Survival Guide: How to Remain Independent in this Value-Driven Paradigm Shift

Exploratory Paper

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Abstract

The focus of this exploratory paper is centered on the idea of sustaining and enhancing independent physician practices within the context of health care’s paradigm shift from volume to value. This objective was achieved through the analysis of numerous factors that contributed to the current volume-based health care environment, from historical trends to the facts behind why the U.S. health care system is comparatively more expensive and inefficient than other countries. Additionally, the analysis extends to infrastructure enhancements and value-focused opportunities that are required for independent practices to positively impact the delivery of value-based health care while resisting the growing trend of consolidation. To ensure a pragmatic approach was taken, the barriers that could prevent the survival of independent practices were also considered. Conclusively, the results yielded the deduction that the survival for the independent practice is ultimately shaped by health care professionals, especially physicians. Furthermore, it was established that independent practices cannot function in isolation in a bid to manage the continuum of care and deliver desirable patient outcomes. They must embrace a coordinate care model with the realization that creating and maintaining independent medical practices is both viable and necessary to combat the rising cost of health care and deliver value.

Keywords: physician-led, medical group, private practice, out-patient, primary care, health care policies, continuum of care, value-based, patient outcomes, physician leadership, coordinated care, health information technology, lean six sigma, governance, capital financing, value payment models, contract negotiation, network theory, organizational theory, FIS, dashboards, IPA, MSO, NCQA, PCMH, ACO, MIPS, MACRA, MU, EHR, ACA
Introduction

In an era of managed care, consolidation of practices into larger entities, and factory-like processing of patients, is there still room for the independent primary care group? Can an independent group of physicians adapt and thrive in today’s changing value-driven landscape? The competitive value-driven environment appears to suggest that it cannot survive. Policies centered on population health management place a premium on robust clinical and administrative infrastructures, coordination and efficient use of resources, increasing investment needs and operational costs for independent medical practices. Therefore, consolidation into a larger health care system appears as a safer option for physicians, and yet large entities like hospital systems are a significant contributing factor to the rising cost of health care and suboptimal patient care outcomes. A closer look reveals that the independent medical practice can resist consolidation and in fact thrive in the value-based world by adjusting its mindset, implementing new systems and processes to increase efficiency while reducing cost, and adjust its care delivery model to maximize patient outcomes. Of course, this all must be done while remaining agile enough to adapt to the constantly changing health care landscape. The purpose of this paper is to delineate ways that physicians and health care professionals can establish and sustain independent medical practices while retaking the leadership role in health care while utilizing new processes to achieve value-based health care goals.

Factors that Created the Current Volume-Based Health Care Environment

Historical Trends

The image of the kindly doctor, making house calls with his medical bag and stethoscope in hand, was forged as the model of the independent medical practice during the 19th Century. At the time, most of the U.S. population lived in rural if not frontier regions, with low population
density (Census, 2015). The hospitals of the day, even in major urban centers, were institutions for
the poor, essentially places where a person went to die (Essential, 2014). Health care for those in
rural areas and the well-to-do urban residents was carried out in the home, from birth to death.
Fueled by industrialization and a growing wave of immigration, the population trend from rural to
urban accelerated at the end of the 19th Century and the beginning of the 20th Century (Essential,
2014). By the 1920s, more people were living in urban than rural areas. At present, some 82% of
U.S. residents live in cities and towns, creating a much higher number of dense population centers
(Census, 2015).

As cities grew larger and more numerous, hospitals changed to become health care service
centers with a centralized treatment model. Physicians usually donated their time or charged
patients directly to keep hospital costs low while continuing to provide medical care to a larger
number of patients (Essential, 2014). The number of hospitals in the U.S. surpassed 5,000 in the
1950s, and with the implementation of Medicare, increased to over 7,150 by 1975 (Statista, 2016).
The increase was a direct response to the growing urban and suburban populations, centralizing
health care services for emergencies, surgeries, and extended care. But by 1975, the industry trend
of consolidation was already in motion. Hospitals that were unable to compete were either acquired
or closed, which created fewer and often larger hospitals that benefited from economies of scale.
By 2015, the number of hospitals had fallen to 5,430 because of this trend (Statista, 2016).
However, consolidation also began cutting into physicians' independent practices, in a pattern like
that of "Big Box" retailers putting pressure on mom-and-pop shops (Neumark et al, 2005). Another
factor favoring consolidation was the increase in the use of technologies for diagnosis and
treatment. The latest cutting-edge devices were expensive and required higher rates for services,
which favored hospitals over independent medical practices that could not afford "the latest
equipment." With competition looming for independent practitioners, they were forced to raise their rates to integrate these technologies. Unfortunately, insurance companies and Medicare favored high rates for hospitals and paid less to independent practitioners for similar services (Steinbaum, 2017).

As competitive pressures increased, and the costs of healthcare technology, malpractice insurance, labor, and reimbursement compliance rose steeply, physicians turned to working in and for hospitals to facilitate their careers. The number of independent practitioners dropped steadily since the 1980s, until in 2017, the tipping point was reached: less than half of all physicians in the U.S. work in independent practices (Kacik, 2017). Change is inevitable and is acceptable if the results of the dwindling independent medical practice equates to an improved health care system with enhanced patient outcomes. By almost any measure of U.S. health care, the results in both aspects are far from positive.

**For-Profit Focus Means U.S. Health Care Is Expensive, Inefficient and Below the Global Average**

The United States is the only industrialized country in the world without universal health care coverage (Novack, 2017). The U.S. system relies primarily on private insurance companies offering a complex range of health insurance plans. While some insurance companies are ostensibly non-profit entities, the majority are profit-seekers that treat health as a commodity, in other words, as a product that can be easily obtained (replaced) from other sources. This focus is ill-advised and serves as the root of failure in U.S. health care. Health is not a commodity. It cannot be a commodity because each person's health is unique, meaning it cannot be replaced by someone else's health. A person's health is exposed to highly unpredictable risks, from genetic causes,
diseases, accidents…etc. Mitigating these risks for a population is what a health care system does or should do.

And yet, as it stands today, this is not what U.S. health care does. Even with the expansions provided by the Affordable Care Act (ACA), over 44 million people in the U.S. still lack medical coverage (St. John, 2017). This even though the U.S. has the world's highest health care expenditure as a percentage of Gross Domestic Product (GDP), meaning that health care in the U.S. is the most expensive in the world (FullFact, 2017). Since 1960, medical care costs have increased an astonishing 818%, while wages have increased only 16% (McKinsey, 2011). The U.S. leads the world with the most per capita expenditures on medications (Statista, 2017), the average cost of most surgical procedures (Statista, 2016), and average costs of hospital stays (Statista, 2015). Combine poor coverage with high costs and it should be no surprise that nearly half of all bankruptcies are directly caused by medical bills (Backman, 2017).

Other aspects of the system are just as disappointing. Among the 35 Organization for Economic Cooperation and Development (OECD) countries, the U.S. ranks near the bottom in annual physician visits per patient (OECD, 2016). Billing administrative costs exceed 16% of the health care industry's time and wastes over $838 billion a year in administrative procedures and billing errors (Ellison, 2016). The other 84% of the industry's time is mainly occupied by treating chronic diseases such as diabetes, cardiovascular problems, dementia, and cancer. Most of the illnesses and conditions are related to obesity (Brownlee, 2010), while poorly-managed treatment of chronic pain has fostered an opiate addiction epidemic (National, 2017). In the U.S., health care has become a platform for high-revenue products and services rather than a source of preventive trends to improve health and well-being.
What are the outcomes of this system? In the 1960s, the U.S. led the world in nearly all major health care categories (Brownlee, 2010). In 2014, the U.S. ranked 50th of 55 nations in overall health care system quality (Commonwealth, 2014). Life expectancy in the U.S. dropped in 2015 and 2016 (Tinker, 2017). The maternal mortality rate in the U.S. is the highest of any nation in the developed world (Martin, 2017), with Texas having the highest such rate anywhere in the industrialized world (Novack, 2017). And in-patient surveys across 11 developed nations, the U.S. ranked dead last in satisfaction ratings (Commonwealth, 2014).

