

# PeRspective

## EMBEDDED MEDICAL GROUP PRACTICES IN INTEGRATED HEALTH SYSTEMS



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As health systems employ physicians in a quest for superior clinical performance and sustainable market share, hospital administrators and physicians alike seek opportunities for positive physician leverage in support of a unified vision. The key to their success lies in transforming an employed cadre of independently minded physicians into an embedded group practice with an identifiable culture, aligned goals and strategic incentives.

A group of health system-employed physicians with individual contracts, disparate professional agendas and non-aligned referral patterns is a natural first step in markets where the independent private practice of medicine has been the traditional model. Employed physicians in this arrangement continue to look to the traditional organized medical staff of the hospital as their focus of leadership, governance, clinical quality improvement and the professional practice of medicine.

A physician group practice embedded within a fully integrated health system operates from a unified agenda, congruent with that of the health system. It usually has a uniform, evergreen physician employment agreement; a single physician compensation plan and benefits package; and a productive physician recruiting platform. It demonstrates its capacity to effectively handle all aspects of the professional practice of medicine within the group practice itself.

## Group Practices in Integrated Health Systems

Physician group practices embedded in integrated health systems have five essential responsibilities. Fully integrated group practices are assigned accountability for these functions because they are recognized by hospital and health system boards and by physicians themselves, as the drivers of clinical services success. A hospital's traditional organized medical staff cannot reasonably be expected to succeed in this leadership role because of its multiple, diverging (and sometimes conflicting) professional agendas.

The five functions for which a group practice assumes responsibility in an integrated health system are:

- Physician leadership and governance
- Physician recruiting
- Quality of clinical services
- The professional practice of medicine
- Physician compensation

## Physician Leadership and Governance

The group practice is most commonly either a division of the health system or a wholly owned subsidiary; in either case, it is "fully integrated." Conversion of the group practice to not-for-profit tax status facilitates strategic and financial operations within the overall strategy and consolidated finances of the enterprise. The group practice aligns its agenda with health system vision, mission and goals.

The group practice is led by an elected Medical Practice Executive Committee, which intentionally develops a recognizable, cohesive group culture. The latter begins with articulating shared standards for clinical and service quality based on recognized health system strategies. The group's culture encourages team behavior, fosters professional productivity and develops physician leadership.

Physician leadership is recognized as essential to the success of the group practice and the overall health system. Physician leaders act across the health system at all levels as partners with administrators in strategic and management decisions. Effective physician leadership, in the setting of an embedded group practice culture, ensures that recruiting, quality, professional practice and physician compensation accountabilities of the group practice are successfully met.

## Recruitment

Group practice physician leaders participate with health system administration in a multi-year plan to recruit "best fit" physicians in a strategic portfolio of specialties to health system practice sites. These are physicians who possess not only the desired clinical and subspecialty credentials, but practice goals which include working as part of a team co-led by physicians and administrative professionals. Recruitment strategy combines anticipated health system geographic footprint requirements (existing and new clinical sites plus subspecialty outreach consultation), local demographics, evolving market conditions and competitor analysis.

Employed physicians work exclusively for the group practice. As the group practice becomes populated by new physicians on the basis of market-based, health system-specific recruiting strategies, the health system sees less need to support (and recruit for) independent physician practices choosing to remain in the traditional model. In fact, as the employed practice grows, the strategic role of independent physicians at health system-owned hospitals lessens.

## Quality

Oversight and management of clinical, service and operations quality is a basic responsibility of the group practice. Physicians manage to quality targets using metrics which they and their administrative partners determine as strategically appropriate. The metrics selected are relevant to physician practice, reasonably achievable and reliably measurable.

