

PeRspective

STRESS TESTING A HEALTH SYSTEM'S PHYSICIAN STRATEGY



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The U.S. economic downturn has given rise to new entries to the financial lexicon; TARP, TALF, stimulus package, subprime, contango, etc. Another, pertinent to this article, refers to the “stress testing” of banks; a proposed model for testing the capital structure, solvency risk and exposure to other economic, market and financial risks. In theory, there is an analytical model that, if well-conceived and properly applied, will yield some composite financial stress score for U.S. banks.

“Stress” is used in a similar vein for this article except applied to the existing or future physician strategies of health systems that are or will be integrated; models where most, if not all, physicians required to meet the mission, clinical programming and strategic needs are, or will be, employed by and engaged as partners in a unified (integrated) health delivery system. Whether fully integrated or not, many if not all, components of the “stress test” that follows is worth consideration by health system leaders.

Seeing Integrated Health System as a “Closed Economy”

So how does the concept of “stress testing” in U.S. banking apply to physician strategies in integrated health systems? Where (and if) integrated health systems reach a point where most (if not all) physicians required are integrated with the health system, a “closed economy” is created, more or less. Said otherwise, the health system is no longer reliant and dependent upon the nature of the

independent practice model to deliver physicians in the right numbers, right specialties and the right locations. Moreover, physicians in integrated health systems are no longer “on the market”, open to competition, or exposed to the market and economic vulnerabilities of the private practice business model¹. To some health system leaders this described state is nirvana, to others it’s high anxiety, depending upon one’s experience and perspective on future health care markets.

The closed nature of the integrated “economy” argues for the ability to actually manage a mission and strategy (including the integrated physician components) rather than designing a health system strategy hoping that independent physicians cooperate and collaborate.

So, how does the concept of “stress testing”, as defined here, and a health system’s physician services strategy apply? If well conceived, well-balanced and well executed, an integrated model of community health care delivery can be an effective organizational design, providing the physician services component of the design is equally well conceived, well-balanced and well executed. The key question regarding the state of any physician services component of an integrated health system is “How do you know?” This is a reasonable question, especially when a community health care system has insufficient experience with the design and management of physician services. It is this issue that has given rise to the application of a “stress test” for banks to physician strategies. The framework provided should be sufficient for community health system leaders to, at least, raise pertinent issues and questions for management teams to consider as strategy is discussed.

Applying Stress Testing to Physician Strategies

While the concept of stress testing banks applies to stress testing integrated physician strategies, in concept, there are characteristics of the successful integrated health systems that can be “tested”, not necessarily for production of a composite score (at least not yet), but for subjective evaluation and assessment by experienced leaders. That which follows is a beginning conceptual model of a stress test for integrated physician strategies; a comprehensive conceptual model with factors that interrelate.

¹ Zismer, D.K., Person, Peter E.; What Does the Future Hold for the Larger, Independent, Multispecialty Medical Group? Is a “Tipping Point” on the Model’s Horizon; AMGA Group Practice Journal, April 2007, Volume 56, No. 4.

Stress Test Factor #1: Sizing and Balance of the Physician Group

When physician services productivity in an integrated health system is arranged and tested for “intercorrelations”, the relative predictive relationships between various clinical services, it becomes clear why multispecialty group practice models have worked. Productivity in one specialty can be highly correlated with productivity in others. This is intuitive and logical, but rarely well managed. If, for example, internal medicine productivity predicts productivity in cardiology and a health system undersizes cardiology, financial opportunity is lost daily. Likewise, if family medicine and urgent care productivity predicts orthopaedic surgical volumes and the system fails to size the orthopaedic specialties to the potential, financial opportunities here are lost, as well.

The efficiency and financial model is directly dependent upon the optimization and balance of the “closed economy”; i.e., the sizing and the balancing of the physician services specialties.