**Need for Change**

How is it possible that the richest, most technologically advance country in history has a health care system that ranks behind many much poorer and less-developed countries? The vicious cycle begins with lack of focus on patients’ health outcomes and minimal access to medical services and preventive care. Medical plans make profits by taking in payments, but restricting payouts, denying services and products or even dropping patients. Drug costs are controlled with an eye towards profit rather than treating patients. Fear of malpractice encourages physicians to request procedures unnecessarily (Allen, 2017). Pressure to maximize revenue and profits limits patient treatment periods leading to the U.S. having one of the highest hospital readmission rates in the developed world (OECD, 2017). The precipitous drop of unions, and stagnant wages, have altered the benefit packages and real wages of all workers (Rosenfeld et al, 2016). The result of this negative combination can be expressed in simple math: 16% cannot keep up with 818%. And when something becomes too expensive, even something as vital as health, the people go without. What does this mean for physicians? Higher operational costs coupled with limited and restricted medical plans means that they must see a larger number of patients to earn enough money to stay
solvent. This volume-based scenario incentivizes the over-provision of services and contributes nothing to improving overall health care.

The only way to see more patients during standard office hours is to spend less time with each one. But to make sure that even remote risks are covered creates a tendency to request procedures (lab tests, imaging, etc.) as a just-in-case process that also adds some revenue (Lyu et al, 2017). And with pharmaceutical companies sponsoring physicians to use their products, the "quick fix" is to use palliative medications instead of investing the time and effort to uncover root causes (Brownlee, 2010). But even when health care providers want to explore root causes, treatment options are often made by payers who lack medical backgrounds. Their for-profit focus views medical services as a process in need of economies of scale, but this strategy has proven to provide suboptimal patient outcomes. Physicians are forced to work longer hours, often taking alternate positions in hospitals to see more patients. They are forced to deal with medical plan changes and procedures intended to slow down payouts or deny them altogether. These same plans, both private and federal, force "efficiencies" measured in volume rather than value. They face an increase in non-payments (bad debt), with the added costs of trying to collect or write them off. They must remain up-to-date through continuing education in a world where a technological generation might be as short as six months. With all this pressure, it is no surprise that health care providers are reporting less satisfaction with their work, higher levels of substance abuse, depression, and many admit to feeling or experiencing burnout (Peckham, 2017). Enrollment at medical schools has stagnated, meaning that at a time of increasing need, the once-attractive medical career path is producing lower graduation rates (Kosarek, 2017).

Hospitals are not doing well either. Even with rampant consolidation and cost-cutting efforts, hospitals have seen steep declines in their revenues, and cost increases continue (Taylor,
Furthermore, hospitals lose an average of $212,000 a year per physician (Hethcock, 2018). In the constant struggle to balance sustainable revenue and services hospitals lack the management capacity and economic resources to continue hiring physicians to meet the demand (Steinbaum, 2017). Most patient care is delivered through hospitals, which further contributes to the overall problem with the U.S health care system. Just as there is a decline in new physicians, the Baby Boomer physicians are retiring in larger numbers (Barr, 2014), and the U.S. has been in an increasingly serious national nurse shortage for the past 15 years (Grant, 2016). What makes the future look even more daunting is that the patient population segment with the highest use of health care services, those aged 60+, will double by 2030 (U.S. Census, 2015).

The need for change was evident long ago. The current health care environment is inadequate for both the healthcare provider and the patient. Physicians are leaving independent practice because they feel trapped in a cycle of volume over value, of patients-as-commodity, and this betrays the “art of medicine” concept (StaffCare, 2016). But the solution is not joining a hospital, for it operates under many of the same constraints and is saddled with a business model that cannot be sustained. In terms of health care professionals, U.S health care needs to allow for the creation of a system that allows greater focus on patient care and a reliable opportunity to earn enough for professional and personal growth. Rather than wait for the system to do that, leaders within independent medical groups can be proactive and utilize the concepts within this paper to make a positive difference.

**Enhancing and Sustaining Independent Medical Practices**

**Through Alignment with Value-Based Health Care**

Under the volume-based system, the physicians’ greatest asset of a personalized approach for delivering health care was cast aside in favor of a generic factory-style approach. With the
health care industry focused on "more per hour," the level of commitment per patient was forcibly reduced. The patient became a number, literally a cipher no one truly knew well. This would ultimately lead to poor patient outcomes and a negative patient experience. For the system to change, health care stakeholders must buy into the changes, and the ultimate stakeholder is the patient. The value-based system correctly places the patient at the center of the coordinated care model. That fundamental change means that the independent medical practice must move from a passive maintenance mode to an active predictive one.

Today, the U.S health care policy mandates a value-based system where positive patient outcomes are delivered in accordance with minimizing the costs associated with that care. In brief, the goal is to maximize every dollar spent on patients so that they can preserve and regain their health to the largest extent possible. Despite a renewed focus under ACA, improvements have been spotty, and in some areas health care outcomes have worsened, as noted above. It is evident that systemic limitations are often misaligned with desired outcomes, as in direct patient care. The current volume-over-value model is a direct result of systemic pressures that forced physicians to seek an "efficient" path with each patient. Rather than focusing on volume, a focus on redefining efficiency can point the way for independent medical practices.

**Innovation: Health Information Technology**

Begin with health information technology (HIT), the progressive utilization of technology is seen as a prerequisite for the realization of an accountable care model. Because the health care system is in perpetual transition to cope with technological advancements and emerging diseases, the transitions should be anchored on cost reduction and improving quality outcomes. For a long period of time, the U.S. health care sector has been focused on the volume-driven business model, which resulted in the increasing cost of care and suboptimal patient outcomes. Even though HIT
innovations are at the forefront of the value driven change, in the U.S., HIT has been designed to maintain the system rather than to transform it. Evidently, HIT has undergone three developmental phases beginning in the 1980s to 2015. In the 1980s, HIT was in the form of practice management systems. In the 2000s, EHRs and clinical decision support system became the hallmarks of HIT. From 2015 onwards, HIT has been in the form of population health management systems and technologies to promote efficiency. Unfortunately, these developmental phases have been reactive responses to conform to the health care market ecosystem. All is not lost because the environment is ripe with entrepreneur’s pushing the latest innovations to improve care quality and improve patient outcomes in the health care sector. For example, the University of Minnesota Health Clinics and Surgery Center is using the real-time locating system (RTLS) technology to manage patient flow, and the overall patient experience in conjunction with LEAN principles.

In the case of the University of Minnesota, RTLS technology is integrated into their electronic health record (EHR), which enhances the utilization of exam rooms and minimizes wait-times. Therefore, RTLS is a tool that optimizes clinical operations and enhances the overall patient experience. Essentially, this system is used to provide immediate real-time GPS like tracking and management of medical equipment, staff and patients within all types of patient care environments by using strategically placed location sensors. Ultimately, the result enables facilities to improve workflow, reduce costs and increase clinical quality. We live in a day and age where nearly any service and social interaction has a technological counterpart from enhancing communication to providing health care services. While technology cannot take the place of all aspects of health care - i.e. procedures or taking bloodwork--it can replace certain aspects which are included in the health care delivery process. This area is referred to as telehealth, which is currently seen as a burgeoning part of the health care industry. The first way that telehealth can drive positive outcomes is for
stakeholders to properly understand how this technology can be applied to patient care in the first place.

This is a realistic short-term goal that is vital for ensuring that providers can give the most effective care. There are remote populations that have difficulty receiving primary care because those services are practically non-existent in the area in which they live. For them, it could mean an expensive lengthy trip to receive such services, or it could be a completely unrealistic notion to visit a physical clinic for a non-emergency situation in the first place (Koch, 2006). The addition of telemedicine can further enhance patient care by increasing the potential number of patient visits, and by providing a more effective means to monitor patients’ health and provide health-related education. Furthermore, telehealth technologies enable the exchange of all types of data (e.g., voice, video, wound, pathologic or radiologic images, device readings) between patients and providers or between providers on behalf of patients. Another example are services comparable to IBM Watson Health, where HIT is used to facilitate the transition to value-based care such as the merit-based incentive payment systems (MIPS) and advance alternate payment models (APMs). Moreover, HIT can be utilized in population health management by analyzing health care outcomes, finding patterns in the population, promoting health, and addressing the population needs (Zukerman, 2005).

