Leading Change in Private Practice through Physician Engagement

Exploratory Paper

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Leading Change in Private Practice through Physician Engagement

Leading physicians through the process of change is a challenging task for practice administrators in today’s health care environment. There are many difficult decisions that administrators and physicians will be faced with, and physician engagement is critical to the success of the change initiative. Addressing various types of physician practice models as well as payment options can help a private medical practice survive and even thrive during periods of rapid change, declining reimbursements, and growing costs of technology arising from health reform.

Physicians and staff expect leadership to be supportive, concerned, and committed to their welfare while understanding that tough decisions need to be made. There needs to be an element of trust between leadership and the rest of the staff, which will make coping with change much easier. Administrators play a vital role in change implementation, from the announcement to the execution of the change (Bacal, 2009).

This paper will discuss how important the physician-administrator relationship is in achieving success in the areas of communication, physician integration, and contracting, and the role of technology in quality measures. The objectives of this paper is to demonstrate the process of change, understand practice objectives for the future, and help administrators and physicians navigate health reform requirements.

**Physician Integration and Alignment**

The practice administrator should consider the many types of physician integration systems. Many physicians in private practice may be approached by colleagues who belong to one of these organizations, and it is important to understand how they may or may not fit their particular practice structure.
Independent Practice Associations (IPAs)

Independent Practice Associations (IPAs) consist of a network of physicians who agree to participate in an association to contract with Health Maintenance Organizations (HMOs) and other managed care plans. Although physicians maintain ownership of their practices and administer their own offices, the IPA serves as a corporate structure for negotiating and administering HMO contracts for its physician members.

Advantages of IPA

- It is a means for physicians to participate in true managed care risk contracting
- There is low capitalization/risk model for physicians to mature into managed care for populations, as a group
- Participating physicians maintain professional and financial autonomy and independent legal status
- Potential access to sophisticated financial/claims processing and utilization review and quality management systems
- Depending on the provider mix it can produce cost efficiencies and improved utilization profiles
- Increased leverage in negotiations with hospitals and payers for capitation or bundled rates and inpatient risk pool
- Advanced IPA models achieve value innovation of well-established integrated group practices

Disadvantages of IPA

- Could be difficult to create same efficiencies as integrated group practice
- Difficulties in capital formation; weak systems infrastructure
- Often unwieldy, specialists-dominated governance
- Does not affect the expense side of physician practice legal issues
- Antitrust may negotiate capitation rates; same antitrust concerns regarding PPO-style discounted fee for service contracting
- Legal form/corporate practice of medicine because providing services must comply with state law regarding medial partnership
- Care must be taken to avoid aggregation and disqualification of participating physicians’ pension plans
- Peer review and credentialing issues; potential for new malpractice liability

What Physicians Want in an IPA

1. Preservation of clinical autonomy
2. Maintenance of business independence
3. Affiliation relationship
4. Negotiation leverage
5. Enjoyment of cost efficiencies
6. Preservation or growth of market share
7. Enhancement of relationship between providers
8. Maximization of economies of scale
9. Access to better advisors than they can afford as individuals
10. Primary data ownership to measure and publish outcomes

Physician Hospital Organizations (PHOs)

A Physician Hospital Organization (PHOs) is an organization that unites a specific hospital and certain physicians through a contractual relationship. When a hospital forms an alignment with physicians in a PHO, the main focus is to strengthen loyalty and alliances so that the physician’s practices will refer and carry out procedures at that particular hospital. Physicians have the backing of the hospital’s resources and the hospital has the referrals from the physicians.
PHO Advantages

- Care Management opportunities
- Information Technology
- Practices can share in resources while remaining in their own independent practice

PHO Disadvantages

- Scrutinized negotiations by the Federal Trade Commission between health insurers and physicians in PHOs
- Difficulty in participating in Care Management

Management Services Organizations (MSOs)

A Management Services Organization (MSO) is an organization owned by a group of physicians, a physician-hospital joint venture, or investors in conjunction with physicians. In some cases, the hospital owns the service bureau that sells various management services to the medical staff. In other cases, it can act as a quasi-third party funded employers, unions, and even insurance companies (Todd, 2013).