The Balanced Scorecard, or an equivalent system, is useful for tracking selected quality, financial and process metrics in day-to-day management of organizational quality. Its components encourage system thinking, strategic decision-making and physician-administrative partnership. Health system management information can be concisely reported across the enterprise at the corporate level using perhaps 25 measures at most. The Scorecard demonstrates the inter-relatedness of key financial outcomes with health system abilities to satisfy customers, manage internal operations efficiently and enhance organizational learning, focusing physician and administrative partners on broadly recognized success drivers of the organization. *(Please see Figure 1).*

FIGURE 1. A Sample Balanced Scorecard

SMDC Balanced Scorecard						
Perspective	Measure	Freq	Actual July	Actual YTD	Target YTD	Status
	Operating Margin	M	PROPRIETARY INFORMATION			★
	Non-Operating Return	M				★
	Days in A/R - Hospital	M				★
	Days in A/R - Clinic	M				★
	Days Cash on Hand	M				★
	Margin on Growth Areas (Annual)	A				★
	Primary Care Clinic Patient Satisfaction (Annual)	A				★
	Growth Area Inpatient Market Share (Annual)	A				★
	Hospital Patient Satisfaction (Semi-annual)	S				★
	Appointment Access	M	Dev. Measure	N/A	N/A	N/A
	Phone Access Clinical Sections Non-Clinical	M				★
	Hospital mortality rate - SMMC (Semi-annual)	M				★
	Specialty Care Access		Dev. Measure	N/A	N/A	N/A
	% Sub Specialized Programs Developed (Annual)	A				▲
	% Studies in Targeted Growth Areas (Annual)	A				▲
	% I/C Targets achieved (Quarterly)	Q				★
	Cost/Adj. Discharge*	M	PROPRIETARY INFORMATION			★
	Cost/Encounter	M				★
	Hours on Diversion - SMMC	M				★
Length of Stay	M	★				
	Gallop survey grand mean (Annual)	A				▲
	% Critical resource positions filled (Quarterly)	Q				▲
	Turnover rate (Quarterly)	Q				▲
	Performance to master facility plan (Quarterly)	Q				▲
	% of patient care activity converted to Epic (Quarterly)	Q				●
* Case Mix Adjusted						
Status	On Plan					★
	Progress toward Plan					▲
	Off Plan					●

Managing the interface of group practice-driven quality and organized hospital medical staff-initiated quality becomes easier, the stronger the group practice's physician leadership capacity becomes. This strength results from employed group practice physicians operating with a single agenda, driving quality decisions by the weight of alignment with health system customer requirements.

Though employed group practice physicians may numerically represent a minority of the physicians serving a hospital, their health system-based consistency of purpose can transcend the multiple, disparate agendas of the independent medical staff. In light of a quality agenda coming from its own health system's physicians in the embedded, integrated group practice, a hospital can hardly expect less from its organized medical staff.

### Professional Practice of Medicine

Oversight and management of the professional practice of medicine within the hospital begins in the employed group practice. The Medical Practice Executive Committee assumes responsibility for the quality, operational effectiveness and sustainability of the professional activities of all physicians in the group practice. It is accountable for its physicians' clinical activity at ambulatory and acute care delivery sites, including work at hospitals and outpatient facilities not owned by the health system.

Standards of clinical and service quality which are defined and maintained by the group practice are accepted by the health system as reasonable for all physicians, including independents working in health system hospitals. For example, if maintaining clinical privileges to perform an invasive procedure is made contingent by the employed group practice for its own physicians on satisfactorily performing a minimum number of cases per year, the same standard

of practice quality should apply to independent physicians. Credentialing and privileging standards in general cannot be less stringent for independent physicians working in health system-owned hospitals, than those articulated by the embedded group practice for its own physicians.

Physician professional activity is a component of health system and group practice quality. Disruptive behavior and clinical competency issues are managed within the group practice. These issues cannot be left to the organized medical staff of the hospital to handle because they are not hospital medical staff issues. Rather, they are part of the accountability of the embedded group practice toward its employed physicians, the health system and its patients.

Group practice values relating to the professional practice of medicine are shared, written and articulated by the Medical Practice Executive Committee in cooperation with the physicians of the group practice. As an example, Duluth Clinic physicians developed a Principles of Partnership statement by which over 400 physicians working across the not-for-profit group practice in multiple, geographically dispersed sites could perceive and value their work as partners in the care of SMDC Health System patients. *(Note: SMDC Health System and Duluth Clinic are part of Essentia Health). (Please see Figure 2).*

## FIGURE 2. Duluth Clinic Principles of Partnership

*SMDC Vision: SMDC, as a world-class organization, will be the best place to receive care and the best place to work.*

*DC Mission: We are here to serve patients.*

### PHILOSOPHY

- We provide high quality, safe, and patient-centered health care.
- We communicate well, collaborate effectively, and work as a team.
- We treat everyone in a dignified, respectful manner at all times.
- We count on each other to succeed.

