Executive Summary

The High-Performance Medical Group

Study in 10 Conclusions

**Seeking Full Value from the Employment Investment**

1. **As Physician Employment Grows, Hands-Off Management Approach Falling Short**
   Many hospitals and health systems are reaching a critical mass of employed physicians, but in continuing to manage practices as autonomous, loosely integrated units, are missing opportunities to realize full value from greater scale.

2. **“High-Performance Medical Groups” Capitalize on Cohesion**
   Organizations that have fostered integration between physician practices offer an alternate model, leveraging the coordinated employed enterprise to achieve strong operational and clinical results.

3. **Group Success Due to Strategic, Not Structural, Factors**
   Successful groups vary in structural factors such as size, market, or history, but share three defining characteristics: identity as a unified, physician-led network; infrastructure to enhance group performance; and incentives designed to engage individual physicians against group goals.

4. **Imperative to Begin the Integration Journey Now**
   Although many medical groups have had decades to organize, systems today must accelerate integration to avoid falling behind amid rapid market changes; even those with just a few employed physicians can begin laying groundwork for group creation.

**Attributes of the High-Performance Medical Group**

5. **Common Physician Culture Undergirds All Group Activities**
   A formal, physician-led commitment to common values drives group strategy and physician actions; while culture varies, all groups treat care as a team-based sport and assess physician value more broadly than the practice-level bottom line.

6. **Integrated Physician Team Key to Referral Retention, Care Coordination**
   Culture-linked hiring and onboarding, combined with partnership-building activities, perpetuate group identity and foster an environment in which coordinated care and in-network referrals are the norm.

7. **Meaningful Decision-Making Authority Placed in Physician Hands**
   Recognizing physician leadership as crucial to engagement of the rank-and-file, groups build comprehensive physician governance structures, invest in leadership development, and involve medical group leaders in system-level strategy-setting.

8. **Infrastructure Supports Collaborative Performance Improvement**
   Full and open information transfer—via an enterprise-wide information network—promotes care coordination, enhances patient access, and drives formal improvement processes; additional tools deployed at scale allow physicians to optimize practice operations and clinical delivery.

9. **Transparency a Primary Tool for Motivating Physician Behavior**
   Respecting physicians’ natural skepticism, groups use open, two-way communication to win buy-in for strategic decisions, while also capitalizing on physicians’ competitive tendencies by sharing (often unblinded) individual performance data to drive behavior change.

10. **Compensation Change Utilized Sparingly and Strategically**
    Unlike hospitals that view compensation as the primary means of influencing physician behavior, high-performance groups turn to financial incentives only when other motivational levers fail—altering compensation primarily when the existing model becomes a legitimate barrier to change.
Failing to Capture Full Value from Rising Physician Employment

Thwarted by Fragmentation, Unable to Make Bigger Mean Better

Confluence of Forces Sparking Sharp Employment Growth...

<table>
<thead>
<tr>
<th>Performance Metric</th>
<th>Potential Improvement with Larger Scale</th>
<th>Reason for Current Performance Gaps</th>
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<tbody>
<tr>
<td>Practice Finances</td>
<td>Achieve economies of scale, eliminate operational variation</td>
<td>Protection of practice firewalls inhibits consolidation, cost-sharing; considerable process variability remains</td>
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<tr>
<td>Referral Volumes</td>
<td>Capture more patients within loyal referral network</td>
<td>Inhibited by weak relationships between practices; many physicians do not know who else is employed</td>
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<tr>
<td>Patient Access</td>
<td>Leverage broad network to expand appointment availability</td>
<td>Few levers to win physician buy-in for disruptive access redesign; practice silos prevent sharing of mid-level providers</td>
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<tr>
<td>Care Reliability</td>
<td>Engage broad physician base against clinical quality and cost goals</td>
<td>Emphasis on individual productivity, lack of system affinity provide little incentive to focus on quality</td>
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<tr>
<td>System Efficiency</td>
<td>Provide full scope of services and coordinate care across provider types</td>
<td>Thwarted by emphasis on individual performance, weak peer relationships, lack of infrastructure</td>
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…But Practice Silos Thwarting the Potential Benefits of Scale

Fueled by demographic shifts within the physician workforce, declining reimbursement, and new imperatives for care delivery redesign, physician employment by hospitals and health systems is on a sharp upswing. Across the country, organizations report that their employed ranks have grown significantly as market forces push hospitals and physicians toward tighter alignment. As a result, many hospitals are rapidly approaching a critical mass of employed physicians across many specialties.

