

# Physician Performance & Payment Report

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### PHYSICIAN PROFILING

## EPISODES OF CARE: LOVELACE CONTINUES TO BENCHMARK AND REFINE

*As integrated systems around the U.S. struggle to create physician profiling initiatives and other clinical quality improvement programs that work and are accepted by physicians, their searches for good working models of such processes inevitably lead to a very small number of organizations nationwide. And even the few programs that are long-established and have made physicians integral participants in their initiatives face continual "growing pains" and market-imposed shifts of emphasis.*

*One of these model organizations, Lovelace Health System in Albuquerque, NM, continues to pioneer in its use of data to support physicians' clinical care management, acting as a beacon of innovation for providers around the country even as it works through its own market challenges and changes.*

Since 1995, when it created Lovelace Healthcare Innovations to spur progress in clinical pathways, disease management, and care coordination, the Lovelace system has developed a variety of programs in numerous clinical areas, focusing heavily on integration of efforts and on reporting regularly to physicians the outcomes of care for their patients with a variety of conditions. Presently, Lovelace's Episodes of Care program provides regular outcomes reports for diabetes, asthma, and preventive care outreach. Diabetes and asthma reports go out to Lovelace physicians

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### PHYSICIAN PRACTICE DIVESTITURE

## EASING THE TRANSITION BACK TO A MARKET-BASED MODEL

Craig E. Holm, CHC, CHE

*In the wake of widespread disaster, rethinking an industry-wide process is often a necessary, if uncomfortable, remedy. Such has been the case in the healthcare industry, following the tremendous expansion in physician practice acquisitions among hospitals and integrated health systems during the early and middle 1990s. What began as a logically grounded impulse among some hospital-based organizations faced with insecure physician referral patterns in a jittery industry became a morass of financial losses and disillusionment on all sides, as hospital-based organizations spent several years buying up individual physicians' practices (mostly primary care practices) at mostly-inflated prices, only to find themselves faced with lower practice productivity, management ills, physician resentment, and, ultimately, many hundreds of millions of dollars in red ink.*

The past year-and-a-half has seen a sudden shift in the opposite direction, as hospital-based and integrated health systems have attempted to shift their "owned" physicians very quickly back to a more market-based contracting system, with very mixed outcomes. In many cases, the panic engendered by massive financial losses nationwide across all types of health systems has led to rather crude attempts at "dumping" poorly performing doctors' practices, with predictable results. These attempts to "stem the tide" of losses have often backfired and

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## Easing the transition back to a market-based model

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led to a rapid souring of relationships with physicians in many markets. In other cases, initiatives aimed at “shifting back” have moved too slowly or become bogged down in political issues.

In my work as a strategic planning consultant with a number of health systems tackling this critical yet oftentimes-sensitive problem, it has become clear to me that there are better ways of accomplishing these difficult transitions than most health systems are aware of. But first, let’s step back for a moment and look at how we got ourselves into this predicament in the first place.

Set in its simplest terms, all the purchasing of physician practices by hospitals and health systems began as a way to secure relationships with physicians, especially primary care physicians, who are the main sources of inpatient care referrals. Of course, direct payment for physician referrals was and remains illegal, but establishment of tight physician-hospital ties will always be an area allowing for some maneuvering. And several years ago, direct purchase of PCP practices seemed like a good idea, particularly in light of managed care-driven changes in physician practice, and a surge in the development of physician practice management companies (PPMs) that came out of the same managed care evolutionary trends.

However, reductions in reimbursement, hospital-based organizations’ inability to manage physician practices, the collapse of the national PPMs, physicians’ own difficulties with practice management in the current operating environment, and numerous other factors have combined to make most arrangements based on direct practice purchases highly unprofitable.

As a result, the current is moving swiftly in the opposite direction. So, for example, in my own local market in the Philadelphia area, where there used to be several buyers for every physician practice, now there might be just one buyer; and where multiples of calculated value were paid for individual practices, buyers are offering just percentages of the previous value of the individual practice. At the same time, the physician glut in Philadelphia (as in many other urban markets), particularly a glut of PCPs, has altered the mathematics of the equation.

