A SERVICE OF nrc HEALTH

System Focus

March 2018

Top Five Trends for Medical Groups in 2018: What Health System Boards Must Know About the Changing Physician Environment

By Susan Corneliuson, Director, Performance Partner, and Guy M. Masters, M.P.A., Principal, Premier, Inc.

Physician alignment remains a top priority for health systems in 2018. The following five trends for medical groups will help governing boards understand the challenges, opportunities, priorities, and concerns affecting both employed and independent physicians. Boards should look for ways to ensure that their strategic plans and priorities address these essential market dynamics.

Key Board Takeaways

- Create a solid ambulatory infrastructure to maximize performance across the physician enterprise through the standardization of operational workflows, integration of governance and management structures, and investment in ambulatory value-based tools.
- Expand traditional primary care access points to accommodate new patients, those with chronic care needs, as well as alternative points of intake such as e-visits, retail clinics, urgent care centers, and others.
- Increase market relevance by bolstering your competency to support and manage diverse and larger patient populations by building care teams and digital strategies that support physicians' unique populations.
- Align digital and social media strategies with characteristics of niche market segments.
- Limit outmigration and increase patient capture rates by optimizing physician referral management systems and using referral coordinators.

1. Focus on Outpatient Accessibility and Optimization

With the transition to value-based care, continued effort is needed to build solid ambulatory strategies that allow health systems to manage care across the continuum. According to the American Hospital Association (AHA) Environmental Scan,[1] hospitals now generate more than 47 percent of their revenue from outpatient care, and a 2017 study by Foley and Lardner shows that more than 75 percent of institutions are offering some form of telemedicine.[2] While these efforts represent positive early steps to expand beyond the four walls of the hospital, the recent spate of acquisitions aimed at vertical integration across the continuum as well as disruptive new entrants aimed at cherry-picking high-value physician targets signals a need for faster action.

What to do: To remain competitive, health systems need to be thinking about ways to expand traditional primary care access points to accommodate new patients and those with chronic care needs, as well as alternative venues (i.e., urgent care centers, retail clinics, and e-visits) for simple/low-acuity patients that can help grow market share. Health systems also need to optimize ambulatory infrastructure through the standardization of operational workflows, integration of governance and management structures, and investment in ambulatory

[1] AHA, *2018 Environmental Scan.*
[2] Foley & Lardner, *2017 Telemedicine and Digital Health Survey*, 2017.

value-based tools to maximize performance across the physician enterprise. Acquisitions alone will not yield the type of results systems are seeking and could lead to further losses if a solid ambulatory infrastructure is not established.

2. Changing Consumer and Payer Expectations: Access, Quality, and Cost

Consumerism continues to proliferate and is seen most acutely in the outpatient arena. Consumers are increasingly more selective in how and when they want to be seen, and have increased access to cost and quality performance data, which is starting to drive their clinical choices. Payers are also looking for lower-cost alternatives as evidenced by Anthem Blue Cross and Blue Shield's recent decision to no longer pay for MRIs and CTs performed on an outpatient basis by hospitals.

What to do: In light of this trend, health systems need to look for lower-cost alternatives to ancillary services, suggesting a potential return of such services to medical group settings or freestanding centers. Quality services can be offered in lower-cost ambulatory settings convenient to patients without the added expense of hospital overhead, while meeting consumer and payer expectations.

3. Individualized Patient-Centered Care Models Compete with Disrupters

New entrants are taking advantage of niche markets that have not been well served by the traditional healthcare system, and are developing new care models to serve these untapped patient populations (i.e., Medicare Advantage, Medicaid). Health systems need to be aware of these market dynamics and should apply strategies to bolster their competency at managing diverse patient populations within their employed and aligned medical groups.

What to do: Systems should work with their medical groups to build care teams and digital strategies that support their physicians' unique populations and allow them to manage larger panels of patients. It will be increasingly important to consider the types of patients being treated and the resources required to maintain their health, be it high-touch (e.g., frequent visits, routine follow-up calls, and care management support services) or low-touch (e.g., self-help/patient portal, text/email, and e-visits) services. Healthcare organizations will need to clearly align their digital and social media strategy with their market segmentation. For example, a clinic located in a rural setting with a high Medicare/Medicaid population and limited Internet service will require a less sophisticated digital/social media strategy and more face-to-face support services than an urban area with an increased appetite for technology and on-demand access. The one-size-fits-all approach to care will have limited effectiveness as we continue to evolve and as more disruptive innovators enter the marketplace.

4. In-Network Referrals and Outmigration Management

Building bigger mousetraps with more accessible entrance points and high-quality cheese will do little to manage cost in a risk-based environment if there isn't a strategy in place to effectively manage referrals within the network. A typical primary care provider with an average panel size of 2,000 patients commands, on average, $10 million in annual revenue—5 percent of which is attributed to the primary care setting and 95 percent to downstream referrals.[3] Yet only half of these referrals result in a completed appointment.[4]

---

[3] F. Mostashari, D. Sanghavi, and M. McClellan, "Health Reform and Physician-Led Accountable Care: The Paradox of Primary Care Physician Leadership," *JAMA*, May 14, 2014, pp. 1855–1856.

[4] M. Barnett, Z. Song, and B. Landon, "Trends in Physician Referrals in the United States," *Arch Intern Med*., January 23, 2012, pp. 163–170.

What to do: It is essential that health systems work with their medical groups to optimize their referral management systems operationally, through the use of enhanced EMR technology and direct contracting with employers. Referral coordinators are key resources that should be included as components of each provider's care team. These individuals are responsible for engaging patients throughout the referral process, and for closing the loop on each and every referral. In addition, health systems should look for opportunities to partner with providers for direct-to-employer contracts utilizing tiered pricing structures to limit outmigration and increase capture rates. Health systems and physician enterprise leaders need to ensure that key players and influencers are engaged at each stage of the referral process, and that there is real-time visibility through EMR workflows and enhanced data analytics into the referral management process.

5. Compensation Models Evolving to Include Risk-Based Incentives

Finally, provider incentive structures will need to mature to incent the right types of behaviors in a risk-based environment. Gone are the days of the full wRVU-driven compensation model. Organizations should look at risk-based adjusted panel sizes as a metric for establishing base compensation in lieu of wRVUs, with non-productivity-based incentives (i.e., patient satisfaction and engagement, quality metrics, citizenship, and financial) representing at least 20 percent of total compensation.

What to do: Incentives should be appropriately tied to organizational goals; reflect local market dynamics; and be transparent, generally accepted by providers, and easy to measure.

Final Board Notes

Governing boards of health systems must take into consideration each of these trends as strategic plans and policies are fine-tuned to take advantage of consumer-oriented opportunities and adapt to changing physician needs. This includes continuing to focus on outpatient accessibility and costs, penetrating niche markets through specialized care teams and targeted digital and social media strategies, addressing healthcare needs of more sophisticated and better-informed consumers and payers, better managing in-network referrals, and ensuring that compensation models incent physician behavior using risk-based criteria, where appropriate.

The Governance Institute thanks Susan Corneliuson, Director, Performance Partner, Premier, Inc., and Guy M. Masters, M.P.A., Principal, Premier, Inc., and Governance Institute Advisor, for contributing this article.
They can be reached at susan_corneliuson@premierinc.com and guy_masters@premierinc.com.

■■■