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HEALTHCARE MANAGEMENT ADVISORS

Physician Engagement in Employed Physician Enterprises: Going Deeper

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You want to reduce physician subsidies in your employed physician enterprise, and you have numerous initiatives to increase physician engagement under way. What matters, however, is not the number of physician engagement efforts, but how thoroughly they engage physicians in operations at the ground level.

Veralon recently surveyed leadership at 30 physician enterprises with 11,000 employed physicians. We found that there was little relationship between the number of different physician engagement efforts reported, and the subsidy per physician required. Interviews revealed that while respondents could list many engagement initiatives, they were handled superficially, typically with very little physician involvement below the medical director level.

Your practitioners are at the core of every critical element of practice success. The model in which employed physicians are relieved of administrative burdens has resulted in physicians being excluded from everything except the exam room. Yet moving them further away from managing factors critical to practice success seems to result in higher losses. While a balance must be struck in occupying practitioner time with non-patient care activities, it is time to bring back the physician manager.

Below, we discuss five areas warranting deep physician engagement. The effort required to implement these initiatives and reduce subsidies will exceed the capacity of a single CMO and medical group director. Only physician participants can do the detailed day-to-day work required to develop the right answers, and involving them will also promote buy-in for their recommendations.

AREAS FOR PHYSICIAN ENGAGEMENT

1. **Program Building with Advanced Practice Clinicians (APCs):** A productive, appropriate mix of physicians and nurse practitioners and physician assistants can

strengthen practice effectiveness. Sometimes this provides the direct benefit of improving the productivity of the whole practice; it can also expand the practice's responsiveness to patient and payer initiatives. A leadership group including both physicians and APCs can define care team models, develop inpatient and outpatient staff models, establish workload, and define clinical roles and appropriate acuity limits. The group can then itemize specific APC position opportunities, create a recruitment plan, and participate in recruitment.

2. **Compensation and Productivity Improvements:** A standing compensation group, including practitioners, should be engaged in managing compensation efforts. The group's responsibilities will include identifying individuals or groups whose productivity is not consistent with compensation and interviewing those individuals or groups to identify impediments to aligning compensation with productivity or other priorities, as well as proposing solutions to those barriers.
   The group should also review how well current incentive compensation aligns with value-based payment initiatives, and recommend improvements. It can identify permanent medical group resources, including clinicians, to support physician compensation and productivity management.

3. **Quality and utilization initiatives:** A quality and utilization review work group should identify where new clinical protocols can address payer opportunities, such as reducing re-admissions, and develop those protocols. It should work with clinicians and operational managers to operationalize and reinforce the protocols at the practice level, as well as quality and UR guidelines. The work group should be empowered to enforce its recommendations by monitoring physician performance against protocols and standards.

4. **Front-end revenue cycle solutions:** Improving the completeness and quality of information that goes into the EMR system—documenting visits and procedures, coding, and charge capture--can help maximize revenues. The work group assigned to identify these front-end opportunities should include administrators, clinicians and revenue cycle staff. They should have a rolling charge, identifying areas for improvement, providing guidance on how to achieve those improvements, and moving on to the next area of focus. The group might consider developing metrics linked to incentive compensation (e.g., closed visits and up-to-date work queues).

5. **Referral loss initiatives:** While discussions about referrals to other physicians and services need to be handled with care, they should not be ignored. A physician work group can help these conversations happen. The group can receive any available data on referral patterns, and group members can hold individual discussions at the

practice level with colleague physicians regarding opportunities or impediments to “in-house” referrals. These may provide the basis for process changes, recruiting priorities, or discussions between clinical directors and their specialists, or improvements in specific clinical programs. Physicians, of course, have some autonomy in their referral choices, but new hires should still receive guidance on expectations or policies on referrals.