Not surprisingly, strategic calculations are changing because of these factors as well. I and my colleagues recently spent time working with a health system in New York state, advising the leaders of that system on a strategy for getting their physicians back to a market orientation. Our conclusion in that situation? We advised them that they would not be able to fix the ownership-based situations they had, and that it was time to cut their losses and sell the practices back to the physicians.

### Step by step, logically and strategically

And that’s the advice being given to a large number of hospital-based organizations and integrated health systems these days. But a strategy of divesting physician practices or rewriting contracts with physicians can be an extremely daunting one, and health system executives know that. Faced with numerous possibilities and a lot of risk, organizational as well as financial, many health system leaders are justifiably intimidated. Where to begin?

I believe that the first thing these leaders need to do once they’ve decided to divest their physician practices and move their physicians back to a market orientation is to identify what the problems are; and to do this, they need to do standard benchmarking, to help establish the priorities.

As part of this process, they need to ask a number of questions. For instance, what are the revenue or expense categories that are a problem? The problem could turn out to be productivity: It could be compensation is too high, or collections are too low, or the facility costs are too high, staffing is too high, or infrastructure is excessive. All of these could prove to be contributing factors.

The benchmarking process helps to sort out what the problems are; and its value in that regard is well-documented in the professional literature. In any case, the benchmarking process establishes priorities, and those priorities can then be used to help decide whether to fix and divest or sell to a third-party organization—though at this time the most likely buyer is the physician.

One of the key questions to ask in this process is, do you want to spend more time on selling or on fixing?

If you are going to try to fix the situation as part of a strategic decision to divest the practices you own by selling to the physicians (rather than selling to a third

party), it's absolutely critical to put maximum effort and thought into aligning productivity with compensation, an element that was lacking in most physician practice purchase arrangements in the first place. Much has been written on that subject, so I'll refrain from detailing suggestions here.

Beyond aligning productivity and compensation, there are many other issues that loom very high on the list of major elements to fix, if fixing is the strategic decision made by the leaders of a hospital-based organization or integrated health network.

**THE BENCHMARKING PROCESS HELPS SORT OUT WHAT THE PROBLEMS ARE. IT ESTABLISHES PRIORITIES WHICH CAN BE USED TO HELP DECIDE WHETHER TO FIX AND DIVEST BY SELLING TO THE PHYSICIANS, OR SELL TO A THIRD PARTY ORGANIZATION.**

One of these is the issue of reducing excessive overhead components. Most organizations that have purchased physician practices have generally allocated one FTE of additional staffing to handle the additional workload for such functions as centralized billing, management, marketing and promotions, and human resources; however, our experience has been that nothing ever goes away within the physician practice, so that the 3.5 to 4 FTEs of staff per physician remain within the individual practice, and the one FTE added in effect creates 4.5 to 5 FTEs per physician, which is almost always too much.

After alignment (or realignment) of productivity and pay and rightsizing of support staff, our experience has been that the third big issue in fixing unprofitable situations is to remedy the hospital's collections system, which is typically inferior to those of physician offices.

And why do hospitals do such a poor job of physician office collections? It's simply that hospitals are used to dealing with bills that run in the thousands of dollars, and physicians are used to dealing with bills sometimes in the tens of dollars; it's a matter of focus and scale.

Having been a hospital administrator, I don't feel hesitant about stating plainly that this has been the case.

Now, beyond strict compensation issues, what the physician is thinking about beyond salary is cash flow. As an organization's physicians are market-realigned, the physicians will be wondering, "What do I do for the first 60 days?" We can be talking about \$100,000 or more in terms of cash-flow disruption in that period of time. What will individual physicians do about cash-flow and working capital if their practices are divested? Some hospital-based organizations are, in the transition, subsidizing the physicians with cash in the first few months. Whether or not this makes sense strategically and financially will depend on the particulars of a given situation, of course, but in many cases, this comes as part of the price of realignment. That said, a hospital's attorneys will inevitably become involved in this process, in order to avoid the classic potential of inurement problems.