Financial Information Systems and Dashboards

Not to be overlooked, the fundamental strengths of a financial information system (FIS) is necessary for the survival of the independent medical practice, as it tremendously aids the executive decision-making process. FIS is software that is responsible for monitoring the financial posture of a business enterprise through gathering, collecting, summarizing, analyzing, and disseminating financial data in a way to effectively make business decisions. Therefore, FIS not
only supports graphical rollup (think dashboards), but also directly supports the implementation of decision-making functions that one might expect to find in an executive information system. Furthermore, the FIS can monitor the flow of funding, by tracking the sources of capital inflows and the destinations of capital outflows within the medical practice. The ability to earmark various flows for expenditure within their requisite functional areas makes it easy to track both accidental misalignments and large misappropriations (Morgan, 2017). The fact that financial information systems can specialize within given functional areas of finance makes them particularly suited to use in vertical markets. These systems are available for environments ranging from stockbrokers to health care organizations. Such systems are carefully and closely tailored to the functional needs of their respective verticals, enabling the sharing of information between the subject matter experts who are responsible for the details of project management and the financial officials who ultimately report to stakeholders and shareholders.

Finally, financial information systems are particularly valuable tools for decision support because reporting functions are available both individually within discrete functional areas and collectively across the entire medical practice. The capability to examine reports dealing with any aspect of financial data gives stakeholders the tools both to track past expenses and to project future expenses. Moreover, these reports can aid in identifying those departments or divisions that consistently stray over budget versus those organizational units that religiously adhere to applicable budgetary constraints (Morgan, 2017). It is necessary to recognize the fundamental difference between financial information systems and executive dashboards. Executive dashboards are more streamlined tools, such as Microsoft BI, a tool that supports decision-making by presenting easy to follow snapshots of key performance indicators, rather than detailed reports that can be drilled down seemingly to no end for significant levels of detail. An executive dashboard
provides superior visibility and insight that provides both current performance along with trending data that is tracked in a highly optimized and visual manner. – This is a highly efficient format for stakeholders within the medical practice. At the same time, the deliberately abstract scope of an executive dashboard makes it altogether less informative than a financial information system *per se* even if it is demonstrably more convenient (Lavinsky, 2013).

Ultimately, HIT brings together the components of health care informatics such as EHRs and financial data to manage the organization more effectively. Furthermore, these performance-enhancing tools can engage providers and administrators through a visual representation which provides measurement and transparency. The goal is to have a single source of truth of actionable intelligence for clinicians that includes relevant metrics such as admitted patients, recently discharged patients, quality measures, panel size, patient access metrics, patient experience data, and additional key metrics that drive performance. To achieve organizational buy-in, from the providers, the dashboard must only include content that is meaningful with functionality that is actionable. In this paradigm shift of value over volume, its key for providers to have the tools necessary for self-directed change.

**Health Information Technology: Electronic Health Record**

Presently, HIT is an integral part of the health care service provision. Thus, various aspects of technology are utilized by health care organizations to enhance the quality of health care services and improve patient outcomes. Given this, the EHR is one of the necessary technologies utilized by successful independent medical practices. It contains the patients’ health record embedded with a multitude of data from the patient visit (PCP’s, specialists, ancillary services), medications, diagnosis codes…etc., and has various components that facilitate data collection, storage, and utilization. The components promote the entry of the patient data into the system,
sharing of the patient data across the care continuum, allows for faster communication, and fosters timely decision-making. The history of the EHR indicates that when the 1965 Social Security Act created Medicare and Medicaid, regulations concerning the patient records management increased. Therefore, the standard for the storage of patient records was mandatory because those records became the primary source to justify claims. With the adoption of the EHR by independent medical practices, leadership plays an integral part in the process. They facilitate the adoption of the EHR by providing and coordinating patient education, designing the clinical decision support systems, developing dataset standards, and engaging the external stakeholders at the local, regional, and national levels to improve the quality of care.

The patients’ perspectives about EHR is that it saves time, supports patient privacy and confidentiality, provides online accessibility of medical information, and streamlines registration. The health care providers’ perspectives are that the EHR increases productivity, improves clinical documentation, and improves performance. While the clinical administrator may perceive the EHR to store patient information, support compliance with regulatory and quality requirements, and facilitate the partnership between physicians and patients. From the independent practice perspective, the EHR improves efficiency, enhances the quality of care, and supports pay for performance. Ultimately, the state and the national government perspectives are that the EHR improves the coordination of care, improves the quality of care, lowers the medical errors, and improves the overall health care services for all the citizens (Merlino & Raman, 2013).

Despite all the advantages of the EHR from the stakeholders’ perspectives, this form of HIT is costly to many independent medical practices. These practices must make a choice: to invest in their infrastructure or succumb to consolidation. Ultimately, the EHR forms an integral part of value-driven organizations because the technology has the capacity to store and transmit
patient data across the care continuum. Moreover, when the EHR and practice management systems are integrated, the outcome can streamline the processes across decision support, administrative, patient care, and practice management functions. Therefore, many consider the EHR as the heart of a value-driven independent practice, for its ability to store and transmit data across the care continuum.

The use of an EHR by an independent medical practice will provide the foundation for risk stratification. Given this, population health is a broader way of looking at the health concerns of an entire population by evaluating the policies and interventions that impact the determinants of health. When they gain insight into their patient population, they can stratify risks through intentional, organized, and proactive processes. With effective risk stratification, the health care providers can ensure that appropriate clinical services reach their intended patients within a given population. The objectives of risk stratification are to predict risks, determine the interventions, and avoid negative outcomes. Evidently, independent medical practices must embrace risk stratification approaches to realize the triple aim of improved health care outcomes, cost reduction, and better patient experiences’.

By leveraging electronic platforms to improve integration between medical and social service delivery, the EHR further allows the ability to better manage referral processes, tracking both individual- and population-level data; and sharing tracked data with community partners (Gottlieb, 2015). With EHRs ability to collect, synthesize, and analyze data for social determinants of a patient population, the independent practice can now *swim upstream* in a sense by utilizing this information for screening and preventative interventions. Ultimately, HIT brings together the components of health care informatics such as EHRs, personal health records; transparency and access to data to improve quality outcomes and reduce cost.
Aligning Analytics with Policy

Analytically, the use of HIT has been addressed by the Centers for Medicare & Medicaid Services (CMS) through the introduction of the Meaningful Use Program, currently in Phase 2 (CDC, 2018). The three-phase program launched in 2010 to integrate better use of EHRs in the industry, aiming to extract the advantages of shared access. Using technology also provides the foundation for enhancing risk stratification. The impact of "big data" on fields with a complex range of variables, such as health care, is significant. It is unlikely for any physician to remain up-to-date on the latest research studies, but technology can place the latest results in their hands in real time. In addition, the sharing of information simplifies decision support and avoids "decision silos" that often jeopardize the provision of health care services. This issue is further addressed by the Healthcare Effectiveness Data and Information Set (HEDIS), a database system used by more than 90% of health plans in the U.S. to measure performance and effectiveness on key aspects of health care and service (NCQA, 2018).

Similarly, organizing and aligning value-based health care should include patient outcomes, patient experience, and cost. Therefore, it is advantageous that independent practices realize the value of transiting from volume to a health care model centered on delivering value. Evidently, the health care industry is now entering a period of significant changes, as the shift from volume to value is a reality that all health care organizations must accept. Thus, the models for health care delivery models are being reshaped and redesigned from the bottom up. The reshaping is being stimulated and speeded up by the desired changes in the payment system from the fee-for-service to the value-oriented payment methodology. For example, CMS has taken the lead by committing the largest share of Medicare payments to reward value rather than the volume of care offered by health care organizations. Further, the commercial payers for health care services have
followed the path set forth by CMS by engaging in the bundled payments model. For instance, bundled payments reward health care organizations that improve outcomes and lower costs of medical services.

