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Who Are You?

When I read this question, I hear the smoking caterpillar from Lewis Carroll's *Alice in Wonderland* (the Disney version…), repeating it over and over, slowly, condescendingly, inquisitively, plunging Alice into deeper confusion with each repetition. Hospital-centric healthcare organizations are not unlike Alice in this healthcare rabbit hole we have found ourselves falling into. Instead of telling the caterpillar that smoking is bad for your health, we need to spend some time digging deeper into the state of hospital-based care in our delivery system, where we are in the transformation journey to integrated, outpatient, technology-enabled patient-centered care, and how we can accelerate that to emerge from this confusing and turbulent rabbit hole before the Queen of Hearts announces, "Off with their heads!"

This level of transformation takes time, as we all know, and I have heard too many times people in healthcare saying that healthcare just moves more slowly. Yet we now have disruptive players swooping in and moving quickly. We know we can't "move fast and break stuff" without causing harm to our patients and communities. But we must find a more feasible niche where we can try things on, test, fail, learn, and improve. And now we must do this most difficult work in an era of political and cultural polarization that is impacting healthcare directly.

In the end, it comes down to strategy. That's not a new answer, but what is new are the goals, objectives, and tactics. The articles in this issue dive into the critical importance of looking at strategy through a new lens, from defining your "who," to the physician enterprise, primary care, and building "two-way healthcare" that creates more understanding between healthcare organizations and patients.

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Editor in Chief & Senior Director

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What Is Our Organization Trying to Be? Strategic Planning after Turbulence

By Amanda Steele and Dan Clarin, Kaufman, Hall & Associates, LLC

For the last several years, healthcare organization boards and leaders have confronted multiple existential threats, leaving little time for long-range strategic planning.

In the late 2010s, a wave of disruptive new tech-savvy healthcare entrants emerged, intent on advancing care delivery to meet evolving consumer demands for more convenient, digitally enabled access. Traditional providers scrambled to keep pace, but the acute day-to-day crises of the pandemic's first two years—from March 2020 through the Omicron wave in early 2022—put many of these strategic initiatives on hold.

Throughout 2022, even as Omicron and the pandemic's overall severity receded, labor and cost pressures continued to accelerate, and federal COVID relief funding began winding down. This perfect storm led to one of the worst financial years hospitals have ever experienced.

Healthcare systems generally responded to these pressures by:

1. Implementing incremental cost reduction and performance improvement efforts to remain financially sustainable
2. Engaging in new partnerships, acquisitions, and mergers to seek the benefits of scale

In the near term, these responses to the pandemic's aftermath may have created breathing room for some organizations. In 2023, median U.S. hospital margins were 2.3 percent at year's end, according to Kaufman Hall's National Hospital Report.

In the long run, though, incremental efforts are not sufficient to effectively transform. Despite being positive, hospital margins of 1–3 percent will not yield long-term sustainability. There is only so much cost an organization can remove from its operations. And scale without a deliberate value proposition can sometimes lead organizations to pursue new initiatives or facilities without a sufficient organizational commitment or alignment to a clear goal.

Enterprise Strategy's Moment

In the first quarter of 2024, we are seeing leading healthcare organizations invest significant time and effort into rethinking their enterprise strategy. Boards and senior leaders can initiate this process by determining "what our organization is trying to be," or what the organization's perceived value is to patients, consumers, and communities—their strategic vision.

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From there, organizations must be able to adjust their strategic vision, initiatives, goals, and metrics to support continuous transformation toward their value proposition:

- The **vision** is a view of the organization's future destination.
- **Strategic initiatives** are the methods used to achieve the vision.
- **Goals** are the outcomes organizations seek to achieve for their patients, communities, and other stakeholders.
- **Metrics** measure the progress toward those goals.

Together, this strategy development effort should be designed to create a differentiated competitive position and mission fulfilment. Board members can and should be at the epicenter of that discussion, given the potential for a new enterprise strategy to fundamentally shift the relationship between the organization and the communities it serves.

Hospitals and health systems need to then establish infrastructure that advances the strategic vision, given the pitfalls that can arise without those foundational elements. For instance, organizational scale can be an advantage when harnessed effectively around a set of cohesive strategic choices. But few, if any, organizations can be all things at once: for example, offer the best clinical quality, the most accessible care delivery model, and the lowest cost in a given market. An "all of the above" approach often ends with organizations forced to retrench and/or sell off services or facilities in the wake of more focused competition from new entrants and/or other legacy providers.

Organizations must also take care to pursue strategic transformation with their overall value proposition front and center. In the past, some health systems have elevated isolated efforts to serve as the linchpin of their strategy, whether in performance improvement, population health, or consumer design. But without a broader plan for competitive differentiation in the markets they serve, organizations run the risk of funding new initiatives without the cultural support or intellectual capacity to implement and sustain even the most incremental changes.

A Time to Choose

As healthcare organizations begin to recover from a prolonged period of acute economic challenges, pursuit of incremental change can be tempting. But as leaders and boards consider where their organizations stand in their markets relative to their competitors on cost,

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KEY BOARD TAKEAWAYS

- What is our organization trying to be?
- What is our value proposition to the communities and other stakeholders we serve?
- Is our entire leadership team—including our board and executive team—aligned around a strategic vision of our place within the future of the healthcare industry?
- Does our organization have the infrastructure and culture necessary to successfully execute a shift in our strategic direction?
- Are we prepared to make difficult decisions?

Without a broader plan for competitive differentiation in the markets they serve, organizations run the risk of funding new initiatives without the cultural support or intellectual capacity to implement and sustain even the most incremental changes.

