Saving Private Practice and the Role of Physician Leaders

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Every rational, independent physician, regardless of specialty or type pf practice model, should be questioning the future of the private medical practice. Instigating factors include macro healthcare economic dynamics; governmental policy; the effects of consolidation of the payer and provider sides of the industry; and the idiosyncratic business model preferences of practice owners, meaning the perpetuation of preferred business models in the face of prevailing environmental contraindications. This article presents the evidence for the survivability of the private medical practice. It presents a framework for thinking and design, based on observations derived from physician-owned practice models. Physician leaders play the key role in moving the vulnerable practice business model toward those with potential for survivability and future growth and development opportunities.

KEY WORDS: Physician leaders; independent practice; market dynamics; future business models; framework for thinking

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One nagging question for many existing and would-be physicians and their mentors is, "Can the independent physician exist in the evolving climate of U.S. healthcare?" We are going to address this question in detail, but first we will define the operative term "independent physician." We define "independent physician" as a professional who can pursue a rewarding medical career within a clinical business model that affords a sufficient level of professional autonomy. The independent physician has control over the risk and reward equation that guides not only their organization's mission, vision, and strategy, but also its financial performance. The short answer to this question is "yes," but with key, critical qualifiers that require assiduous adherence to the business principles discussed in the following sections.

It is important to understand that a mission to remain independent, in and of itself, is not a business strategy; it is a cause. While causes may be laudable, they are not substitutes for well-reasoned, well-executed business strategies.

What foretells against the physician in independent practice in the United States? Before proceeding with descriptions of the key business principles that apply, let's review five important healthcare marketplace maxims:

1. Private practices exist in a consolidating payer marketplace – fewer third party payers will control an increasing proportion of the revenue flow to all health care providers. These fewer and larger payers will apply more and more rigorous downward pressures on service unit price, patient and provider control over service utilization, and controls on total costs of care.
2. So long as the existing institutionalized entities that control the front-end of the healthcare economic equation (i.e. commercial and governmental healthcare insurers) are able to exact a coverage premium flow inflation rate that is greater than their actual costs, they are not incented to share financial risk with providers. Their better business strategy is to use market power to drive down the total cost of care at the expense of the provider side.
3. The overall medical practice operating expense inflation rates grow at a higher rate than the reimbursement rates. This disparate relationship can be predictive of deteriorating financial performance for a practice. Active management can positively affect the trajectories of these curves.
4. The majority of U.S. healthcare dollars will be spent on the management of chronic disease. Payers will value providers based, in part, upon their outcomes as compared with total costs of care, including variations of provider practice, and cost patterns as compared to those of similar practices.
5. The total U.S. healthcare spend will continue to consume multiple trillions of dollars; an amount that will attract

innovative entrepreneurs bent on disrupting consumer behaviors to redirect revenue flows.

An independent, comprehensive, adult and pediatric, medical and surgical eye care practice operates multiple clinical sites, owns ambulatory surgical centers, sells optical wear, and offers general clinical services, and sub-specialty programming. The typical consumer of surgical services is a Medicare beneficiary. Commercial payers have been applying significant downward pressure on reimbursement for surgery center facility fees. An increasing number of patients seeking non-surgical care are covered by vision plans that reimburse at a fraction of the average of other payers. The group's wage and benefits inflation rate exceeds reimbursement rates. Retiring physician owners expect significant buyouts when they exit the practice, and younger physicians' interest in assuming significant debt to become an owner in the practice is waning. At the same time, large area health systems are offering physicians signing bonuses, on top of high salary guarantees, to become employees.

In light of the conditions and dynamics just listed, the practice owners cited decide to proceed with a concerted effort to grow and expand the business, guided by a blueprint of business model principles. Eleven principles apply:

