently during the visit
Panel	Physician manages panel, off-loads patients and tasks to APP	Physician and APP co-manage the panel

1. According to Advisory Board's Integrated Medical Group Benchmark Generator, average APP compensation in internal medicine is $116,133 compared to $258,777 for physicians.

Source: "Occupational Outlook Handbook," U.S. Bureau of Labor Statistics.

4. DEPLOY APPs AUTONOMOUSLY

Accomplishing this requires medical group leaders to shift away from a pilot mentality, where APPs are deployed ad hoc across the group based on individual physician or clinic preference. Instead, groups deploying APPs autonomously centralize APP hiring, deployment, and oversight aligned to larger strategic priorities. Working with APPs in this way also requires elevating APP leadership roles to recognize the pivotal role APPs play in group performance.

Executives should also continue hiring APPs. Specifically, APP deployment in specialties and markets lagging behind in primary care before Covid-19. For more research and implementation support, download our toolkit Four Keys to Maximizing APP ROI.

Parting thoughts

Now is the time to drive momentum toward a more cohesive medical group. Below are our recommendations for your next steps to make progress against the four suggested actions for physician executives.

Define episodes of care that blend in-person and virtual visits

- ❑ What are the most popular episodes of care for your patient population?
- ❑ What physicians and care team members are already interested in helping set the telehealth standard?
- ❑ What changes to care team workflow would make it easier to consistently meet telehealth demand?

Pay physicians for group performance over individual productivity

- ❑ What group goals are the most important to include in physician compensation?
- ❑ Which physicians should be involved in redesigning compensation?
- ❑ How will compensation changes be rolled out across the group?

Set expectations for group flexibility

- ❑ What flexibilities does the group need for surges in Covid-19?
- ❑ Where are places **within** a given specialty that increased flexibility would help with patient access and growth?
- ❑ Where are places **across** specialties that would help with patient access and growth?

Deploy APPs autonomously

- ❑ Where are APPs already in roles that should be standardized across the group?
- ❑ How do training, recruiting, and performance management reinforce those roles?
- ❑ Where do we have gaps in our workforce that we should hire APPs into?

More takes on the post-Covid-19 world

For more takes on how Covid-19 is reshaping the future of the U.S. health care industry, please visit advisory.com/covid-19impact

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DEMAND

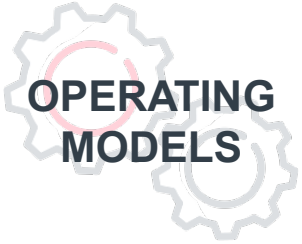
+ …the health status of the U.S.?
+ …telehealth?
+ …behavioral health?
+ …senior care?

PURCHASER LANDSCAPE

+ …payer enrollment mix?
+ …employers' health benefits strategies?
+ …the government's role in health care?
+ …the future of value-based care?

COMPETITION & INNOVATION

+ …disruptive market entrants?
+ …public perception of the industry?
+ …health system philanthropy?
+ …the health care innovation pipeline?



OPERATING MODELS

+ …"systemness" efforts?
+ …capacity expectations?
+ …the structure of the U.S. supply chain?
+ …the future of the clinical workforce?

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