Governance during an Era of Political and Cultural Polarization

By Anne M. Murphy, ArentFox Schiff, LLP

The United States, as it heads into the 2024 presidential election cycle, is experiencing an unprecedented degree of political and cultural polarization. For hospitals and health systems, this polarization impacts numerous organizational levels, including community relations, workforce management, policy and advocacy, executive management, and governing board process. At the governance level, health sector provider organizations inevitably must address hot-button issues such as reproductive and gender orientation healthcare services, vaccination policy and COVID mitigation strategies, treatment of undocumented individuals, extent of involvement in entitlement programs and delivery of healthcare to uninsured individuals, the extent to which diversity, equity, and inclusion (DE&I) considerations are embedded within the organization's culture, and potentially gun safety considerations related to worker and patient safety concerns. While these issues are inherently challenging, governing boards will be well served to focus on objective, mission-driven approaches that diligently avoid partisanship in the boardroom.

There should be agreement that external politics and partisanship should be kept out of board dynamics and decision making, but with an awareness that hot-button issues will require board and management attention and consideration.

External Political and Cultural Issues That Create Potential Polarization Concerns

As a hospital or health system governing board evaluates best practices during the upcoming presidential election cycle and, more generally, during an era of political and cultural polarization, it should acknowledge and assess those highly charged issues that inevitably must be addressed, including:

- **Reproductive healthcare services**: It almost goes without saying that, in a post *Roe v. Wade* era and with varied state legislative and legal actions and continued uncertainty as to federal law and policy, hospitals must grapple with complex legal and policy questions as to scope of permitted reproductive health services. These services potentially include abortion, birth control, and assistive reproductive services such as IVF and related embryo storage and policy. Boards must provide diligent, competent, objective, and nuanced oversight, taking into consideration the organization's best interest, purpose, and relevant law. For a religious-sponsored organization, purpose and mission factors will be different than for a non-secular organization. Because the law on this topic is rapidly evolving, the board should regularly revisit it and receive competent legal advice.
- **Gender confirmation and LGBTQ services and policy**: Organizations providing gender confirmation services and surgery may experience enhanced external and internal criticism and scrutiny. Similarly, issues related to healthcare services, and cultural inclusiveness, for LGBTQ patients and employees may serve as a flash point. As with the case for reproductive healthcare services, the board should keep its focus on mission-driven and objective organizational criteria, perhaps with ancillary attention as to the proper extent of focus on DE&I initiatives within the enterprise.
- **End-of-life care**: As the U.S. population ages, end-of-life care continues to evolve. More widespread use of hospice services and hospital-in-the-home care, for example, has increased acceptance of palliative care at end of life. While perhaps less of a hot-button issue currently than reproductive, gender confirmation, and LGBTQ-focused healthcare, boards nevertheless should be aware of innovations in end-of-life care being deployed by the organization and be prepared to address any community or other external questions that may arise.
- **Communicable disease management and vaccination policy**: As the last several years have made clear, one area of political and cultural polarization impacting healthcare delivery is hospital vaccination, masking, and other communicable disease management policies affecting patients, visitors, and employees. Governing boards, management, and clinical leadership should have principled dialogue regarding these issues as circumstances warrant, taking into consideration a variety of factors such as clinical data, government policy mandates and recommendations, and prevailing practice.
- **Patient and employee security considerations, including violence prevention**: An unfortunate fact of life in public spaces such as hospitals is the potential for violence. In recent years, there have been numerous instances of violence impacting clinicians, patients, and employees in hospitals and other healthcare settings. Many hospitals have policies prohibiting guns and other weapons on hospital grounds, and other security protocols are commonplace. Governing boards should have a thorough understanding of violence prevention strategies deployed by the healthcare facilities they oversee, recognizing that the potential for gun and other violence may be increasing in certain communities and in relation to the delivery of polarizing services such as in the area of reproductive healthcare.
- **Extent of service delivery to uninsured and Medicaid patients**: For non-profit hospitals and health systems, a key mission focus, and purpose mandate, has been delivery of

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››› KEY BOARD TAKEAWAYS

- **Consider application of fiduciary duties** during the presidential election cycle and related political and cultural polarization. Senior board and management leadership should meet on this topic and consider meetings with the broader governance and management teams to heighten awareness regarding possible issues that might arise.
- **Take measures to ensure that partisanship does not impact governance** or senior management in overseeing the mission and operations of the healthcare enterprise.
- **Spend time addressing "hot button" issues** in healthcare delivery that may require attention in this climate, such as reproductive healthcare, gender confirmation and LGBTQ services and policies, end-of-life care, communicable disease management policies, and application of security and violence prevention measures designed to protect patients, visitors, and employees.

A New Physician Enterprise: Rethinking Physician–Hospital Alignment

By Susan Corneliuson and Ryan Harris, Guidehouse

In recent years, physicians have largely abandoned the model of independently owned private practice in favor of being employed. Nearly three-quarters of all U.S. physicians are now employees, and about half are employed by health systems or hospitals.[1]

The trend has continued to accelerate over the past few years as new disruptors and innovators have entered the space, resulting in an 88 percent increase in corporate ownership of physician practices.[2] Yet it's become clear that current physician alignment structures within hospitals and health systems are struggling to remain economically viable.

As payers shift more volume to ambulatory care and physicians become further isolated from market forces, health systems need to start thinking differently. Progressive health systems are beginning to position ambulatory services on par with acute services, opening up opportunities for new physician enterprise structures that can succeed under changing market forces. This has created an imperative for board leaders to recognize the existing market opportunity to unlock physician potential by realigning economic incentives and the value of the physician enterprise.