Since policy drives the creation of systems, some fundamental changes can be made to directly support the stated goals. A physician's job is not to simply see the patient: Their job is to enhance the patient's health. Therefore, the system's parameters need to focus more on quality outcomes rather than the suboptimal outcomes resulting from the volume model. The most significant incentives for value over volume come from government entities, as they apply to the entire health care industry. This change was implemented in 2015 by the Medicare Access & CHIP Reauthorization Act (MACRA). In conjunction with the National Committee for Quality Assurance (NCQA), MACRA was developed to more closely align compensation with value while maintaining a parallel focus on controlling costs. MACRA also streamlined the wide range of quality care programs into the Merit-Based Incentive Payments System (MIPS) and repealed the Sustainable Growth Rate formula that tilted health care decisions in favor of an impersonal approach (NCQA, 2018).

The greatest impact on health comes not from palliative care, but from preventive care. A focus on value means that the current system can truly make preventive care a priority, and government support allows time for the change in health outcomes to occur, estimated at 10-20 years (CDC, 2018). This is a timeline that private insurers cannot abide by, as their profit-based incentives are measured in 90-day spans. The benefit of the new government policy also has a long-range impact on private sector metrics to maintain a focus on value. For example, HEDIS has a direct impact on the payment and reimbursement levels of roughly 90% of medical plans in the U.S., representing billions of dollars within the health care industry (NCQA, 2018). Evidently, the
health care value equation puts a lot of emphasis on value by emphasizing outcomes, patient experience, and operating margin (cost). Based on the patient-centered care model, the patients’ experience coupled with the care services offered by independent practices can provide a clear picture of the value delivered. When patients’ have a positive experience, it is evident that the independent medical practice is on the path to be a value-driven organization. On the other hand, when patient experiences are unsatisfactory, it demonstrates that the practice has not shifted from to value care delivery system (Drickhamer, 2015).

Another essential element of the health care value equation are outcomes delivered to the patient by the independent practice. Therefore, the objective of the practice should be to provide care services that enhance outcomes. Regarding the cost as a component of the health care value equation, when the changes in patient outcomes are divided by the costs associated with care delivery, then the true value of care is realized. For patients seeking care services, what is of utmost importance to them is their health care status, pain reduction, sense of wellbeing, provider interaction, and the coordination of team-based care to address their medical conditions. It should be noted that the U.S. has the most expensive health care system in the developed world. Thus, the independent practice can be of value to patients and the U.S. health care industry alike by addressing patient outcomes, patient experience, and stem the rising cost of health care. Therefore, the health care value equation must be the cornerstone of a successful value-driven independent medical practice. The U.S. health care environment parameters have changed, but still much more is required to return the U.S. to its once pre-eminent position. Independent medical practices have yet to truly seize these opportunities, but the groundwork is laid for those ambitious enough to remain independent.

Lean Principles
The Toyota Production System is arguably the most important invention in operations and has spawned numerous similar approaches all based on the same principles: relentless attention to detail, commitment to data-driven experimentation, and charging workers with the ongoing task of increasing efficiency and eliminating waste in their jobs. These collections of ideas are often termed “lean.” (Staats & Upton, 2011). Waste associated with all types of health care organizations is rampant and is a significant contributing factor in the rising cost of health care. Lean in terms of health care points to the reduction in time taken to deliver services and increase efficiency without compromising quality. In this value-driven era, independent practices must improve their operational efficiency and productivity to combat the rising costs associated with delivering care services. Accordingly, the best opportunity for cost reductions, without jeopardizing patient care, is to look for alternative methodologies not traditionally associated with health care. Lean and Six Sigma are the most widely used process improvement approaches in the industry. Lean focuses on the elimination of waste and the improvement of overall cycle time within a process, while Six Sigma focuses on the elimination of variation in processes (Langer & Renaud, 2010).

Practitioners trained in Six Sigma use the steps of the DMAIC (define, measure, analyze, improve, control) model in a specific order to solve problems based on the application of statistical process control, quality tools, and capability analysis, and is ultimately used to help design and redesign processes. The DMAIC methodology involves defining the problems in a process, measuring the available data within the process, analyzing the process’s performance and identifying associated issues, selecting solutions to the root cause of the problem, and implementing a control plan that demonstrates how standards and improvements can be sustained and risks managed (Kowlsen, 2014). The use of process maps, pareto charts, histograms, and
brainstorming techniques also provide opportunities to reduce variations, cost, and enhance the patient experience.

Lean is concerned with evaluating the stream of processes with the objective to eliminate the actions that are deemed as non-value-added waste by the independent practice and its patients. Lean is essentially about removing anything that the customer — or, in the world of health care, the patient — is not willing to pay for. This concept is simplistic in nature and can be easy to implement; it’s common sense. With lean in health care, the basic principles are centered on understanding the needs of the patient. Those who take part in a 5S exercise (sort, simplify, sweep, standardize, self-discipline), for example, whether in manufacturing, health care or another industry, quickly gain an understanding of how lean works (What is Lean 2018). A byproduct from eliminating non-value-added activity ultimately results in enhancing the overall patient experience. Lean takes rigor and collecting and measuring data is an essential part of the lean process, but the work is not centered on a time-consuming process of gathering and analyzing statistically significant statistics. It’s about people. It’s about creating a system in which all employees in the organization are empowered to collect and measure data, and to create their own ideas for improvement. When staff members are engaged with these principles, they incorporate them within their work and keep making incremental improvements. When implemented correctly, Lean principles foster a culture of continuous improvement by empowering employees to participate in the systematic collection of data, development of action plans, and evaluation of solutions. Furthermore, Lean enables senior leaders to understand operational problems by tracking and analyzing objective data while interacting in a meaningful way with all staff members within the independent medical practice. Another benefit is that it allows the breakdown of silos by encouraging interdepartmental communications and collaboration. Independent medical
practices can utilize *Lean Six Sigma* to create a well-balanced and organized solution to reduce costs, enhance patient experience, and reduce variation of services.

Health care is highly variable, but lean is adaptable and flexible enough to adjust to the ever-changing landscape. Incorporating lean principles into organizations greatly enhances their ability to deliver goods and services; therefore, lean can provide the basis for determining whether the independent medical practice is value-driven or not. Principally, health care organizations are service organizations where the value of care is defined by the patients’ expectations and offered by health care providers. Lean methods are about people and relationships. Everyone — whether a front desk receptionist, a physician or an administrator — can participate and they all understand how it applies to their work.

**Leadership and Governance**

Leadership is a driving factor for transitioning the volume driven independent medical practice to one of value. From physician leaders to effective administrators, leadership must span across both clinical and administrative functions. It’s important to note, that effective leadership within an organization’s C-Suite must be transformational to inspire, motivate, and clarify the vision for all employees within the medical practice. This must be done all while managing the organizational culture, and upholding the mission, vision, and values for which the independent practice was founded upon. With that role comes a responsibility to enhance organizational knowledge, and to drive acceptance for stakeholders to address the business of health care as a patient-centered care system. It should be noted that physician leadership is impactful as a change agent and should be at the forefront of strategic initiatives. Therefore, it is essential to either recruit leaders into the medical practice or develop them internally. Oftentimes, the appropriate strategy combines both tactics.
Lack of leadership in the health care industry is apparent in a study cited by Castellucci (2018). The survey of 621 physicians found that 78% of the respondents did not believe that value-based payment models worked for health care quality improvement or cost control. However, the same study noted that roughly 68% of the surveyed physicians were unfamiliar with the payment models, and as many as 96% have in-depth knowledge of MACRA (Castellucci, 2018). To contrast these findings, the same survey asked 538 employers and 5,031 consumers about the health care system, with about 70% stating that fundamental changes were needed or that the system had to be rebuilt. And yet, in a surprise finding, 72% said they were satisfied with their medical plan coverage (Castellucci, 2018). The disconnection is obvious because 70% cannot be dissatisfied with the system while 72% are satisfied with what keeps them in the system. Furthermore, it is disturbing that only 4% of physicians are well-versed on the importance of MACRA. The solution is also obvious: Physician leadership.