The effects are pronounced in markets where specialists are competitive with community health systems. The health system controls primary care, the primary care network reliably delivers referrals to specialists, the specialists control related profitable revenue streams, the health system’s financial performance deteriorates. Too often the costs related to the employ of primary care physicians is to blame when the primary care network did its job, it’s just that “competitors” were the beneficiaries of the referral opportunities.²

Stress Factor #2: Managing the “Front Door”

This factor is related to #1, but differs in an important way. Zismer, McCollough and Person showed that aggregate physician outpatient services productivity (patient access to all outpatient physician services across specialties) was a strong predictor of health system revenue overall.³ This finding suggests that the “physician office” (in all specialties) is an important revenue generator of a health system. Restrict access here (by any method) and the health system restricts its own access to necessary revenues. In the traditional health care delivery design (i.e. hospitals and independent physicians) the numbers specialty mix

² Zismer, D.K., The Physics of Market Consolidation and the Likely Effects on the Private Medical Group Practice; Perspective, July 2008.

³ Zismer, D.K., McCullough, J., Person, P.E., In Press, Integrated Healthcare Economics: Understanding the Revenue Drivers in Fully Integrated Community Health Systems, Physician Executive.

and geographic location of physicians is left to the design of the independent medical staff. The result may or may not be sufficient for the related hospital(s).

Stress Test Factor #3: Physician Compensation Design and Incentives Alignment

All physician compensation plans are typically well-designed for the results they achieve. Opinions on physician compensation in integrated health systems are all over the map. The opinions that favor designs that put physicians at “full risk” for the economics of the physician services component of the health system; i.e., at risk for payor mix, collections, all practice overhead, bad debt and charity care, will often observe physicians behaving accordingly. Isn’t that good (i.e., of benefit to the integrated model)? Not if physicians working within this model: cherry pick for payers, refuse lowpay or no-pay patients, control access for more complex, “slower” patients who reduce productivity at the office, or create schedule management methods that increase “throughput” while decreasing patient satisfaction. It is often too easy for health system executives to tilt to the “full risk” compensation model for employed physicians; the unintended consequences are the risk (and stressor).

Stress Test Factor #4: Regional Reach

A significant risk inherent in the private practice models are the negative incentives for geographic outreach when physicians are busy “at home”. Likewise, the compensation model that causes the integrated physician to stay close to home is equally problematic; “I have a negative financial incentive to do outreach for the system because it doesn’t recognize that it costs me production and compensation to reach out geographically”. This is an easy fix in the integrated model⁴, yet the problem often persists. It is a compensation design problem that causes a great deal of potential to go unrealized.

Stress Test Factor #5: Managing for Real Economic Growth - The Balance Sheet Effect

Real economic growth occurs in a health system when per unit revenue production growth rates exceed per unit cost production growth rates; for specific clinical service lines and for the organization overall. Real economic growth coupled with good management displays itself on the balance sheet of the organization (improved balance sheet performance ratios).

In pressured market cycles (such as those ahead), the more traditional community health delivery models wisely use the tools at-hand to positively affect operating and related financial performance; operations improvement, supply chain management and expense reductions. Effective integrated health systems employ these tools as well, but also focus on enhancement of the “leverage” potential of the physician services component of the model. Two examples of leverage, in this sense, include:

- Use of physician extenders and the electronic health record to leverage the potential of primary care physicians. Integrated systems are anticipating the expansion of the primary care physician panel up to a factor of 3 with these models (including the application of standardized disease management standards and protocols).⁵
- Use of specialty trained family physicians in, for example, a “med-ortho” model to manage access, initial diagnosis and triage for orthopedic patients. The results include: improved access, optimal utilization of diagnostic imaging and enhanced productivity of orthopedic surgeons; model being adapted for neurosurgery and spine patients.

Real economic growth potential is more readily available in the integrated models of care delivery if leadership (including physician leaders) chooses to exploit the potential of the model.

Stress Test #6: Applying Physician Services Potential to Improve the Operating Expense Structure and Asset Performance Ratio of the Integrated Health System.