››› KEY BOARD TAKEAWAYS

- **Transform your perspective.** Understand the true value the physician enterprise brings to your health system and take a transformative view.
  - » Has the system maximized its physician enterprise value?
  - » Is the physician enterprise driving market growth?
  - » What community impact are you creating related to prevention, wellness, and outcomes?
- **Consider a more deliberate approach for aligning economic incentives with physicians.**
  - » Which structure is best for your system?
  - » How can the physician alignment model evolve to drive long-term value for the system and for physician stakeholders while delivering quality care to the patients served?
- **Be willing to give up some control.** Creating economic alignment will require a loss of control and increased investment from physicians in not only the corporate structure but also management of operations.
  - » Which tradeoffs of control and hospital outpatient department revenue are you willing to make in exchange for decreased physician enterprise financial losses and greater physician alignment?
- **Do your due diligence.** Changes of this scale require thoughtful consideration related to governance, leadership, and legal matters. Work with trusted partners to develop a well-laid strategy and achieve the ideal structure, partnerships, and operating model.

How We Got Here

In the 1990s, as health maintenance organizations were gaining a stronghold, health systems raced to employ physicians with the intention of securing those primary care gatekeepers. Then, as professional fees were squeezed in the early part of the new millennium, health systems felt pressured to secure specialty business by employing specialty-care physicians.

The initial impetus for these strategies was driven by the expectation that employing physicians would:

- Expand patient access to necessary services.
- Provide a pathway to value-based care and population health.
- Secure financial viability for acute care services.
- Create opportunities for enhanced continuity of care.

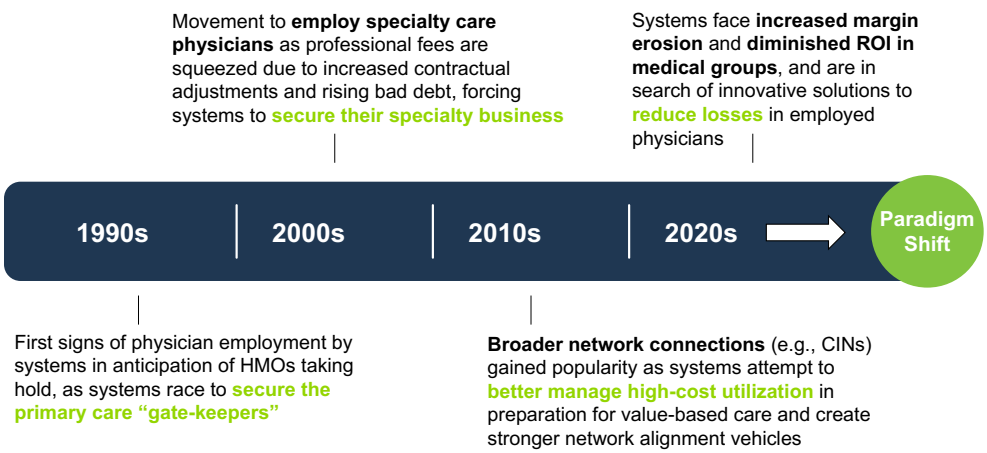
Over the next decade, CMS's push toward value-based care and desire to control total costs of care, combined with health systems' desire to better align with independent physicians, led to increasing development of clinically integrated networks (CINs) and other broad network connections. However, these networks often lacked appropriate incentives and the right balance of physician risks and rewards, resulting in lackluster performance. And with the pandemic accelerating margin erosion and diminishing medical groups' return on investment, health systems have been searching for innovative solutions to mitigate these growing losses.

An Outdated Model

Current market dynamics and increasing financial losses are driving health systems to rethink their physician enterprise and alignment strategies. In order to create a viable future-forward structure, organizations must understand how some or all of the following features of existing models are impacting their ability to succeed.

Insulation from market forces: Employment of physicians has led to conflict

Exhibit 1: Health System Employment of Physicians: A Quick Timeline



1 *Physician Employment and Acquisitions of Physician Practices 2019–2021 Specialties Edition*, Physician Advocacy Institute, June 2022.
2 *Ibid.*

between the provision of healthcare and the realities of business economics, with insufficient risk to induce behavioral change and insufficient reward to fire the entrepreneurial spirit. Incentives implemented as a measure to balance quality and cost have been minimal. A study published in *JAMA Health Forum* notes that quality and cost performance-based financial incentives average just 9 percent of total compensation, while volume-based productivity incentives comprise the majority of physician compensation.[3]

There has also been minimal disincentive when physician productivity has underperformed. Sheltering physicians from market forces and economic realities has resulted in higher health system expenses, aggravating losses. In a recent American Medical Group Association (AMGA) survey, reported average physician enterprise losses were in excess of $250,000 per physician, with expenses outpacing revenue gains due to high labor costs, stagnant fee schedules, and regulatory changes.[4]

Employment of physicians has led to conflict between the provision of healthcare and the realities of business economics, with insufficient risk to induce behavioral change and insufficient reward to fire the entrepreneurial spirit.

Loss of ancillary revenue: Changes in hospital financial reporting have made it appear that the physician enterprise is losing money when compared with how successful independent medical groups operate. For example, hospitals have typically realigned billing for ancillary services such as imaging and lab tests to capture higher hospital outpatient department (HOPD) rates, which were previously billed for and collected by physicians. What remains for the physician enterprise to bill and collect on is evaluation and management services—resulting in higher incurred losses and lower income for the practice.