MSOs generally provide practice management and administrative support services to individual physicians, Independent Practice Associations (IPAs), Physician Hospital Organizations (PHOs), or small group practices. One function of MSOs is to relieve physicians of nonmedical business functions so that they can concentrate on clinical functions and patients.

Management Services Organizations should have three basic elements as part of their relationship with providers.

1. Management service and access to capital for expansion and growth
2. Economic integration, governance, real estate, compensation, and quality improvement
3. If desired by the physicians, the MSO can purchase certain assets of the group to provide equity that might not have been available previously (Todd, 2013).
MSO Advantages

The primary advantage to joining an MSO is to have access to management services and to ensure best pricing on supplies and services. In addition, listed are other advantages:

- Operational management
- Financial management
- Personnel management
- Staff education and training
- Billing and collections services
- IT resources and consolidation
- Expanded benefits for staff (health insurance, 401K)
- Managed Care and contract management
- Group purchasing

MSO Disadvantages

- Time Investment
- Cultural Mismatch
- Implementation
- Legal Issues

Some disadvantages of Management Service Organizations include the time investment once entering into an agreement. It is important to review the package in depth to ensure the service offerings cover all your requirements. Once the practice has entered into an agreement with an MSO, it is important for both physicians and employees to get up to speed on policies and procedures the MSO uses across all services it provides as these will differ in many cases from what the practice currently has in place.
Another common problem to outsourcing is cultural mismatch between the MSO and the practice which can lead to loss of trust and communication. Practices will in most cases be required to convert over to the MSOs IT standard and use one computer system, this can create disruption in normal business activity. Converting over to the MSOs IT standard also means a loss of control over a significant portion on your business. This loss of control can make it difficult to adjust for both physicians and staff.

Types of Payment Models

Practice administrators are expected to keep up with the direction of healthcare regarding government regulations and payer contracts. Examples would be the most recent changes in payer contracts with regards to quality measures. Communicating to providers about how demonstrating quality and the effect on reimbursement is key to the success of the practice. With the introduction of shared savings/risk contracts, it is important to communicate to physicians what type of measures their specialty should report and how those quality metrics affect compliance with requirements of certain insurance plans. Some examples include shared/risk contracts and Bundled Payments—Episode-of-Care.

Reimbursement in shared savings/risk contracts is based on fee-for-service methodology but may include risks as well as components to reward quality and cost efficiency (Jacobsen, 2016). These fee-for-value models represent an evolution in clinical and payment methodologies that focus on creating quality outcomes, fostering greater accountability and substantial medical technology innovations requiring a higher degree of risk from providers relative to payment for services. The reimbursement models are transforming to include Triple Aim, narrow networks, patient liability, transparency and quality metrics. The goal is to take value-based contracting and align incentives with payers, providers, and patients to improve health outcomes, lower costs, and provide a better patient experience. The following chart outlines the example of the Triple Aim concept:
Commonwealth Fund explained the significance of the Triple Aim:

Pursuing these three objectives at once allows healthcare organizations to identify and fix problems such as poor coordination of care and overuse of medical services. It also helps them focus attention on and redirect resources to activities that have the greatest impact on health. Without balanced attention to these three overarching aims, healthcare organization may increase quality at the expense of costs, or vice versa. Alternatively, they may decrease cost while creating a dissatisfying experience for patients (McCarthy & Klein, 2010).

**Bundled Payments—Episode-of-Care**

Pay-for-performance and episodes-of-care are two types of bundled payment alternatives that payers are engaging providers to help lower healthcare costs. Pay-for-performance contracts are a shift from traditional fee-for-service contracts to rewarding value. The fee-for-service agreements simply pay a provider for the service codes at a negotiated rate and are based on health outcomes and lower healthcare
costs. The savings gained in the quality agreements is typically shared 50/50 with the provider and payer, saving the plan by lowering cost as well as giving the provider incentive for higher quality care.

Physician owned private practices will either chose to participate with the Merit-based Incentive Program (MIPS) if they have the Medicare volume or if the volume is below the threshold of $30,000 billed to Medicare in claims and provides care to more than 100 Medicare patients in a year. If yes, they would need to report measures, if not, they would be exempt. It is important for the manager to know how many Medicare patients they serve within their practice. This will also depend on the type of practice specialty and the geographic area. If a practice meets the requirements to report MIPS yet does not report it, the providers will receive a downward adjustment of 4% the following year. If providers are exempt, their reimbursement will remain the same with no downward or upward adjustment.