Several theoretical frameworks are used to explain and evaluate leadership within the independent medical practice. For example, trait theory presupposes that people have the innate traits that make them leaders. Therefore, leaders are born equipped with the leadership traits to lead. While behavioral theories state that production, goal initiation, interpersonal relations, and consideration of employees are behaviors that make people leaders. Evidently, contingency theories argue that effective leadership is displayed when leaders display contingency thinking when facing uncertainties; which may be considered as a prerequisite for adjusting to the everchanging health care landscape. Examples of the contingency theories include Fiedler’s Contingency Theory, Leader-Member Exchange Theory, Situational Leadership Theory, and House’s Path-Goal Leadership Theory. Contemporary theories of leadership bring together the traits, contingencies, and behavioral theories that define leadership. Further, contemporary theories
encompass the transformational and servant leadership which is often found in successful health care organizations.

Leadership style and leadership competencies go hand in hand within all health care organizations. However, strong leadership is especially crucial to those independent practices adjusting to the new value-driven health care landscape. In a health care setting, the vital health care competencies include: technical skills, knowledge of the health care industry, interpersonal and communication skills, analytical and conceptual skills. Because independent medical practices face obstacles, they require supportive and effective leadership to drive the organization forward, identify threats, and implement contingency plans to manage those threats. Furthermore, effective leadership motivates and empowers employees, fosters healthy communication, and creates unity towards a common goal. Therefore, if the goal for an independent practice is to be value-driven, then effective leadership is a prerequisite.

Even though the above theories of leadership explain different approaches to organizational leadership style, overall, the role of a leader is to set goals, solve problems, manage external stakeholders, manage internal stakeholders (staff), and influence the organizational culture. However, it is likely that a mix of various leadership styles would be more effective, as one style is inadequate in addressing the variety of conditions that emerge in most independent medical practice settings. Leadership means that a physician's practice must be managed in a systematic manner, not informally as most physicians typically do (Borschuk & DiMarco, 2015). Leadership is vital to the practice, as it brings a business focus at a level that can sustain and expand effective health care services and positively impact the value-based system on a population.

A governing board cannot exist without strong leadership. Whether independent or affiliated with a hospital system, medical practices are facing greater complexity when it comes to
internal governance, due to meeting the demands of being a value-driven healthcare organization. Thus, the board provides executive management oversight, quality assurance, financial accountability, and strategic planning (Fabrizio, n.d.). The key is finding the right balance between physician input, executive stakeholder involvement, and effective decision-making. The prevailing thought is that a smaller board is more effective than a larger one, as its nimbler, and debating can be more productive. Additionally, a governing board should incorporate a variety of perspectives, while maintaining a physician-led focus. Progressive medical practices are including a variety of non-physician board members both from internal and external sources aside from the standard health care provider. These members can range from local business owners to subject matter experts in specialty areas, such as finance, and IT (Halim, 2015).

Several factors should be considered when creating a governing board, such as meeting frequency and duration, written board policies and procedures, annual governance goals, leadership development, and succession planning. It’s important to note that if practice ownership is central to decision-making and control, the owners’ needs must be separated from the needs of the practice. Furthermore, ownership must buy-in to the idea of governance to effectively manage the practice, or the governing board will fail to be effective. The organizations CEO, and ownership can serve as the Board Chair; however, this is not recommended. The board led by the Chairman serves as an oversight function that can generally appoint/remove a CEO. Thus, a board should focus on the big picture: ensuring the right people are filling the C-Level roles, ensuring the practice is conducting business legally, ethically, and effectively. Finally, the board should ensure if the independent practice is following its vision? The CEO on the other hand, should focus on: practice revenue, if the right employees are doing the right job, with a clear, shared, vision. Perhaps most importantly, the CEO should focus on execution of the strategic objectives set forth by the
governing board. No matter, the structure of the organization, the fundamental obligation of the board member is to represent the interests of the independent medical practice.

**Value-focused Opportunities for the Independent Medical Practice**

The methodologies with which independent practices are paid have the capacity to positivity influence patient care. Evidently, the payment methodology can impact the practice’s business model by prioritizing health care investments, infrastructural development, and design of the care processes. For example, the fee-for-service care delivery and the volume-based financial inducements have led to the overutilization of low-value care services leading to suboptimal care. For these reasons, a consensus is emerging among stakeholders consisting of health care professionals, purchasers, payers, and patients to shift to alternative payment models (APMs). The desire to shift to APMs is necessitated by the urge to incentivize the value delivered to patients as the primary stakeholders, by making high-quality and affordable care available to them.

In 2014, the Center for Medicare and Medicaid Services published a scheme for the classification of APMs. In this regard, the health care Payment Learning and Action Network (LAN), which is a public-private partnership has been working with all stakeholders in the health care sector to speed up the transition and adoption of the APMs by health care organizations. LAN works by accelerating the use of APMs by incorporating the views and expectations of the patients, consumer representatives, payers, purchasers, and health care professionals. These models have been clarified as pay for performance, population health payment, and APMs built on the fee-for-service model. The analysis of fee-for-service alternative payment models show that it’s a traditional form of payment where health care services are separated and paid for individually. The fee-for-service payment model provides incentives to health care organizations that offer more care services because payments are tied to quantity, not the quality of the health care delivered.
Even though the fee-for-service payment model is the dominant model in the U.S., it increases medical costs and discourages efficiency. Thus, the debate to replace the fee-for-service model with an alternative payment model is on the rise.

Pay for Performance is seen as an alternative payment model to traditional fee-for-service because the former puts emphasis on the quality of the health care service, rather than the quantity of care. This model is a form of value-based purchasing since it provides independent practices with financial rewards and incentives for realizing certain performance measures such as enhanced patient outcomes. On the same note, the performance-based APM will penalize independent practices when poor patient outcomes are delivered, medical errors are registered, and when there is an unjustified rise in the cost of delivering care. Thus, the value payment models focus on results in determining how much will be paid for services.

The health care industry is now focusing on the patient's overall health and well-being, so care delivery system's incentives align directly with positive outcomes throughout the continuum of care. A basic payment model that significantly reduces or removes barriers for patients’ seeking medical services is capitation. In it, the patient pays a set amount per month or year for defined services, without limit, and often without any minimum. As with insurance, the payment covers the period whether services are needed or not (Valence, 2013). The advantage of this model is that it encourages timely visits for prevention, diagnosis, and treatment as an incentive for improved outcomes. The risk is that a patient or group of patients may take up a significant percentage of services, causing significant expenses to the medical practice. This type of risk can be mitigated with a shared savings model, where a group of providers coordinate services to improve care. The Medicare Shared Savings Program (MSSP) was instituted to control costs in the fee-for-service model, but the concept is equally applicable to independent practices, where managing resources...
and costs to offset the varying changes in risk within a given population are necessary. (Valence, 2013).

The population health payment method is an APM that brings various models together. It encompasses the Medicare Shared Savings Program (MSSP), the Comprehensive Primary Care Plus (CPC+), and Accountable Care Organizations (ACOs). Thus, the MSSP is an alternative payment method that facilitates accountability in the care services offered to patient populations, it coordinates the health care services, and encourages the investments in efficient and high-quality health care services. Moreover, the Accountable Care Organizations (ACOs) brings health care providers, physicians, and groups of hospitals together to provide high-quality care at an affordable cost to Medicare patients. Similarly, the CPC+ is a public-private partnership arrangement that aims to improve the quality of care by reducing unnecessary care services that increase the cost of medical care to the patients.

In contrast, a shared risk model removes the hidden costs that so often plague U.S. health care by using a similar concept of group providers focused on community-level accountable care. The evaluations would center on comparing costs to results for the purposes of reducing or avoiding unnecessary procedures, reliance on medications, etc. (Doss, 2014). In both models, independent practice stakeholders can take the lead in developing key improvements for community or regional levels of health care because they are freed from overall risk-related factors inherent in a population. Yet another option is, the bundled payments (or episode-based) model, which essentially places the physician in a controlling position by providing a lump sum payment in advance to manage costs in a specific service need, such as illnesses, chronic conditions, or transplants. The pre-payment budget eliminates the financial concern and allows for greater focus on quality outcomes, rewarding best practices in evidence-based care (Valence, 2013).
Perhaps the global capitation model is considered the most impactful APM for delivering value. The payment arrangement for patients enrolled into a health plan and puts the physician group “at full-risk” for services provided for patient outcomes and services. The capitation payments are reimbursed per-member per-month (PMPM) for the entire network population and pays a set fee per patient, giving physicians an incentive to avoid over utilization of services attributed to higher costs. Typically, there is a “risk pool” which is established as percentage of the capitation payment and is withheld from the medical practice until the end of the fiscal year. If the health plan does well financially, the money is paid to the practice; if the health plan performs poorly, the money is kept paying the deficit expenses, hence the term “full-risk” (Alguire, n.d.).