Payers are now shifting site of service to the ambulatory space and to lower cost-of-care settings, resulting in a loss of HOPD business. This space has also become ripe for disruptors, who are aggregating ambulatory surgery centers and other ancillary revenue streams to capitalize on this economic dynamic. Hampered by outdated models and regulatory constraints, the physician enterprise faces increasing pressures to turn around losses despite the reality that there's no good way to do that under the current employment model.

Increased administrative burdens: With increasingly stringent documentation and regulatory requirements falling on physicians' shoulders, the time they must devote to administrative tasks has increased. Studies estimate that physician time spent on administrative work can range from about 50 minutes per visit to six hours a day interacting with electronic health records.[5]

To address these administrative duties, physicians increasingly find themselves working outside of normal business hours to stay afloat. And the persistent volume of messages they have to review and respond to has been linked to physician burnout as detailed in a research article published by *Health Affairs*.[6] The impact of these burdens—which often stems from poor operational efficiencies, insufficient technology-enabled solutions, and high workforce turnover—limits the number and types of patients physicians can see each day. This further restricts access to care and opportunities for revenue generation.

Lethargic employment structures: Today's physicians have become burdened with the traditional hospital structure's inherent slower pace at a time when they need to be significantly nimbler and more responsive, especially given the speed of technology advancements and patient care models. Overburdened with high overhead cost allocations, sluggish information technology platforms, and limited capital investments, the physician enterprise is unable to keep pace with the market. And rigid hospital employment models often fail to address the growing desire for increased flexibility, enhanced work-life balance, and greater autonomy expressed by many physicians.[7]

The Consequences

As a result of these factors, many physicians are choosing to either leave the workforce entirely or take advantage of new opportunities such as virtual care delivery work or roles with private equity-backed organizations—believing that this will allow them to focus more on patient care delivery and quality of care while achieving a better work-life balance.

Employed physicians are also earning less money in real dollars as a result of inflation outpacing flat to modest salary gains.[8] Combined with the number of doctors aging out of the workforce, this is expected to lead to physician shortages—particularly in key specialties such as primary care, cardiology, and oncology. The American Association of Medical Colleges predicts a shortage of at least 37,000 physicians to potentially more than 100,000 physicians nationwide over the next decade.[9]

These weaknesses in the current physician employment model have

3 Rachel Reid, et al., "Physician Compensation Arrangements and Financial Performance Incentives in U.S. Health Systems," *JAMA Health Forum*, January 28, 2022.
4 "New Survey Finds Medical Group Operating Costs Continue to Outpace Revenue" (press release), AMGA, December 18, 2023.
5 Lisa Rotenstein, et al., "System-Level Factors and Time Spent on Electronic Health Records by Primary Care Physicians," *JAMA Network Open*, November 22, 2023; Brian Arndt, et al., "Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations," *Annals of Family Medicine*, September 2017.
6 Ming Tai-Seale, "Physicians' Well-Being Linked to In-Basket Messages Generated By Algorithms in Electronic Health Records," *Health Affairs*, July 2019.
7 Leslie Kane, "Medscape National Physician Burnout & Suicide Report 2020," *Health Affairs*, 2020.
8 Kim Abraham and Daniel Novinson, "Physician Salaries Not Keeping Pace With Inflation, Delaying Retirement for Many," Voices from the Doximity Network, August 30, 2022.
9 "AMA President Sounds Alarm on National Physician Shortage" (press release), AMA, October 25, 2023.

led to the rise of physician enablement organizations and new-entrant disruptors such as private equity firms, retailers, and tech companies. While provider enablement companies are generally incentivized to work together with physician groups, partnering with a private equity firm can be problematic depending on how expectations are structured.

According to a recent study by the American Antitrust Institute, acquisitions by such firms can be associated with price and expenditure increases—and these conditions can be exacerbated when the firm controls more than 30 percent of the market.[10] Physicians in that situation may also feel a greater loss of autonomy, increased pressure to maximize profits, and higher levels of burnout and dissatisfaction with the practice of medicine.

Despite these concerns, more physicians are turning to new market entrants. Without making changes to compete with these disruptors, health systems now face increased risk of deteriorating financial conditions and market position—with the real possibility of takeovers or insolvency looming on the horizon for many.

For Consideration: A New Approach

The health system physician enterprise model of the future must look radically different from historic models, evolving to drive long-term value for system and physician stakeholders while delivering quality care to patients.

To achieve this vision, health systems should consider models that create a higher level of economic ownership with their physicians as well as partnerships that appropriately capitalize the physician enterprise—allowing them to compete with new market entrants and disruptors. Models to be explored could include physician enterprise joint ventures or other mutually beneficial partnerships that drive value and win-win solutions for stakeholders.

These partnerships could be augmented to include third-party investors such as private equity companies, venture capital firms, or other market disruptors, including tech and retail players. Doing so could allow for fresh injections of capital, innovative business management principles, and technical capabilities for the newly formed partnerships.

From a health system perspective, this next-generation model would:

- Accelerate the shift to a value-based care model—a paradigm shift that's critical to addressing healthcare's rising costs while improving patient outcomes.
- Create a platform for long-term value creation by helping to reduce high-cost utilization, hospitalizations, and length of stay—allowing a stronger focus on prevention, wellness, access, capacity, and the patient experience.
- Right-size system investments in employed groups through reduced physician subsidies—a prudent, significant cost-control measure.
- Improve patient capture rates, reduce leakage, and support patient continuity of care.