Value-based contracting is about aligning incentives with the goal of creating a relationship with the payer, network, or employer that will reward the practice for effectively implementing the Triple Aim. This transformation involves a number of considerations for providers to contemplate including: identification of high-quality/low cost providers through quality metrics and cost comparisons, claims based outcome data, consumer education regarding provider performance, and increasing patient liability and driving transformation through the patient (Jacobsen, 2016).

**Value Based Managed Care Advantages**

- It makes payment easier
- There is a huge incentive to providers to be cost-conscience
- There is incentive for providers to remain up-to-date on ways to control costs
Value Based Managed Care Disadvantages

- Technology changes—what make sense for bundled payments today may not in five years
- Revising bundles is difficult
- Because revising is difficult, a disincentive may arise for remaining up-to-date using better technology
- Accounting and overhead cost remain difficult
- Addressing items that are not covered in the bundle can be difficult

Considerations in Managed Care Contracting

Establishing a successful contracting strategy requires ongoing oversight and a contract monitoring system. These are some suggested steps to consider during the contracting evaluation process:

- Define practice roles and responsibilities for contracting
- Analyze current contract performance and establish baseline performance
- Establish timelines for negotiations
• Secure a provider champion to support the process
• Remove emotion from the equation
• Focus on creating a collaborative relationship with payer partners
• Focus on short and long term goals
• Consider new approaches and focus on bringing the practice into value-based contract agreements

When approaching a payer, one should consider where one is as a practice, what value does the practice bring to the payer and how the practice or the providers are better than the competition. Once the foundation has been developed, the provider can approach the payer and let them know they would like to negotiate, listing all the things that make their practice add value to the network.

**Using data as a negotiating tool**

Knowing how the practice is performing is critical for the practice administrator in contract negotiations. The payer knows how the provider is performing with regards to levels of service for outpatient services and how often they perform certain procedures. Payers profile providers and it is important to know where a provider stands with the payer. Practice administrators should monitor payer websites to see how their providers are ranked; for example, some payers will rank a provider based on quality measures and cost.

**Improving Data**

Common practice data should include the following:

• Charges and relative value units (RVUs)
• Payments and adjustments
• Accounts receivable
• Staff working hours
• Number of appeals per payer per CPT code
• Pending authorizations
- Referral pattern by referring providers
- Number of days to the next available appointment

It is important to monitor outstanding claims as well as the number of new patients by the provider on a monthly basis. Monthly reporting is important to discover any change in payer or provider patterns that may need to be addressed. For example, is it taking too long to get a new patient an appointment? If it is taking long periods of time to get patients in the office, it may be time to consider adding additional providers to accommodate the patient demand. One should monitor payer’s performance, such as payments and denials, to determine if the practice should stop accepting certain payers based on performance or lack of reimbursement. Continual monitoring of practice performance can help the practice administrator find areas of improvement before major issues arise and make for smarter business decisions. Knowing the aspects of Triple Aim and how they tie in with the managed care vision will help the practice in meeting all three areas in the negotiations (Medical Group Management Association, 2013).

**Technology’s Role in Healthcare**

It is important to have transparency and make information about quality and cost available to the patient before services are provided. This can be challenging because with computers and the internet, patients can review providers online as well as on the payer’s website. It is important to note that having good ratings in both online reviews and with payers can make a difference in reimbursement and patient volume. A study by Judith Hibbard, D.P.H., senior researcher at the Health Policy Research Group, University of Oregon sought to determine how different representations of cost and quality information affected the likelihood of consumers making high-value choices (Jacobsen, 2016).

The study, which involved 1,421 consumers, found that significant numbers of respondents—though not a majority—viewed higher cost as a proxy for higher quality. This was true even among those with high-deductible health plans that would expose them to a higher share of costs. But when the cost
and quality information was reported side by side in an easy-to-interpret format, more respondents made high-value choices. Labels indicating that providers made “appropriate usage” of resources or were “careful with your healthcare dollars” also led more people to choose high-value providers.