### PURPOSE

Striving to become the best place to receive care and the best place to work, as members of the DC practice, we share these principles:

#### Quality Care

Our goal is that our patients experience compassionate, confidential care with optimal outcomes. We focus on the whole patient and his or her environment. We need to communicate with each other to ensure we follow current best practices. We strive to use scientific, evidence-based methods to remain on the forefront of health care research and delivery.

#### Respectful Relationships

- **Trust and Collegiality** We value everyone's contributions to patient-centered quality care, and strive to achieve an environment of trust and collegiality. We expect mutual integrity, open communication, honesty and transparency at all levels of the organization. We recognize that physicians and members of the health care team may occasionally have concerns regarding one another's behaviors or performance. When issues arise, we agree to address them and work toward resolution together.
- **Diversity** We work in an environment of diverse backgrounds, interests, and beliefs. We wish to provide a welcoming, supportive atmosphere where patients and coworkers feel valued and safe. We will show respect for those who may be different from ourselves.
- **Balance** Life requires a healthy balance of activity. We will support each other in times of peak stress. We recognize each others' need to maintain a satisfying life in and out of the work environment.

## Physician Compensation and Productivity

Physicians in embedded, fully integrated group practices have no incentive to sort prospective patients by payer. The physician compensation system recognizes units of work, not units of revenue.

Physician productivity expectations are market-based. Work RVUs derived from the Resource Based Relative Value Scale, the physician payment system for Medicare, form a national benchmark and internal expectations for productivity by specialty. Specialty departments compile an annual work RVU total for their physician complement which translates into the operating revenue budget.

The definition of physician productivity expands beyond clinical billable work RVUs. Time, effort and expertise spent in significant physician leadership roles as well as in essential but minimally billable clinical activities, e.g. outreach specialty consultation, is recognized in budgeted productivity projections using work RVU equivalents.

Physician cash compensation is market-based. The compensation plan is developed and administered day-to-day by a committee of the Medical Practice Executive Committee. The physician compensation plan is approved by the health system's Board. The health system supplies a group practice physician benefit package in addition to cash compensation.

All revenues, including ancillary revenues (billable services not rendered by a physician), are health system revenues. They are not part of calculating physician compensation. Productivity is co-managed by physicians and administrators.

All expenses, including professional liability coverage, are health system expenses. Overhead expense is not part of calculating physician compensation. Physician compensation is a line item of the income statement, not unlike other operating expenses. Like productivity, practice expense and costs of care delivery are co-managed by physicians and administrators.

## Managing an Embedded Group Practice in an Integrated Health System

### *System Thinking*

“Thinking as a system” is a key organizational behavioral requisite of integrated group practice physicians. Physician engagement in improving operating efficiency, care effectiveness and team behavior across the health system is clearly understood as promoting economic sustainability of the health system. Teamwork becomes a key “embedded” skill of employed physicians. Physician productivity is measured at several levels; the most important is “total system performance.”

### *Comparison of Traditional and Integrated Health System Group Practice Models*

The traditional independent group practice model is under significant pressure from evolving customer/payer-driven health care. Reasons for this include (at least) the following: increasingly sophisticated expectations on the part of patients and physicians relative to the presence or absence of an enterprise-wide electronic health record; customer dissatisfaction with perceived levels of clinical and service quality in traditional fragmented care models; lack of unified billing for an episode of care; and health care navigation fatigue resulting from multi-stop shopping, conflicting treatment plans and impenetrably complex insurance options, within a socioeconomic environment of no universal coverage base.