From the physician group perspective, an effective model would:

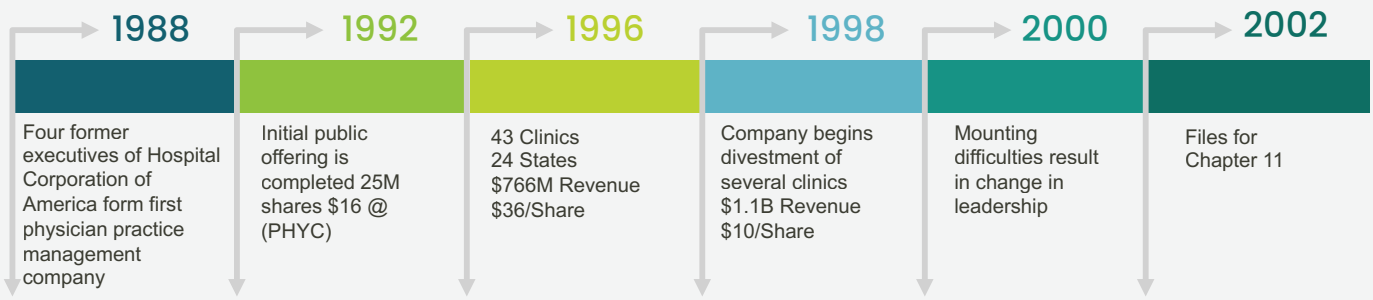
- Increase physicians' earning potential through a share of technical fees and other profits made possible by a joint venture ownership stake (subject to regulations).
- Realign incentives to drive revenue and cost containment, thereby improving access, keepage, and high-cost utilization.
- Create a nimbler, more responsive management structure to enable rapid change, mobilization, and enhanced technology/automation.
- Give physicians more autonomy when it comes to clinical decision making,

> *Health systems should consider models that create a higher level of economic ownership with their physicians as well as partnerships that appropriately capitalize the physician enterprise—allowing them to compete with new market entrants and disruptors.*

A History of Physician and Private Equity Ventures

PhyCor, Inc. and its subsidiaries provided administrative management services to physician networks and medical groups. The company managed 40 medical groups with more than 2,500 doctors in 21 states and nearly 26,000 physicians through networks in 29 healthcare markets. Through PhyCor's subsidiary, CareWise, Inc., the company provided support and assistance to more than 3.3 million consumers in making decisions about medical care. To create, with physicians, the best value in medical care for its community.

As interest rates have gone up, disruptors are facing demands for margin overgrowth. This quickly impacted "insur-techs" like Envision Healthcare and Cano Health, Inc.



10 Richard Scheffler, et al., "Monetizing Medicine: Private Equity and Competition in Physician Practice Markets," American Antitrust Institute, July 10, 2023.

their approach to patient care, and practice management.

The combination of this type of structure with an emphasis on economic alignment can attract physicians by providing entrepreneurial rewards, quality-of-life enhancements, and greater control over day-to-day practice decisions.

When executed with thorough planning and precision, a new physician enterprise model can lead to:

- Better patient care through improved operational and clinical efficiencies
- Improved margins and a better market position for health systems
- Enhanced physician autonomy, investment, and satisfaction with the practice of medicine

The result? A true "win-win-win" for health systems, physicians, and patients.

The combination of this type of structure with an emphasis on economic alignment can attract physicians by providing entrepreneurial rewards, quality-of-life enhancements, and greater control over day-to-day practice decisions.

Caveats

This type of model might be easier to accomplish in markets in which physician groups are accepting higher levels of risk reimbursement and have a greater level of control over total cost of care. Essentially, physician organizations that can tap into new revenue sources by controlling costs and aligning incentives will have a greater potential to drive profits. Organizations that have been moving more slowly into value-based care will need to evaluate the probability of higher levels of productivity, as well as the potential opportunity to bill for ancillary services and the total impact on margin before the physician enterprise strategy can be reset.

The reality is that in employing physicians, hospitals have destabilized physician practice economics and asserted "divine rights" over what was once considered physician revenue streams. Board leaders and executives need to acknowledge that this type of restructuring means giving up a portion of that revenue—recognizing that physicians aren't a drain on resources but are rather the engine that can drive revenue if properly positioned.

Of course, contemplating a new physician alignment model represents a significant shift for leaders who have already been struggling with so much change and market pressures in recent years. It can't be accomplished overnight, and health systems need to consult with their advisors and partners to thoroughly consider various options. This requires a more intensive investment of time and strategic thinking—meaning leaders may need to first determine the depth of internal commitment before pursuing these options further.[11]

Case Study: Evolving Physician Enterprise Strategy Supports Larger Transformation Initiative

Guidehouse is working with a nationally recognized health system that is in the thick of pursuing this new physician enterprise model today. After developing with full board support an enterprise transformation initiative, the organization redesigned its clinical operations and invested in a future-focused, high-tech ambulatory strategy. Within just a short period, system leaders were able to mitigate risk, enhance safety, and meet community needs against the challenging backdrop of a volatile industry environment. Having successfully strengthened its market position through that initiative, the health system has recently decided to sell off a portion of its clinical assets to a physician enablement firm, which will allow for an infusion of capital for needed technology and infrastructure that will further its transformation.

Making the Business Case

From a board perspective, if significant investments in physician groups have already been made and continue to lose money, how can you create a different model to lessen or eliminate those losses?

It can be difficult to globally identify whether this next-gen physician enterprise model would be ideal for a health system to pursue because that largely depends on unique state laws and regulations. Being able to make the business case for doing so requires a thorough independent analysis that considers your organization's broader strategy, current business health, and pending capital investments.

A True Market Opportunity

The ultimate aim of this type of structure is to marry a nimble, responsive organization with a patient-centric mindset. When done right, organizations can create a real market opportunity to not only attract new physicians but also regain the trust of employed doctors who are facing burnout as well as independent physicians struggling with the burdens of private practice.