With physician compensation incentives aligned well with organizational goals, physician services potential can be applied to better manage clinical service variation to the benefits of patient care and operating expense results. Effective management of clinical pathways, protocols and care processes by physicians will improve fixed asset efficiencies as well (measured as fixed asset turnover rates). The integrated physician strategy should demonstrate results in these areas at the high-end of available performance benchmarks. An integrated physician strategy that does not optimize operating and asset performance wastes potential. Given that physician compensation expense in integrated models can, in the aggregate, exceed that of the independent markets, an organization’s operating

⁴ Zismer, D.K., A Focus on the Clinical Specialties, Perspective, September, 2007

⁵ Property Presentation, SG-2, Chicago, Illinois.

and balance sheet performance will be stressed, in the negative, unless physicians are engaged in clinical care variation performance management.

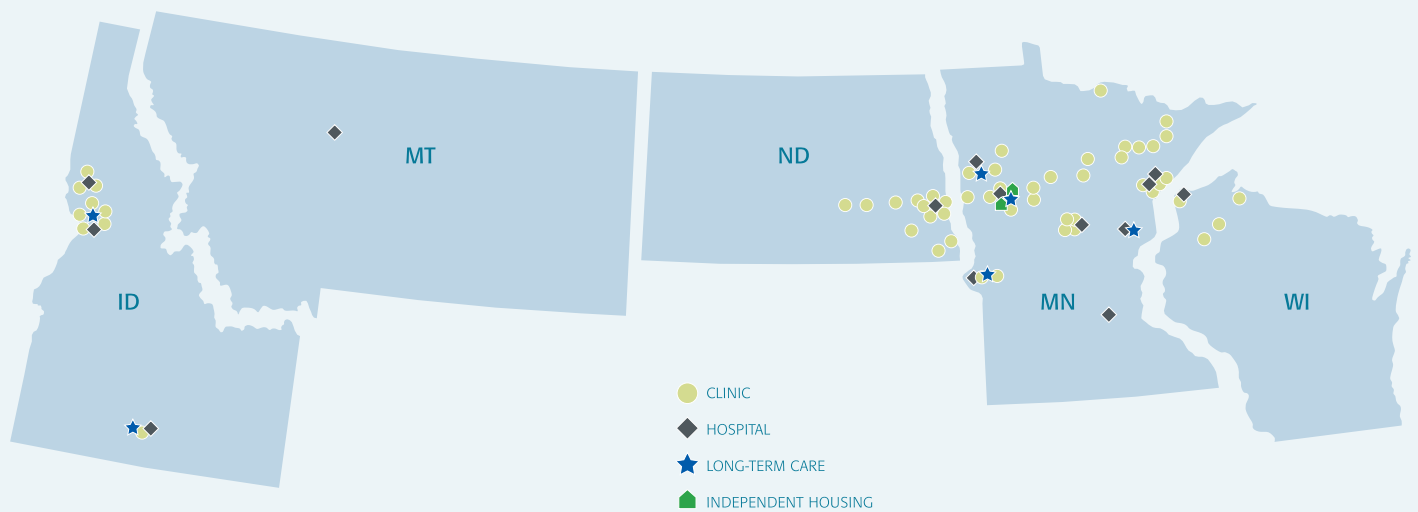
Summary: Grounding the “Stress Test” Model in the Practical

Just as with the stress tests being applied to our U.S. banking system, the goal of the construct, as presented, is a reliable model by which integrated health system leaders can test their physician services models and strategies against the overall strategic, financial operating and economic goals of the health system. Specifically, the model must test existing performance against goals that, if achieved, will build the mission, financial and strategic strength of the health system.

As cited, critics of the integrated model of community health care delivery discredit the model’s ability to do anything but degrade the balance sheet; “integration just adds costs to the health system”. The counter argument is there is nothing inherently useful about an integrated business model. The value is in the execution and, when well executed, the ability of the model to produce superior results.

The “stress test” model prescribed here may not prove to be wholly sufficient, but experience shows it likely passes the bulk of the key factors worth testing.

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