Over time, for all the economic reasons described above, the traditional independent group practice model has begun shifting toward group practices embedded within integrated health systems. Evolving customer/payer-driven health care tilts marketplace attractiveness toward those group practices which are built to respond to (and collaborate with) customers and payers. This integrated group practice model becomes more durable than the traditional model and we believe will be ultimately more successful. *(Please see Table 1 on next page).*

**TABLE 1: Approaches to Managing a Group Practice**

Group Practice Characteristic	Traditional Model	Integrated Model
PURPOSE OF THE GROUP	The group exists to provide a place for individual physicians to practice. Administrators are hired to manage group practice operations.	The group practice is an integral part of the health system. Employed physicians are intentionally partnered with administrative professionals in co-managing quality, effectiveness, cost and efficiency of clinical programs, and services across the continuum of care.
PHYSICIAN EMPLOYMENT	Physician employment agreements are negotiated as “one-off” contracts, usually with significant resulting inter-physician variability.  Recruiting an additional physician may be delayed by income concerns of other physicians in that specialty.	All group practice physicians have the same employment agreement.  Recruitment decisions are based on market need and health system strategy, set jointly by physician and administrative leadership.
PRACTICE FINANCES	Physician partners distribute all profits among themselves as compensation. Few or no funds remain for practice growth; surplus income is taxable.	Group practice finances are part of the consolidated finances of the not-for-profit health system. Growth of the group practice is a health system strategic priority. Surplus income is non-taxable.
OVERHEAD AND ANCILLARIES	Overhead expenses and revenue from ancillary services (e.g. lab and imaging) are significant components of physician compensation calculations.	Overhead expenses are a health system expense. Revenues from ancillary services, whether office or hospital based, are health system revenues. Neither are included in calculation of physician compensation.
PRACTICE COST MANAGEMENT	Managing practice costs is seen as the domain of hired administrators, not as a part of physician accountability for the success of the practice.	Physicians are routinely engaged in managing costs as part of their responsibility toward continued viability of the group practice and the health system.
PHYSICIAN LEADERSHIP	Strong physician personalities run the group; they may be elected and provided a stipend, or may be unpaid “volunteers.”	Physicians are selected for leadership roles based on demonstrated skills and experience. Significant time commitments are funded by the health system using “Work RVU equivalents.”

**TABLE 1 *continued*: Approaches to Managing a Group Practice**

Group Practice Characteristic	Traditional Model	Integrated Model
<p>PATIENT REFERRALS</p>	<p>Physicians in the practice are expected, sometimes pressured, to keep all referrals within the group for business purposes, including retaining specialty referral patients in the group for primary care regardless of whether the patient already has an outside primary care physician.</p> <p>Specialty physicians function independently within the group, often competing with each other in the same referral market. Relationships with referring physicians inside and outside the group are specific to each specialist trying to attract personal referrals.</p>	<p>Physicians refer patients on the basis of quality of care and patient convenience. The group practice positions its quality and service goals to preferentially attract those referrals from both internal and external physicians.</p> <p>Active, respectful relationships with referring primary care and specialty physicians are built by the group practice using personal communication, outreach consultation and administrative systems. Patients seen by group practice specialty physicians are returned to their referring primary care physicians for routine care.</p>
<p>PHYSICIAN COMPENSATION</p>	<p>Compensation of high revenue-producing specialists is perceived as “diluted” by compensation needs of lower revenue-producing specialists, leading to strained or fractured relations among physicians within the group.</p>	<p>Compensation of all physician specialties is at market rates. The compensation pool recognizes the value of each specialty as an integral part of the enterprise.</p>
<p>PHYSICIAN PRODUCTIVITY</p>	<p>Expectations of physicians may be vague regarding productivity or time away from the practice. Physicians choose their level of productivity based on personal income and lifestyle requirements. Projecting a need for another physician in the practice becomes difficult due to a lack of definition of what constitutes a full-time practice.</p> <p>Patient appointment access standards generally vary by physician practice.</p>	<p>Expectations of the group practice are clear to existing and recruited physicians regarding WRVU productivity and time away (vacation, CME). These are specialty-specific, aligned with health system strategy. Full-time practice is defined in terms of WRVU productivity, on-call and time away expectations.</p> <p>Achievable, customer-acceptable appointment access standards are articulated across all specialties, serving as a quality goal and as a need-based recruiting driver.</p>
<p>NONCOMPETE (RESTRICTIVE COVENANT)</p>	<p>The restrictive covenant protects remaining physicians in the group from exposure to escalating overhead if a physician leaves.</p>	<p>The restrictive covenant protects strategic growth opportunities of the group practice and the health system.</p>
<p>REVENUE STREAMS</p>	<p>Limited number of revenue streams; not easily capitalized.</p>	<p>Far more expansive set of revenue streams is available to fund the totality of the enterprise.</p>