The Governance Institute thanks Susan Corneliuson, Director, Physician Enterprise Services, and Ryan Harris, Managing Consultant, Physician Enterprise Services, Guidehouse, for contributing this article. They can be reached at scorneliuson@guidehouse.com and rharris@guidehouse.com.

11 Thomas Zenty and Danielle Dyer, "Moving from 'Yes Boards' to 'Best Boards': 5 Things to Consider," Guidehouse, January 10, 2023.

Health Systems Must Embrace a Comprehensive Primary Care Strategy

By Jennifer Moody, Alan Lassiter, and David Willis, ECG Management Consultants

A wholesale reimagining of primary care has not been a priority for many health systems—until now. A growing number of market drivers are pushing ambulatory services to the forefront. Forward-thinking organizations will reconsider the need for a comprehensive primary care strategy to gain competitive advantage. As they do, there are key trends boards should be aware of when positioning their health systems for success.

››› KEY BOARD TAKEAWAYS

- **Investment in primary care** is a critical strategy for high-performing health systems and should be undertaken with the same discipline and resources given to other specialties.
- **Supporting the primary care workforce** to promote long-term, satisfying careers requires rethinking compensation, work expectations, and care models.
- **Disruptors will continue to chip away** at primary care market share, absent a renewed focus on consumers, health equity, and wellness.
- **Primary care plays a critical role** in driving system strategy for all patient populations under Clinical Integration 3.0 and requires proper investment in resources to inform and drive tactics to achieve success.

1. Primary care is a critical (and undervalued) partner for health systems.
Clinical, operational, financial, and strategic outcomes hinge on a well-designed, high-performing primary care enterprise that understands the intersection of business and medicine. As such, any health system strategic plan should include meaningful primary care participation in system-level governance and decision making. Health systems have the scale, experience, and tools to elevate primary care to new levels of service for the full community. Primary care deserves the same service line discipline (including dedicated dyad leadership, equitable resource allocation, and strategic focus) given to other specialties.

2. The status quo will be unsustainable for most markets, and disruptors are poised to take more primary care market share.
The challenges with access to primary care are well known (and getting worse). A recent ECG study of ambulatory access trends across several metropolitan markets in the U.S. found that commercially insured patients wait, on average, one month for a new patient appointment in family medicine. Many markets are more significantly challenged, and the strain is noticeable. Burnout of primary care physicians and advanced practice providers (APPs) is at an all-time high. Compounding the problem, the U.S. Health Resources and Services Administration (HRSA) predicts a shortage of more than 23,000 primary care physicians by 2025.

Meanwhile, private equity and venture capital-backed entities continue to invest in primary care, offering tailored, segment-specific value propositions based on price, access, experience, and convenience. While such efforts may effectively meet the needs of certain subsets of patients, they risk further exacerbating the access challenges across the system as a whole.

3. We got it wrong: we can no longer separate a provider's clinical and business roles.
There is no relief in sight for traditional reimbursement models focused on relative value units (RVUs). Health systems need new alignment and compensation models that drive value creation across the care continuum. To accomplish that, primary care physicians must become legitimate business partners in the drive for system financial success. Work standards for providers will need to evolve, and compensation models should be adjusted to incentivize coverage and optimize teamwork.

4. The spotlight on health equity is only going to grow brighter.
Inequities in access and outcomes are increasingly visible to payers, regulators, and the public. Care models, including clinic locations and virtual tools, will need to be flexible enough to meet the needs of many different patient segments. Health systems must consider multiple points of entry and distinctive styles of practice to meet the needs of increasingly diverse patient populations.

5. Labor shortages across the clinical spectrum will force unprecedented creativity.
Traditional physician-centric care models will be overwhelmed by demand or become obsolete altogether. Systems must concede that there is no one right model for how to deliver care for all patient populations or levels of health. Primary care workforce supply-and-demand disparities contribute to widespread access and service issues, and the predominant physician-centric care models that originate from traditional "private practice" and outdated training models are ineffective. Tomorrow's primary care network may include traditional practices, subscription models, concierge medicine, hybrid primary care/immediate care centers, and medical home models, all coexisting within a comprehensive service line offering.

As systems move beyond the physician model, they need to acknowledge that APPs are also an indispensable part of the primary care workforce and should be enabled to practice at the top of their license. Current work standards and traditional compensation models must give way to plans that reward team-based care and patient-centric work. At the same time, health systems must also invest in centralizing administrative and clinical support functions to maximize capacity and create more flexibility for both patients and providers.

> *Private equity and venture capital-backed entities continue to invest in primary care. While such efforts may effectively meet the needs of certain subsets of patients, they risk further exacerbating the access challenges across the system as a whole.*

6. Strategic integration will precede operational integration.
The current focus on margin improvement has led many organizations to pursue operational synergies through system integration. However, such a focus may be misplaced in primary care. Primary care needs a wholesale redesign first. Systems need to reimagine the roles of employed and affiliated physicians, along with APPs, digital tools, and virtual

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What Is Our Organization…

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quality, reputation, access to care, and other key metrics, it becomes quickly apparent that their organization cannot excel in every area.

Without competitive differentiation, organizations run the risk of simply being "good enough" on most indicators. The current environment demands more. Today's healthcare leaders must embrace the opportunity to actively choose their future and fully align their capabilities and culture to achieve their goals.

This article is part one in a series on reigniting the strategic plan and growth opportunities. Part two will dig deeper into steps the board can take to elevate strategic planning efforts.