1. The business should consolidate all the revenues derived from clinical care, optical sales, and surgical services, including surgery center facility fees. All revenues must be fungible within the business model. Individual partners should not have ownership positions in clinical care entities that are not otherwise owned by the group (e.g. outside surgery center interests).
2. The operating economics, and financial productivity of each clinical service line within the medical practice will differ, and each contributes variously to the practice's bottom line. The balance of the service line portfolio must be actively managed. Physician leadership is necessary, as decision-making depends on knowledge of both the business and clinical sides of the equation.
3. The capital structure of the practice should be remodeled to produce an affordable buy-in and buy-out to encourage the recruitment of future partners. The remodeled buy-out should also relieve the owners of the burden of financing buy-outs through reductions in compensation of those who stay behind.
4. The practice should relieve itself of facilities ownership, freeing up capital for clinical programming and investments in practice development strategies with higher returns potential.
5. Physician leaders should be compensated for non-clinical "administrative" time. During this time, the leader can focus on issues and projects such as: effective utilization of practice facilities and other hard assets, unproductive practice style variation, appropriate clinical services coding and documentation, provider behaviors challenges, strategic partner and referral source relations, productivity of clinical team staffing, communication of policies with staff, and clinical risk management.
6. Digital marketing strategies should focus on the efficient acquisition of patients that best fit the clinical expertise available, the professional interests of the providers, and the operating financial and operating economics demands of the practice. The goal is the acquisition of new patients that best fit not only the clinical, but also the strategic and business needs of the practice.
7. The ratio of employed providers to partners should best ensure that the risk and reward calculus of ownership will encourage partners to productively reinvest in the practice, and not merely "drain cash" whenever any is available.
8. The practice should invest in its staff compensation and benefits plans to encourage the attraction and retention of the best staff. The principle here is the practice can afford higher employee costs if they are effectively balanced by the increased productivity that higher-level staff should bring.
9. Mission-critical services that provide unfavorable economics can be provided, but the level and total costs must be actively observed and managed to levels deemed responsible, given mission obligations to communities served.
10. A productive, culture will positively influence practice performance at several levels, including the patient experience, the ability to attract and retain qualified staff, professional satisfaction of providers, operational productivity, and effective clinical risk amahegement.[1-4]
11. The size of the group (number of providers) along with its revenue potential, must be sufficient to economically acquire and deploy the practice support systems, related assets, and staff required to effectively operate in a complex medical economics environment. These support systems include electronic health care record, information technologies, electronic and online scheduling, tele-medicine capabilities, and human resource management support. Investments in these systems do not scale up linearly; they require stepwise investments that must be made in advance of a services growth plan. Growth of clinical, revenue producing services then scale into those support system investments as revenue productivity increases.

The obvious question raised is, "Will adherence to these principles guarantee the success of a private practice in pressured markets?" The obvious answer is, "No. There is no plan that guarantees the success of any business in any industry." Success or failure of every business plan comes with execution. However, we believe that

adherence to them will give the independent physician the best chances for success.

In addition to the eleven medical practice business management principles provided, there are a few other useful observations worthy of note by physician leaders:

- Success with independent practices requires dedication and investments of time and effort by the owners. This time and effort is not "unproductive time". It is required.
- Practice style preferences of owners will not necessarily meet the tests of a challenging healthcare economics environment. Often times such unmanaged internal dynamics will have a greater influence on the failure of a medical practice than external market pressures; decreasing reimbursements, for example.
- The eleven principles provided above operate independently and together as contributors to the success of an independent practice. Independent medical practice owners should be cautioned that, as with the successful baking of a cake, application of the entirety of the recipe, and in the right measures, is required.

Physician leaders of independent, private medical practices are encouraged to reject the false postulate that the independent, private medical practice is doomed to extinction, and accept that success, even in the face of external "headwinds", remains a product of physician/owner choices modulated by effective business risk management.

REFERENCES

1. Zismer DK, Utecht BJ. Culture alignment, high-performing healthcare organizations and the role of the governing board. Part one: culture and culture alignment – the foundation of a board's game plan. *The Governance Institute: E-Briefings.* 2018:15(2). https://www.governanceinstitute.com/page/EBriefings_V15N2#hide2.
2. Zismer DK, Utecht BJ. Culture alignment, high-performing healthcare organizations and the role of the governing board. Part two: setting a culture of high performance and the responsibility of the governing board. *The Governance Institute: E-Briefings.* 2018;15(3). www.governanceinstitute.com/page/EBriefings_V15N3#hide2.
3. Zismer DK. The science of culture—a look inside health systems. *Minnesota Physician.* 2021;34(10).
4. Zismer DK. Leading a high-performing culture—ten practical lessons. *Physician Leadersh J.* 2021; 8(3):27-28.