Narrow networks were created by payers, comprising of a select panel of providers in response to their customers seeking high-value healthcare at a low cost. Payers steer their members through these networks and expect certain benefits from providers, such as cost-efficient care, successful adherence to quality metrics, and high patient satisfaction. Results such as these are expected to drive down cost, which in theory should lower premium cost to members. Narrow networks were popular in the early 1990s, however are now back in existence as defined in the following:

Figure 3. Source: Narrow Networks

Network definitions are characterized as follows:

- Clinically integrated: Network of providers collaborating to improve and maintain the health of a given population
- High performance: Providers deemed to demonstrate high performance levels in cost efficiency and quality measures
• High value: Providers deemed to demonstrate strong performance in areas of cost efficiency and quality
• Employer/client specific: Network created by and for a specific employer/client group
• Tailored/narrow/sub network: Generally, a subset of the larger provider network
• Tiered: Network providers are assigned a tier based on cost efficiency and quality measures. For example, patients out of pocket cost vary based on provider selected; Tiered 1 provider: $25.00 co-payment, Tier 2 provider $75.00 co-payment (Jacobsen, 2016).

**Patient Liability**

Increasing patient liability as a trend in healthcare today makes the upfront time of service collections more important than ever. Healthcare is moving from volume based to value based with increasing deductibles and out of pocket co-insurance from members, and this has a huge impact the ability of a medical practice to grow and offer new services. It is very important for the practice administrator and physician leader to evaluate work flow processes when managed care contracts change. An example would be to collect upfront patient portion of office visits and surgeries and not wait until or if the insurance company pays the claim. This is a process that should be evaluated on an annual basis as plans change from year to year in many cases. An example of this change is when the Accountable Care Act (ACA) stated that every woman would receive 100% coverage for contraception services and no out of pocket cost would be incurred by the members. Now that some aspects of the ACA are no longer legally practiced, patients no longer have 100% coverage and have out of pocket costs which should be collected upfront at the time of service. Some patients will choose a less expensive alternative, and it is important to be aware of these types of changes before the practice provides the service so that it does not have to find out the coverage change after the claim is not paid in full and go after the patient for their portion of the service. Other considerations during the ACA were the retro-eligibility considerations. An example of this would be if a member had not paid their premium for 90 days, the plan may still pay for
the covered service. However, at day 91 they could come back to the provider of the service and state that the member was terminated and not covered due to non-payment. It would be important to know what type of plan patients have prior to providing services to make sure reimbursement is not negatively impacted and maximize contract performance (Hibbard, Greene, Sofaer, Firminger, & Hirsh, 2012).

If a practice has quality scores, accreditations that attest to it being a high-quality provider make sure that information is reported appropriately. Patients will likely use this information to facilitate the purchase of health services. If a practice is a specialty practice, primary care physicians will work with their patients to make referrals to providers that are high-quality and low-cost. It is important to be aware of the cost of provider services as it will have an impact on referral patterns and consideration of payers to offer value based managed care contracts.

Understanding quality measures and how they play a part in treating patients is important as well as having information readily available to the practice manager and physicians. Streamlining the prescribing process has become a major focus in health reform, and ensuring the electronic medical records system (EMR) has the ability to electronically prescribe, disease management capabilities, and integrated patient portal will help the practice manager comply with healthcare quality measures (Magnis, 2000).

**Leading Physicians through Change**

An administrator’s role in implementing change is to communicate the urgency of the change by planning and assessing the need to break away from the status quo. Managers can build a change culture by sharing information with as many staff as possible, allowing for suggestions, input, and participation in the change. When physicians feel insecure about what is happening, it can have a tremendous effect on how they react to the changes (Fischer, 2014).

With the increased demand for value, efficiency, productivity, and safety improvement, having mutual trust and respect for physician leaders and administrators is extremely important to the change
process. Understanding the changing landscape of healthcare such as hospitals acquiring other hospitals or medical groups to ensure referrals, young doctors coming out of residency are gravitating towards jobs that offer work/life balance. Many older physicians are dissatisfied with their chosen profession as patients have higher expectations than ever and want to play a larger role in their healthcare. (Kornacmi & Silveresin, 2012)

Shared vision helps build change, and it helps to have a vision statement, a mission statement or both so both providers and staff move in the same direction. Physicians want to treat patients and expect the administrator to do the rest, unfortunately it takes more than that to make a practice successful in a time of change. Administrators and physician leaders must work together to understand the requirements of insurance companies so that the practice can provide high quality, low cost healthcare to their patients.