The Governance Institute thanks Amanda Steele and Dan Clarin, Managing Directors and Leaders of the Strategy and Business Transformation practice at Kaufman, Hall & Associates, LLC, for writing this article. They can be reached at asteele@kaufmanhall.com and dclarin@kaufmanhall.com.

Governance during an Era…

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healthcare to medically underserved populations, including uninsured individuals without ample resources and Medicaid beneficiaries. At the governance and senior management level, these issues demand continued attention across reimbursement, financial, and policy metrics, keeping in mind legal and mission mandates. Within this, it is important to recognize external political and cultural polarization around illegal and undocumented immigrants, particularly heading into the presidential election cycle.

- **Government stance on competition in healthcare**: While perhaps less of a widespread cultural concern, federal and state efforts to prioritize competition in healthcare services, particularly among hospitals, has impeded hospital consolidation efforts in a number of cases over the last several years. As health policy issues are brought into higher relief during the presidential election cycle, boards should monitor this issue for trends and possible opportunities.

Recommended Governing Board Actions

The north star for any governing board is the exercise of its fiduciary duties in accordance with the entity's mission and purpose as expressed in its organizational documents. Pursuant to the duties of diligence, loyalty, and obedience, the board is charged with diligently addressing difficult issues, including those challenging considerations outlined above, with diligence, adherence to the organization's purpose and best interest, and without the influence of individual board member personal interests. Considering this, boards should contemplate the following steps:

- **Board and management leadership meeting**: Board and management leadership should consider meeting to discuss election cycle and polarization issues, likely as a precursor to follow-up meetings with the board and the management teams. At a high level, there should be agreement that external politics and partisanship should be kept out of board dynamics and decision making, but with an awareness that hot-button issues will require board and management attention and consideration. Similarly, there should be a candid discussion as to whether there are any problematic partisanship issues at the executive level that are adversely impacting organizational policy or decision making.
- **Board and management team meetings**: After leadership alignment, a dedicated discussion at the governing board, and with hospital management, should be considered. Ample time for these meetings should be allotted, in order to explain the issues that may arise and the preferred enterprise approach for handling them. The topics that might be discussed include:
  - » Fiduciary expectations including expectations that partisan politics will not be part of governance or management decision making or discussion.
  - » Acknowledgement of hot-button polarizing issues affecting governance and operations with an opportunity for questions and concerns to be expressed.
  - » A refresher on external communications policy, and constraints on political activity by directors and executives, to ensure a shared understanding of protocol.
  - » Agreement on policy topics to be monitored closely in light of the volatile external climate, and any adjustment to strategic planning efforts precipitated by that volatility.
  - » Consider requesting that the communications team be prepared to address any emergent issues that may arise.
  - » Consider requesting that executive leadership formulate a plan for addressing any workforce relationship issues that may be raised by the hot-button issues identified above, especially DE&I initiatives, workforce safety and security concerns, vaccination policy, and delivery of reproductive and gender confirmation health services. If the organization has union employees, this should be factored into the strategy.

Conclusion

Governing boards, with involvement from executive leadership, should consider the impact that the presidential election cycle and volatile external political and cultural climate may have on hospital strategy and operations. It is important that leadership be oriented to proper governance and management decision-making priorities that are insulated from partisan politics and be prepared for hot-button challenges that may arise in areas such as scope of healthcare service delivery, DE&I implementation, violence prevention, infections disease management, and workforce concerns.

The Governance Institute thanks Anne M. Murphy, Partner, ArentFox Schiff, LLP, for contributing this article. She can be reached at anne.murphy@afslaw.com.

Health Systems Must Embrace...

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care models, to meet their communities' unique needs. Innovative health systems are partnering with disruptors and aligning with independent providers to ensure a diversified pathway to long-term financial viability beyond traditional employment. Operational integration must follow from, rather than precede, such strategic decisions.

7. Provider organizations cannot abdicate their role in winning back consumer loyalty.

Consumers who are often focused on wellness increasingly perceive health systems as costly, inconvenient places to receive primary care. Organizations that develop competencies in consumer engagement and behavior change will have a sustainable competitive advantage. Patient-friendly and technology-driven disruptors recognize that consumers drive most of their own primary care decisions.

Clinical Integration 3.0

Clinical Integration 3.0 requires that primary care play an integral role in driving system strategic, operational, and financial performance. Key success factors for Clinical Integration 3.0 include advanced analytics, redesigned care delivery, and a robust IT infrastructure, all of which must be deployed across all specialties, including primary care. To manage the quality and cost of caring for diverse patient populations, systems must embrace the dual role of primary care: identifying unnecessary services for non-complex patient populations and simultaneously providing advanced outpatient management for rising-risk and high-risk populations.

Wellness-focused millennials and Generation Z are now the largest purchaser market for primary care. This consumer segment will demand solutions that deliver care in a user-friendly environment, prioritizing access, convenience, and a seamless care experience over a personal provider relationship.

Primary care will continue to elbow its way to the front of strategic agendas. As the backbone of the U.S. health delivery system, investment in a new generation of delivery options will allow health systems to stay ahead of disruptors. Transformation in primary care will shore up the position and viability of healthcare systems.

The Governance Institute thanks Jennifer Moody, Partner, Alan Lassiter, Principal, and David Willis, Principal, ECG Management Consultants, for contributing this article. They can be reached at jmoody@ecgmc.com, aklassiter@ecgmc.com, and dhwillis@ecgmc.com.

Healthcare Is a One-Way Street...

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My favorite question from that one board member in the back is, "What if we do nothing?" Well, patients will continue to wait until they are sick (or really sick) to come see us. Or they will go through our red emergency door. Some will defer care and never come at all. The health of America will remain tenuous at best.