Many hospital executives reading this will naturally find it difficult to think about giving doctors more money to get rid of these unprofitable relationships; but if that's what's necessary, then one must be realistic and accept the situation. Assuming that one's lawyers will handle this deftly from a legal standpoint, the bottom-line logic of the process often becomes, "We're losing \$100,000 a year per physician already; and if we lose an additional \$30,000 a year per physician for one year, then we're done with the process, and we won't be wasting community resources any longer."

An additional complication usually comes in at this point regarding support staff. One of the attractions to physicians of employment by hospitals has been the excellent benefits the hospitals could give support staff. Hospital executives will have to think through specific strategies and tactics in this area as well, in order to help support staff as well as physicians make the transition, particularly if the physician practice divestiture does result in support staff reductions, or even salary reductions, at the practice level.

### **Bringing back the "entrepreneurial spirit"**

All of this relates, obviously, to the critical need for hospitals to bring back the "entrepreneurial spirit" in their physicians, who may have spent several years in a non-entrepreneurial environment. In thinking through this issue, I've found that there are, generally speaking, three broad categories of physicians, and that their challenges tend to be quite diverse. Looking at this in

terms of age, there tend to be three segments of physicians: the young, newly trained physicians; the middle-aged physicians in their mid-40s to early 50s; and then the mature physicians.

Things are most difficult for the mature physicians who've gone from an entrepreneurial environment to having things done for them. The transition is also exceptionally difficult for the young physicians who have never been entrepreneurial, and who may well have started practice in a market-protected environment. The transition is probably the least difficult for the middle-aged physicians, though in reality there probably never were too many real entrepreneurs among those in that age group who sold their practices.

On a practical level, what things can hospitals do to help facilitate a successful transition, once the divestiture is moving toward implementation?

There are several things they can do. First, they can offer a staffing pool for employees, or offer group purchasing for health benefits. In this context, I should mention that one of the unique challenges of academic medical centers is that, in some cases, these organizations will have offered tuition assistance for dependent children of physicians in an effort to bring them a competitive sign-on package that community hospitals couldn't offer. This is a problem, and it often ends up accounting for a lot of money. Academics aren't the only organizations that have done that, but they're the ones that have done it the most, and such matters often end up in the hands of lawyers.

The physicians will almost certainly mention the cash-flow issue if the hospital doesn't first, and will likely ask for assistance with staff benefits; but they will also have concerns over their employment contract. Sometimes, this gets very complicated. In many cases, individual doctors resist the rewriting of their contracts to make them more incentive-driven, and things end up in the lawyers' hands; and sometimes, it ends up being an issue that the network manager has to tackle, by going to the doctors and offering to tear up their contracts and make them more incentive-driven, or offering the alternative of making their lives very difficult—with the prospect of working the ER on Friday and Saturday nights, doing school physicals, and so on. At that point, the doctors are usually ready to make concessions.

In addition, physicians often will need help getting a line of credit from a bank, financial assistance with accounting, and other matters of that sort. All these

items fall under the general category of the hospital providing support services for the transition. Whether or not the hospital provides financial "pro formas" for the transition, offering resources is highly recommended, both at the MSO level and, more strategically, at the physician network administration or planning department level. In fact, involving the strategic planners in this process is strongly recommended as well, in order to achieve a more comprehensive overall result.

## IN MANY CASES, THE FUTURE STABILITY OF THE HOSPITAL-BASED ORGANIZATION OR INTEGRATED NETWORK IS AT ISSUE.

All these elements of support can help facilitate a successful transition. But beyond the practicals I've mentioned here, all of my advice relates more strategically to the need for the hospital-based organization to rebuild a relationship of trust on a more realistic, market-based footing, while overcoming an environment of mistakes. Is this a challenge? Of course it is, and it's an enormous one. But it can be met successfully. Indeed, it must. In markets like mine in Philadelphia, and others, where massive practice acquisition has taken place over the past several years, and where the realities of the marketplace have come back to haunt the decisions of the past, there is little alternative.

Fortunately, the physicians in these markets, whether they are always psychologically ready to move into the transition or not, are aware of what is going on, and that awareness will help facilitate what is inevitably a complex, challenging process. Clearly, the stakes are high: In many cases, the future stability of the hospital-based organization or integrated network is at issue. Given the broad challenges facing the healthcare system as a whole going forward, nothing less dramatic should be expected. **PPPR**

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