**Summary**

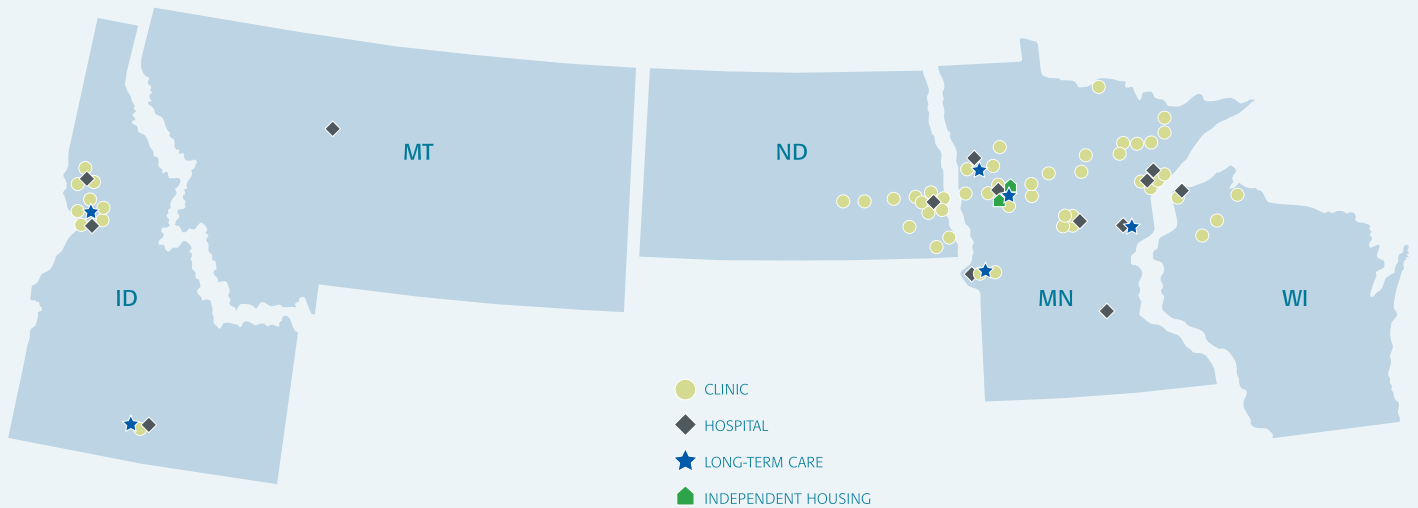
Group practices embedded within integrated health systems are able to bring to the health care enterprise focused physician leadership, aligned clinical incentives and a group culture which takes responsibility for the professional activity of its physicians across the health system. This model derives from the integrated health system organizing itself to meet evolving customer and payer demands for reliable quality, intuitive ease of use and high degrees of satisfaction with the experience of a single episode of care.

The fully integrated group practice model, over time, is preferable to physicians. Why? Through dampening compensation vulnerability to reimbursement volatility,

providing greater scope for physician participation in health system decision-making and encouraging clinical innovation (e.g. chronic care management, clinical research, specialty outreach consultation programs), the health system maintains a strategic recruiting platform from which to staff the practice across specialty mix and geographic footprint requirements.

This model is also attractive to patients in their search for greater reliability and less complexity in health care. One-stop shopping, a single bill, aligned diagnostic and treatment plans and a seamless electronic health record are reasonable patient expectations. They are actually achievable targets in group practices embedded in integrated health systems.

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