All these alternative payment models come under the Pay-for-Performance concept, inverting the system to ensure that outcomes rather than tasks are the basis for physician revenue. Although the medical profession does not or should not treat patients as numbers, the pay-for-performance model reinforces the “patient-centered focus” concept. But the unpredictable nature of health care is a question of having the appropriate infrastructure in place, and to offset those very real factors, independent medical practices must seek support.

Enter the Independent Physician Association (IPA). This widely used association is essentially a network of physicians working together as a single business network. The IPA structure provides resources to the independent practice that are unavailable otherwise. Even if the practices or the IPA lacks a complete infrastructure, the model creates the opportunity for a third party to assume uncovered risks. Many IPAs also offer Management Service Organization (MSO) options that take on many if not all administrative duties, leaving the physicians free to focus more on providing quality care (Doss, 2014). Examples of how health care services are expanded with the IPA model include extended office hours, the development of Urgent Care centers that enhance
prevention, as well as telephonic triage services which reduce the need for a physical follow-up. This model optimizes the resources of individual and pooled facilities while simultaneously encouraging peer support to provide services in the best interest of the patients. This further aligns the physician's financial incentives with positive health outcomes, with every IPA member making a valid and measurable contribution.

In similar fashion, Accountable Care Organizations (ACOs) combine independent practices, hospitals, and health support systems to develop a network among a community of like-minded professionals. The collaboration in health care services help physicians succeed within value-based payment programs. What powers the model is accountability, once again with a focus on critical patient outcomes rather than on tasks. This point bears repeating simply because it crystallizes the fundamental reorientation of the U.S. health care system to focus on patient outcomes. An ACO offers the independent practice an alternative to joining hospitals. By establishing a model that supports providers, the benefits extend throughout the ACO network because independent practice patient referrals increase hospital and health support system patient populations without the need to employ physicians directly. Patient care is thus guided primarily by physicians, with physician-led ACOs outperforming those led by management firms or non-medical providers (Woodcock, 2015).

The ACO focuses on the care continuum and coordinates health care resources to provide a highly-integrated health care service model. The framework allows equal flexibility for physician-led and managed facilities and combines both for greater resource allocation. Services can be coordinated in-house, provided by external entities, or both. The ACO framework easily coordinates in-patient and out-patient care, and by fostering a broad range of care services, it increases the total number and overall impact of health services, a model for leverage that places
patient care first and assures its prominence throughout the health care system (CareFirst, 2016). Utilizing a value-based model requires a dedicated effort by the independent practice by focusing on delivering quality care. A value-based system affords the independent practice the opportunity to once again practice the art of medicine in accordance their revenue stream; these two essential factors will maximize success and minimize provider burnout. Furthermore, the more inclusive value system relies on health care leaders providing more input into policy development, thereby, creating a new level of political influence within the community, as well as within state and national levels. A system that relies on self-reporting does not have the financial incentive or trustworthiness to have a sustained impact. For that reason, a private non-profit organization called the National Committee for Quality Assurance (NCQA) was created in 1990.

The goal of the NCQA is to improve the quality of health care within the U.S. To support this goal, the organization accredits and certifies a wide range of other health care entities, emphasizing preventive care. Using its evaluations, the NCQA measures quality based on factors such chronic disease management, reduced emergency room visits, declining readmission rates, and more. The result is the ongoing development of best-in-class guidelines for care coordination and management on a regional, state and national basis. The NCQA evaluations can lead to recognizing high quality health care organizations by awarding them with a gold seal, bestowed on facilities that combine quality and consistency. There are additional rewards for clinicians and practices with excellent ratings in key performance areas. These awards are not just recognitions of dedication and service: They come with significant financial incentives as well. The NCQA ratings are used as part of reimbursement payment programs such as Meaningful Use and the Merit-Based Incentive Payment System (MIPS), two of the largest such programs in the U.S. The direct tie-in with financial incentives motivates physicians and health care administrators to
implement as many of the ratings parameters as possible to maximize potential scores. The alignment is not directly tied to the score *per se*, but with the quality of care processes that leads to the scores, along with greater revenue.

The processes of quality care are a continuum, not a series of staggered steps. The phrase "continuum of care" is central to the NCQA program known as the Patient Centered Medical Home (PCMH) Accreditation. The purpose is to focus on the health care continuum by bringing together physicians, nurses, pharmacists and administrators to use information and evidence-based practices in a coordinated effort. The NCQA gives accreditation for PCMH programs that supports this program. Given the above, the objectives of population health are to promote patient engagement, improve patient self-efficacy, reduce emergency department visits, and lower the rates of hospital admissions and readmissions. When the objectives of population health are realized, the quality of life increases and the cost of care decreases. The population health concept is an aspect of the high-performing medical practice where care coordination is given the highest priority. The care coordination is where care providers and health care organizations utilize the team-based approach that facilitates collaborations and communications among all the stakeholders including providers, patients, and ancillary services. Health care providers from across medical specialties come together as a unit with the goal to improve patient outcomes. The care continuum that meets the needs of population health care include primary care, emergency department visits, specialist care, diagnoses, and hospitalizations. Therefore, activities include the shared-decision-making where collaboration between the patients and health care providers key. In addition, the collaboration ensures that the patients are well informed regarding their medical status, the availability of the alternative treatment options, and the benefits and costs of all the available treatment alternatives.
Evidently, the collaboration empowers patients during the decision-making process and encourages their active participation with their health care. But what about the physicians who wish to remain solo practitioners and explore the growing trend in delivering customized care? For them, the concierge model could be an option. The physician establishes a certain number of patients, charges a monthly or annual fee, and becomes a "personal physician" to that population. The concierge model has found a niche in cities with many professionals that have children. The model thus makes use of higher urban densities to tap into as a market for personalized services. The fees average about $2,000 a year per patient, the health care provider helps negotiate special rates for common services and may charge a small additional fee for house calls and visits outside of office hours (Concierge, 2018). By focusing on a small group of people (usually 100-350 total), the physician enhances time, knowledge, and care with each patient, much like the traditional doctor from generations past.

Enhance the Independent Medical Practice by Removing Common Barriers

The historical decline of the independent practice that once sustained physicians is the result of systemic change. Policy changes made it harder for physicians to practice medicine in a manner that once placed the U.S. as the gold standard for health care. It was not perfect: no system is. But its results were better than the outcomes of the current volume-based model that is rampant in health care today. For independent medical practices to leverage the greatest benefits from these value-driven policy changes, more changes are needed to overcome barriers that favor larger health care organizations. For example, in the alignment of payments with Medicare "site of service" differential should be eliminated, because it inexplicably pays hospitals more for services that are readily available in independent practices. Additionally, insurers should place a greater emphasis on short-term progress in delegating the responsibilities of risk and cost management to physician
groups and IPAs, as they are better positioned to cost effective quality care. Furthermore, advantageous policy changes could impact health care legislation in favor of small business like independent medical practices to fulfill ACA and Medicare requirements. This single change would affect some 53% of all employees in the U.S. (Catalyst, 2016), a significant impact in both savings and improved quality of care.

Managing the Continuum of Care

Analytically, the coordination of care looks at the care services across the care continuum including ambulatory, emergency, acute, and post-acute care. When the continuum of care is coordinated properly, the patients can receive proactive ambulatory care. As a result, the patients become equipped (through their provider) with predictive analytics that improve their capacity to self-manage the conditions such as chronic diseases. At the emergency levels, barriers to discharge are minimized and there are attempts to avoid unnecessary hospital admissions. At the acute level of the continuum, health care providers work collaboratively with the patient to manage their conditions throughout a variety of scenarios: primary care visits, telephonic care services, telehealth applications, home health visits, hospital admissions, bed days, and discharges…etc. The effective management of the care continuum will result in a reduction of the provision of unnecessary health care services. Coordinated care is an essential aspect of the value-driven independent medical practice because it prioritizes the type of care needed for the patient. Furthermore, this approach brings all the medical services together to deliver the highest-quality care possible to the patient.