Yet even as the employed ranks swell, many hospitals continue to manage practices as standalone units. Still cognizant of practice losses in the 1990s, they have focused primarily on stabilizing practice solvency, mimicking the structure and incentives of private practice. In addition, hospitals have taken a hands-off approach to practice management in a belief that autonomy is attractive to physicians wary of hospital control.

In protecting practice silos, however, hospitals are failing to capture the potential benefits of growth in the employed ranks—an expanded referral network, enhanced patient access, operational economies of scale, opportunities to improve quality, and enhanced care coordination. As a result, many are seeking a new approach to practice management, one that enables them to leverage the employed enterprise as an integrated medical group.

Source: Health Care Advisory Board interviews and analysis.
A subset of organizations have taken an alternative approach to practice management, successfully managing employed physicians at scale. By fostering cohesion among practices, these “high-performance medical groups” have historically generated strong financial, clinical, and operational results.

Yet little guidance exists on what specific organizational attributes and practices make high-performance medical groups successful. To answer that question, the Health Care Advisory Board launched the High-Performance Medical Group Initiative.

Through this Initiative, we identified more than 25 medical groups that excelled on financial, clinical, and other strategic indicators and conducted in-depth conversations and site visits with these organizations in order to understand the sources of strong performance. This publication details the key findings from that research effort.

The groups profiled in this publication differ significantly on structural factors such as size, composition, or history. Yet all have something deeper in common, sharing the 15 core attributes listed on this page. These attributes, explored further in this publication, are the foundation of the groups’ strong performance results.

**Defining the High-Performance Medical Group**

Wide Variety on Surface Factors, But Set of Shared Strategies at Root

**Areas of Variability Between High-Performing Groups**

- **Size**
  - Range from 200 physicians to 1,400

- **History**
  - Age range from a few years to more than a century

- **Ownership**
  - Mix of hospital-owned subsidiaries, independent groups, integrated delivery systems

- **Market Type**
  - Mix of urban, suburban, semi-rural and rural

- **Payment Model**
  - Range from pure fee-for-service to capitation

**15 Attributes in Common**

1. **An Integrated Identity**

   **Creating Common Culture**
   1. Shared Vision and Formalized Cultural Expectations
   2. Unified Identity Projected to Non-Physician Stakeholders

   **Fostering the Partnership**
   3. Cultural Expectations Hardwired in Recruiting and Onboarding
   4. Meaningful Interpersonal Relationships Between Physicians

2. **Infrastructure for Shared Success**

   **Extending Performance-Enhancing Tools**
   9. Enterprise-Wide Information Network
   10. Formal Processes for Data-Driven Performance Improvement
   11. Scaled Resources to Support Care Delivery

3. **Individual Behavior Aligned with Strategy**

   **Leveraging Transparency**
   12. Effective Bidirectional Communication Processes
   13. Dissemination of Unblinded Physician Performance Data

   **Designing Strategy-Aligned Compensation**
   14. Compensation Narrowly Tailored to Advance Group Objectives
   15. Staged Adoption of New Compensation Plans

Source: Health Care Advisory Board interviews and analysis.
Shifting from Aggregators to Integrators, Starting Today

This publication profiles mature medical groups, painting an aspirational picture of what a successful employed physician network may become. For many hospitals, building a similar high-performance group will require a significant investment of time and resources. The timeline here, which shows the typical progression of medical group development, describes the journey ahead.

While building an integrated medical group requires investment, the decision to forego or delay this journey may be equally costly. As the ranks of employed physicians grow, so do the risks of failing to capture full value from that investment. In the near term, those risks include missed opportunities for quality and cost improvement, revenue lost to out-of-network referrals, or strategically inappropriate acquisition offers. In the long term, failure to build an integrated partnership with employed physicians jeopardizes hospitals’ ability to meet emerging standards for care coordination and management.

Although many successful medical groups have organized over decades, hospitals today must accelerate integration to avoid falling behind amid rapid market changes. Even those with just a few employed physicians can begin to build common culture and invest in network infrastructure. Ultimately, these steps lay the groundwork to create not just a high-performance medical group, but a high-performance health system.

Timeline for Constructing the High-Performance Medical Group

Laying the Foundation for Coordination
- Define and codify common culture
- Create communication protocols
- Build physician governance
- Invest in leadership training
- Begin to invest in common EMR

Capturing Early Returns from Integration
- Develop group dashboard
- Share individual performance data
- Design onboarding program
- Establish peer hiring, service standards
- Centralize referral scheduling

Leveraging the Enterprise for Care Redesign
- Establish access protocols
- Redesign primary care
- Reward coordination
- Reward quality
- Arrange clinical pathways
- Define medical management resources
- Deploy care management resources

Source: Health Care Advisory Board interviews and analysis.