We reject this version of the future. Two-way healthcare is not a pipe dream—it's already happening. We must audit how "one-way" we are and seek out our patients and give them opportunities to engage us more easily. If we aren't sure how to do this, we must ask them and partner with them. After all, the best thing about a great relationship is that it benefits both parties. Both ways.

Two-Way Example Outside of Healthcare: Uber Eats

Your favorite restaurant didn't get that way solely because of the food. Chances are it provides a unique experience and holds countless memories. And now, in many places, you don't always have to travel there to enjoy the food (and the memories). With a few taps, Uber Eats will bring your favorite food to you, to enjoy when you want, wherever you want. The core product doesn't change but how I experience it, and the direction it travels, does. It also doesn't mean you never go there again, but rather you know the relationship you have with your go-to restaurant goes both ways.

The Governance Institute thanks Ryan Donohue, Strategic Advisor, NRC Health, and Governance Institute Advisor, for contributing this article. He can be reached at rdonohue@nrchealth.com.

Healthcare Is a One-Way Street (and Nobody Knows How to Drive)

By Ryan Donohue, NRC Health

Do you remember the first time you drove down a one-way street? I do. I was a college freshman and I didn't realize it was a one-way street. I felt a stinging confusion, immense tension, and a deep desire to simply survive. Sound familiar? It also sounds a lot like healthcare.

Chances are your last healthcare journey was tense, confusing, and at times: never-ending. Healthcare lays down a gauntlet and places the pressure squarely on the patient to travel "one way," to somehow successfully navigate a barrage of information, instruction, appointments, and outcomes—with little to no practice in doing so, and often alone.

Telltale signs of one-way healthcare include:

- Responsibility to seek care falls almost entirely on the patient.
- Patients must navigate any and all points of care—before, during, and after the core experience.

> *"Understanding is a two-way street."—Eleanor Roosevelt*

- Hospitals and health systems remain passively involved, known mostly as backstops for health emergencies.
- Hospitals and health systems blast messages into the community, hoping it reaches future patients.

Examples of One-Way Healthcare (Each Way)

One-Way (Consumer to Hospital): new surgical services wing is built, celebrated among surgeons, seen by public walking/biking/driving by with no understanding of what it is or how it might be used.

One-Way (Hospital to Consumer): previously out-of-network hospital has been restored to in-network for a large employer but there is no messaging outside of a memo during open enrollment.

Like traffic, one-way healthcare is at its worst when everyone hops to it. The post-COVID access crisis has created a truly untenable situation. People aren't receiving the care they need. Wait times are excruciating. Patient expectations—after waiting three, six, or even 12 months—are understandably through the roof. Waiting on the other side is a physician or nurse who is still burnt out. One-way care affects both sides, and it has taken its toll.

The Great Brand Blur

Ready to add another crisis into the mix? Last June in the *Boardroom Press* I argued that we are at a crossroads.[1] Our unified COVID messaging was effective at reaching our communities but now what? When we don't communicate our value *outwardly* to the community, learning what our patients want and aligning our brand to those desires, then we miss an opportunity to shine. Our patients default to our most basic services. We may simply be an emergency department to them. Meanwhile, Amazon provides one-click telehealth, urgent cares pop up on every corner, and more convenient primary care options pull patients in.

Two-Way Healthcare

Enter two-way healthcare. Instead of waiting for patients to show, proactive hospitals and health systems are openly considering what their future patients want. They are resourcing faster, more efficient pathways to care that don't always require a physician. Where they can't build, they are partnering, and putting their brand first. Hospital-at-home is being firmly pursued. They are humble enough to take a learning approach to pre-experience issues like access and post-experience issues like affordability. Their boards are reconsidering their role in the community and rejecting the idea that hospitals are simply service stations for the sick.

Consider the push/pull dynamic already present in healthcare. Patients must push through barriers to seek care, and hospitals and health systems pull in patients to stay in business. Patients pull in as much information and guidance as they can get, and hospitals and health systems push out messages to the community. Busy on both ends, but do the two connect?

KEY BOARD TAKEAWAYS

- **One-way healthcare isn't working** anymore—not for patients and not for us—so we must audit our main offerings to understand just how one-way we are right now.
- **Our future patients are looking for a sign** from us, some kind of gesture that shows we are willing to come to them and partner with them through their journey of care.
- **Two-way healthcare creates more understanding** between healthcare organizations and patients, more predictable outcomes due to better communication, and stronger trust, which keeps patients from staying home or straying to other care options.
- **We don't need to be perfect;** we need to be patient-centric by viewing our patients as a focal point for learning and evolving our experience to better meet their needs.

How to Build Two-Way Healthcare

Two-way healthcare benefits both parties. It also already exists and at least part of your business model already demonstrates it. Here are three ideas to build it further:

- Extend COVID outreach mechanisms into today. For example, keep telehealth going. It's not just a substitute for the physical experience, but a healthcare service that travels toward the patient, not the other way around.
- Push for hospital-at-home as your stretch goal. One recent example that includes a blueprint is the partnership between Mass General Brigham and Best Buy.[2]
- Leverage increased outpatient/long-term-care services. We have quietly extended our experience and it's time to fully promote.

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1 Ryan Donohue, "Branding Is Back: Revisiting Who We Are After Three Years as the COVID Care Provider," *BoardRoom Press,* The Governance Institute, June 2023.
2 "Best Buy Health and Mass General Brigham Collaborate to Meet Patients' Growing Healthcare-at-Home Needs" (press release), November 8, 2023.