Unlike larger health care entities that have the luxury of transferring their hospital admissions to their own post-acute facility, the independent practice can manage the transition of care in a coordinated effort with ancillary and specialty services while keeping the primary care
physician as the *captain* of the patients care program. Although independent practices are unlikely to own every aspect of the continuum, they can manage it by using relationships grounded in network theory. The theory states that organizations are social networks comprised of relationships operating in the same environment that share social, as well as economic motives (Rowley, 1997). For example, an independent primary care practice can manage the continuum of care through mutually beneficial relationships with narrow network of external medical services, such as specialists. All actors benefit from this relationship in different ways: the primary care physician sets the expectations on value for external medical services; which in turn enhances patient outcomes, and the specialists preserves a pipeline of referrals.

**Payer Negotiations**

The health care sector is focused on population health with the need to steady rising costs associated with delivering care; therefore, health care organizations and payers must negotiate terms of value-based contracting. There are consequences that are mutually beneficial: a larger revenue stream for payers, better patient satisfaction and engagement, and better patient outcomes (Gruessner, 2016). Negotiating with payers is stressful and requires a skillset not often associated with the typical health care professional. Additionally, knowledge of the ever-fluctuating regulations and payment models is required. Typically, payers negotiate their terms, and independent medical practices have little leverage to steer negotiations. Generally, these negotiations hinge on 3 factors: the financial terms including reimbursement rates; the operational components of working collaboratively (case management and accounts receivables); and strategic initiatives centered on value-based agreements (health care, n.d.). Therefore, the independent practice must address these needs, and plan accordingly if the goal is to deliver value. The ability to negotiate effectively with payers is essential if the independent practice hopes to survive.
First, a committee of key stakeholders must be organized which should include a variety of leaders representing the finance department, physicians, executive management, and additional subject matter experts as needed. This internal committee would be tasked with reviewing and maintaining the contract portfolio. Furthermore, the committee would monitor, improve, and dictate the contracting strategy going forward for the medical practice. The negotiation process includes a series of steps. First, the committee should estimate the yield expected to the practice from the contract terms, then determine actual yield. This involves reviewing service line data, and the overall financial impact to the organization. Second, data must be used to formalize the negotiation process by reviewing past organizational performance and the contract’s impact on past performance. Furthermore, vulnerabilities must be identified, and there must be a consensus on the negotiation strategy upfront. This will ensure the committee is prepared in advance. (Get Exactly, n.d.). Third, a clear plan must be created. Best in class health care organizations plan for contract negotiations three to six months in advance. In the plan, the baseline patient population must be defined for proposal iterations that include specific date ranges, payers and services. Additionally, the plan should contain clear achievable objectives for the medical practice (health care, n.d.). Contract negotiation is both an individualized skill, and a coordinated team effort amongst the stakeholders involved. It’s important to note that specialized knowledge is required to articulate and decipher contract terms, provisions and the overall jargon often associated with contracts.

**Funding Capital Expenditures**

Financial pressure threatens the existence of independent medical practices. At this point, it’s estimated that only 1 in 3 physicians remains in private practice. The trend intensified between 2012-2015, when the number of hospital-employed physicians increased by 50 percent. In a recent
survey, featuring more than 1,100 respondents from across the nation independent physicians are impacted financially and choose to be employed by a hospital or hospital system. It was found that physicians affiliated with these larger entities are paid about $74 on average for office visits coded for new patients, while independent physicians are paid an average of $58.40 (Rosty, 2017). Of course, this is not surprising news since hospitals have the leverage to negotiate better rates with insurers. Furthermore, hospital systems have been buying physician groups at a steady rate to strengthen their provider networks and prepare for the time when they will be paid based on their effectiveness in enhancing enrolled populations outcomes.

Reform and market changes are accelerating the need for capital to fund physician employment, remodels, expansions, HIT, supplies, equipment, and support labor for the independent medical practice. The emerging value-based care delivery and payment system requires new and expensive organizational competencies which require substantial capital investments. As mentioned before, the MU incentive program has offered substantial financial rewards to providers who implement EHR to report quality metrics. These types of incentive programs have prompted a significant expansion of HIT; which in turn, has led for the need for independent medical practices to understand the financing mechanisms that make this expansion possible. It is estimated that the EHR implementation cost for an average five-physician practice is $162,000, with $85,500 in maintenance expenses during the first year (Fleming, 2011). It’s important to note that these figures do not include the hundreds of man-hours needed to prepare for and implement the EHR. Ultimately, independent practices must invest in HIT to improve patient safety, reduce errors, create efficiencies, and capture analytics to enhance patient outcomes.

Independent medical practices must evaluate the best way to fund capital expenditures, or they will eventually succumb to consolidation into a larger entity that will provide these resources.
However, this is not an option for those that wish to remain independent. Most independent practices have experienced limited capital access, fewer borrowing options, higher cost of capital, more restrictive terms, less flexibility, and higher risks related to the borrowing options available when compared to larger health care organizations. Before evaluating the various options to consider, the leadership team must have an accurate picture of the organization’s current strategic and financial position, including market and competitive standing, key market demand/volume trends, programs/service line strengths and differentiators. The same amount of rigor must be applied to understand the weaknesses and needs within the organization as well: financial standing, capital position, and debt capacity with respect to its current financial trajectory. Furthermore, every independent practice should assess the expected impact of health reform and market forces on an ongoing and regular basis.

Financing for independent medical practices can be done in a variety of ways such as debt financing (lender), leasing, private equity financing, outsourcing or other legal arrangements. Each option is worth understanding and tracking as executives begin to access their options. Access to capital by independent practices is crucial not only for their own future, but to the future shape of the overall health care system. It’s important to note that independent practices can buy resources outright if operating cash flow is sufficient. The ability to reinject profits back into the organization is a sure sign that the organization’s model is already profitable and the added investments in infrastructure will further enhance the organizations success. For those practices seeking a lone, a strong credit position can prove invaluable. During times of need, health care organizations with stronger credit profiles (creditworthiness) have more flexible borrowing alternatives that result in access to lower-cost restructuring opportunities. Oftentimes, the state of the economy influences the best course of action. For example, interest rates may be lower during
an economic slowdown; therefore, its more affordable to borrow money. Loans to buy equipment are usually secured either through banks or through equipment financing companies. Bank term loans often last for the expected useful life of the equipment, with five years being typical (Lips, 2010).

Private equity firms are showing an increased interest for investing in independent medical practices and offers a viable option for those that are seeking capital. This increased interest is a direct result of independent practices believing they need to secure a partner to better navigate the transition to value, all while retaining its independence. There is a growing number of investments that private-equity firms are making in primary-care physician practices. Specifically, these investors are targeting medical practices that are at the forefront of offering new care delivery and payment models (Rogerson, 2016). According to S&P Global Market Intelligence, private equity firms made 217 investments in health care in 2017, more than 7 percent of all deals. Five years ago, they made 172 investments, or 4.8 percent of all sales (Brennan, 2018). Partnering with a private equity group can give the independent practice both, capital and a strategic partner. There can be advantages on the operational side as well. The partnership could provide administrative support, and subject matter expertise that the practice is lacking otherwise. Additionally, and perhaps most importantly, the partnership will provide the capital needed to invest in the infrastructure needed to deliver value-based care. For example, private equity groups can provide capital to update equipment and technology, improve operations and efficiency, add service lines, and expand facilities. This option offers the independent practice an alternative to being acquired by a hospital system (Gregory, 2017). Private equity may be attractive to physicians who seek to retain equity and control their medical practices, while also benefitting from the expertise and resources provided by private equity firms (Herschman & Schtern, 2017).
If groups wish to keep their independence, selling to a hospital might come with less complication, but it also comes with less control; whereas, private equity partnership will provide a more flexible structure but comes with a heavier administrative burden. Also, it should be noted that these private-equity firms see the opportunity to eventually sell these independent medical practices to insurers or health systems (Rogerson, 2016). In fact, the primary goal of private investors is to maximize the purchase price should the practice ever sell. Practice stakeholders may have been offered equity in the arrangement as well, which would allow them to participate in the proceeds upon sale. It’s important to note that private equity groups have as much power as is allowed by the agreed upon terms that outline the partnership with the medical practice. Therefore, private equity groups can own a lesser percentage, while original ownership retains overall control of practice. Of course, the private equity group’s percentage is dependent on the amount of resources provided to the medical practice.