Communicating with Providers

Communication is a process that allows people to exchange information by using several methods. Communication also is defined as the process of meaningful interaction among human beings (Littlejohn). When communicating with multiple providers, both male and female, in a practice, it is important to know what type of communication the providers respond to and their preference. Within the workplace, there are several forms of communication channels such as email, written memos, voice mail, and face to face communication.

Gender also plays a role in communication as men and women communicate in different ways. Our understanding of gender differences between the two can make communication much easier. According to a study by Deborah Tannen, she found the following differences in communication styles: Men tend to talk more than women in public settings, but women tend to talk more than men at home. Women are more inclined to face each other and make eye contact while talking, whereas men are more likely to look away from each other. Women tend to talk at length about one single topic, where men tend to jump from one topic to another. Men tend to listen in silence whereas women will say things such as “I
agree or I understand” while listening. Men tend to debate where women are more inclined to express agreement and support (Tannen, 1990). If people could just understand the differences in gender when communicating, there would be fewer misunderstandings.

In private practice, having a physician champion is critical to the process. A champion is someone who plays a significant role by lending their creditability and support to a change. They are opinion leaders who are influential because of their reputation or informal leadership qualities. Because many physicians are suspicious of management’s motives, the views and attitudes of peers are particularly powerful in fostering receptivity to a change among physicians. (Kornacki & Silversin, 2012, pp. 2–3).

Once the change team responsible for carrying out the change has been formed, frequent communication to develop an action plan and remaining aligned as the process unfolds is extremely important. Understanding how providers want to receive communication while moving forward is important to keep everyone moving in the right direction and up to date on progress.

For instance, practice administrators need to find out how providers want to receive updates—do they prefer written communication or face-to-face dialog? A determining factor is the type of information and how often it needs to be communicated. Some practices meet once a month face-to-face to exchange ideas with the targeted change team while the rest of the group prefer written updates and less frequent meetings.
Best Practices for Organization Change Management

Change is rarely easy and many people resist it. The following are some best practices to help facilitate the change necessary within a private practice to help in the transition.

- **Plan carefully**: Have a vision of how the end result will be once complete. Make a list of necessary tasks to be accomplished and outline how and by whom tasks will be performed.

- **Define your governance**: Have a framework for making decisions, roles and responsibilities for implementing change and keep physicians engaged in the process.

- **Assign leadership roles**: It is important to establish organizational leadership both with physician leaders and staff. The chosen leaders should be committed, reliable, and able to influence others.

- **Keep stakeholders in the loop**: Lines of communication should be kept open so that employees aren’t given information merely to help them understand what’s going on, but so they are also

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*Figure 4. Source: BOUNDLESS*
able to ask questions and voice their concerns along the process. Keeping staff and physicians informed about how the proposed changes will benefit them will go a long way.

- Find and support advocates: Good advocates should demonstrate strong leadership abilities as well as other professional and personal strengths that earn the respect of others. By having strong leaders who are respected by others within the practice, one can set a more positive tone, and that will ensure a smoother process.

- Constantly assess and review: By monitoring the change as it happens, measuring whether the implementation is successful, and making changes as necessary, one can avoid more costly mistakes that will cost them dearly later on. Ask for feedback once changes have been made and adjust accordingly.

- Address workforce concerns: It is critical that you keep the workforce in harmony as you make changes within the organization. Addressing staff concerns early on to prevent negative emotions concerning the changes taking place and how it is affecting them is important.

**Conclusion**

Leading a medical practice executive through health reforms by using the methods and information outlined in this paper will assist in improving medical practice’s operational impact and financial viability. Knowing the needs of the practice and understanding how to make the right decisions in a timely manner will have a positive effect on the practice. Having more options for the practice, such as physician integration or mergers, and understanding the different types of payment models will help successfully lead the medical practice through health reform. In addition, installing a proper electronic health-records system, and hiring employees who understand this system can play a key role in meeting the requirements for new government mandates and quality-measure reporting, is important in navigating
new types of reimbursement models. Adequate information and an understanding of the future directions of health reform will help administrators and physicians navigate the complex systems of change and shifting expectations from payers.
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