Independent practices may find it more economical to lease equipment rather than purchase it outright. A lease is usually cheaper than a conventional loan, and some leases offer a more flexible payment schedule than is permitted by typical bank financing. For example, leases today often give the lessee an option to purchase the equipment within the first half year and terminate the lease, although this option often requires an additional fee to exercise it. A lease involves small up-front costs or even no up-front costs which allow the practice to use cash for other business needs. The health care sector is at the forefront of cutting-edge product development fueled by key innovations. As a result, equipment and technology becomes obsolete quickly; therefore, leasing resources rather than owning them will allow the independent practice to replace equipment as technology and equipment continue to evolve. An added benefit is that health care providers can pilot new equipment and processes without fully committing to them. It’s important to note that
capital budgeting is subject to closer scrutiny and a longer approval process than leasing is (Lips, 2010).

Leasing a medical facility offers some benefits when compared to purchasing a facility outright. This is especially true for those expanding into untested pockets within a geographic area or attempting to expand into new markets altogether. It’s important to note, that this strategy allows the practice to test the growth potential in a given area without allocating a large sum of funds for the purchase of a facility. However, the practice will likely be responsible for the cost of the build-out, which can be significant; unless, the practice leases a previously existing medical facility. Yet another consideration is that leasable space is much more plentiful while commercial properties for sale are limited. Approximately 98% of all suitable commercial space is for lease, not for sale. Some points to consider when faced with the decision of whether to lease or buy facilities: It is beneficial to pay a mortgage versus a lease, assuming the monthly payments are roughly the same, because the mortgage will eventually be paid off. Additionally, equity in a purchased property will increase over time (Grandfield & Willerton, 2014).

**Resources for the Independent Medical Practice**

Independent practice stakeholders, especially health care providers, must accept and learn the rules for delivering value. Part of their leadership role is being an advocate for the merits of a value-based health care system, and for preaching the advantages of remaining an independent physician-led medical practice. The attitude of "I don't have time for that" is another way of saying, "I don't have time to focus on patient outcomes". It's as simple as that. It is unlikely that the independent practice will survive unless leadership adjusts its mindset to align with changes in the health care industry. But if the obstacle in the health care professional’s mind is "I can't do it alone," they can simply turn to one or more organizations that have specific expertise and a
willingness to offer guidance. Physicians and administrators seeking to establish or enhance an independent practice can join forces with America’s Physician Groups (APG), the American Medical Group Association (AMGA), and the American College of Health Care Executives (ACHE). However, many independent practices may identify with the very popular Medical Group Management Association (MGMA), as it’s perspective is closely affiliated with the group practice model.

These associations can empower practices, providers and administrators, to be at the forefront of change in the health care industry. Furthermore, members can utilize the wealth of resources made available by these associations to achieve personal goals, advance professional careers, initiate change and drive results for their respective medical practice. Additionally, these associations provide benchmarking data and statistics, foster peer-to-peer support, and offer educational conferences centered around the latest health care trends. These associations are more like a community of like-minded leaders that offer political advocacy, professional certification, mentorship and networking programs. Independent medical practices should also seek guidance from the established independent practices, IPAs, ACOs, and accredited PCMH entities that offer practical experience and resources. Leadership in the full potential of a successful independent practice is choice health care professionals must make to maximize their positive impact, but they do not have to carry the weight alone.

**Conclusion**

This exploratory paper discusses how the U.S. volume-based health care system emerged and ultimately weakened positive patient outcomes to sub-par levels. While independent practices have fallen to historical lows, they represent the leading factor in developing the value-based system the nation needs, using new models aimed at sustainability for current and future health
care providers. The current state of health care in the U.S. reveals a dramatic need for improvement in both quality of care and cost control. To that extent, the following four conclusions are evident:

1. The Front Line for Health Care Solutions Lies in the Hands of Health Care Providers

   The transition to value-based care is the conceptual antithesis of the previous system, the one that saw U.S. health care costs skyrocket since the 1960s, rising at a pace over 50 times faster than real wages, while achieving a ranking in the bottom 10% of 55 nations. The U.S. system outscreens every other country when it comes to health care, and yet some 44 million people lack any type of medical coverage, the nation's life expectancy is dropping, and for mothers giving birth, almost any other country would increase her odds of surviving. Yes, there is a need for cost reductions so that U.S. health care is more affordable and accessible. No nation, not even one as rich as the U.S., can afford to spend billions of dollars a year in actively caring for its people, and billions of dollars more in caring for those who have no other viable access to the health care system. Therefore, the goal becomes to merge cost reductions with improved access to services, to make health and well-being the goals, and develop the new system with that concept as its foundation. The only way to achieve that goal is by developing patient-centric practice models centered on physicians as the key drivers. Their profession and training, along with that of other health care professionals in the industry, must place their focus on the patient. Ultimately, this will drive alignment of the health care system to a common goal: quality outcomes for its patients.

2. Direct Primary Care Models Cannot Do It Alone

   Health care providers working together with strong administrative support is a good start, but for the system to achieve industry-wide success, health care professionals must prepare for policy changes and seek policy changes through advocacy programs when appropriate. The rules
of the game must also align with the goals and processes of the value-based system. Policy creates the incentives that propel actions. To secure the proper alignment, health care professionals must provide constant and consistent input. The independent medical practice must lead the way in creating new models that focus on better health outcomes. This requires a more proactive attitude about the benefits that a coordinate care model offers, a change that embraces preventative care rather than palliative care. The large-scale health problems in the U.S., such as obesity, chronic diseases, reduction in vaccinations, rising costs, and unnecessary medical procedures, did not arise overnight, nor can they be treated with a loan silver bullet. Addressing these issues to see them significantly reduced means using expertise coupled with communication, technology, and a flexible mindset that adjusts with the latest trends in health care. Physicians working individually and in independent practices must help patients understand the difference between current and new models of health care. That the new model will enhance their ability to successfully achieve their health care outcomes. And to the physician who ask, "Why should I take that on?” the answer is simple: Because it’s about what’s best for the patient.

3. Health Care Professionals Need to Integrate into a Value-Based Network

The traditional doctor model, as a single practitioner seeing people in the office or visiting patients in their homes was a successful model for decades. But times changed, and the solo practitioner of the current period faces a wider range of barriers that make it more difficult to sustain an independent practice, much less a one-person operation. Furthermore, a network is essential to delivering quality care. The options are clear: join other physicians and health care professionals in an established independent support network or build one. Positive community health outcomes are easier to achieve with a community of health care support. Physicians need to understand the new environment, the laws and regulations that impact health outcomes as well as
revenue and accept their role as leaders of the transition. The strength in unity within an independent primary care network is a path to success for health care professionals and for patients.


The data is clear: independent physician-led primary care models rate higher in success factors than hospitals (Concierge, 2018; Goldmsith, 2017). The sustainability of independent medical practices is crucial. This is not to say that hospitals should be dismissed, but rather that the value-based system is better served by physicians leading the way to better patient outcomes while stemming the rising cost of health care. The flexibility of networks consisting of IPAs, ACOs, PCMHs, along with a myriad of independent medical practices offer a blueprint for those medical practices that are steadfast in their quest to remain fiercely independent. The volume-based system did not work: it weakened U.S. health care in ways that could take decades to overcome. For the transition to become a fruitful reality, physicians and administrators alike must step forward as health care leaders and embrace change. We can enhance and sustain the independent medical practice model through the consideration of the elements outlined in this exploratory paper.
References


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