Transforming the Provider Enterprise – The Path to Sustainability and Results

Authors: Steve Levin, Mark J. Werner, MD, and Michael Tsia
As health systems seek to address COVID-19’s economic and patient care challenges, success increasingly hinges on the ability to create high-performing provider enterprises. The current situation is no longer sustainable. Transformation of those enterprises is required to remain successful. The challenges highlighted below show that many provider enterprises are structurally and financially unsound, a situation which has become untenable in the current environment. The remainder of this paper describes how health systems can enhance patient-centered care while reducing their investment per physician and improving operating margin by 20-30 percent or more.

**Challenges Facing Many Provider Enterprises**

- Continued growth in financial support as increases in physician compensation outpace revenue growth
- Significant performance variability in key areas, including productivity, provider engagement and patient satisfaction
- High provider dissatisfaction and costly burnout in some disciplines
- Inefficient use of facilities, which increases operating costs and results in sub-optimal capital deployment
- Ineffective utilization of advanced practice providers (APPs) and other care team members, which increases costs and frustrates team members who are unable to provide patient care services for which they are trained
- Insufficient integration and coordination of care across disciplines, with implications for patient service and care

**Unique Considerations for Academic Health Systems**

Addressing these issues is especially complex in academic health systems due to the significant level of teaching in the ambulatory setting and the part-time clinical role of many faculty, which often reduces efficiency and limits their willingness to invest significant effort in its restructuring. The federated structure of many academic health system ambulatory practices, in which departments often manage their outpatient operations, makes it difficult to implement and enforce uniform standards of care and provider performance across the enterprise. Faculty compensation approaches, which sometimes provide minimal reward for clinical success or focus primarily on individual RVU production, also impede development of team-based models to improve economic and patient satisfaction performance.
What Needs to Change

The provider enterprise must be fundamentally redesigned to achieve required financial and operational improvements. Redesign should start by focusing the care model on the types of patients the enterprise expects to serve and adapting delivery to the needs of those patients. Incremental improvements to business models will not achieve the required degree of change. The entire enterprise needs to be reimagined to achieve a set of core principles and performance requirements which inform the design of key processes. These principles should include:

**Primary care models should be tailored to care for the unique patient cohorts that a practice expects to serve**, typically including groups such as healthy, rising risk, high risk, and medically complex and frail patients. The role of physicians, APPs and other care team members should be tailored to each cohort, as illustrated in the figure below; most practices do not currently customize their approaches to reflect the different patients served.

**Care Team Staffing Tailored to Patient Cohorts**

**Integrated, interdisciplinary specialty teams** should be organized to care for a shared group of patients based on specific conditions and diseases.

**Physician time and effort** should be focused on providing care that requires their unique expertise. For PCPs, this means the majority of physician time is invested on creating the plan of care for medically or diagnostically complex patients, rather than on sick visits for healthy or medically stable patients.

**The roles and composition of teams** supporting these physicians should be structured to fully utilize the unique skills of each clinician and to best care for each patient cohort served by the practice.
Care should be delivered through multiple modalities (virtual care, in-person physician office visit, off-campus imaging center, home or other remote monitoring, etc.) to meet the unique needs and preferences of each patient. As our telehealth adoption tracker shows, The COVID-19 crisis has accelerated the deployment and adoption of virtual care. It will also emphasize a broader long-term trend of care migrating to the most accessible and affordable setting, such as ASCs, home and congregational care facilities. Providers will need to reconfigure care models to adapt to these modality shifts.

COVID-19 Accelerates Shift to Alternative Modes of Care

Ambulatory care facilities should be located, sized and staffed to enable effective utilization, in light of changing care modalities, team compositions and economics.

Integrated data and information should be used to optimize both care and operational efficiency.

A Potential Model Forward

The approach to designing and implementing new care models based on these principles will vary for each specialty. The section below describes how these principles can be used to redesign primary care and orthopedic care (as an illustrative procedural discipline).
Most primary care practices operate with a ratio of well under one APP per physician, with limited customization to patient cohort and underutilization of APP capabilities. This care team typically manages the health for approximately 1,600–2,000 patients. The graphic below illustrates one potential example of a fundamentally different model in which each physician works with a team of two APPs and two RNs and shifts a meaningful portion of visits to virtual care, enabling the team to manage a panel size of approximately 5,500–6,000 patients. This team composition and other attributes, such as more streamlined business functions, enable the practice to serve significantly more patients at a much lower cost per patient.

The practice’s costs per patient under the practice’s management could drop from what is typically around $425 per year to $275, a reduction of about 35 percent, even after including the increased costs for a larger team working with each physician.

Illustrative Primary Care Model Transformation
For procedural disciplines such as orthopedics, clinic visits consume a notable portion of the physician’s time in traditional practices. Many health systems and proceduralists recognize that meaningfully reducing outpatient clinic time to increase time in the procedural suite can be economically attractive and allow more patients to be served. However, few have realized that goal. Now is an opportune time to make meaningful progress toward that objective, particularly given patient and physician concerns about unnecessary office visits. At one major academic health center, a physician leader estimated that there was an average of 10 office visits per surgical procedure, with the orthopedic surgeon handling most of those visits. The health system was able to successfully transition to a model where the surgeon provides roughly four office visits per procedure, with the remaining visits managed by other care team members such as APPs or non-operative physicians, which dramatically raises physician productivity and revenues. In the end, surgeons should strive to have new patient case conversion rates closer to 60–70 percent, which reflects both the team care model described and assertive use of clinical pathways embedded in robust referral management utilizing non-surgical physician colleagues.
Similar to the example offered, a new orthopedic care model would be to have non-operative APPs manage more office visits, transitioning two of every three visits currently managed by surgeons to APPs. This approach could free physician time, enabling an increase in surgical time of up to 40 percent. RNs would be used to better screen referred patients and direct cases to the most appropriate provider, again reducing unnecessary office visits for physicians. The model would also better integrate and leverage other members of the care team (physical therapists, athletic trainers, etc.) to improve medical management when appropriate, improving outcomes and patient satisfaction.

Illustrative Orthopedic Specialty Care Transformation
A robust referral management process is used to ensure patients are seen by the most appropriate provider.

Encounters are distributed to the right provider through comprehensive clinical guidelines, which match patient needs with the unique skills of each clinician.

The care team is optimally utilized, increasing surgeon’s operative capacity.

Physicians develop the plan of care and perform procedures, shifting pre- and/or post-op visits to APPs.

Highly protocolized clinical guidelines are established and used to direct care.

Self-directed virtual patient education is mandatory for patients.

Non-operative clinicians augment surgeons.

Clearly established protocols for PCP co-management are communicated and implemented.

Relationships (referral or direct access) with specialty and general urgent care are clearly defined.

This significant increase in surgeon productivity is enabled by a number of care model changes, including:

- The reduced provider expense, paired with some reduction in nonclinical support staff due to higher efficiency from IT-enabled business functions, leads to a 15–20 percent reduction in the cost of care delivery per patient.

Put differently, with the same number of providers in the practice, increased physician time in the OR rather than the clinic will create considerable capacity for new patient growth, enabling significant improvements in the numbers of patients served and the practice’s financial performance.

The Path to Sustainability and Results

The care team transformation described above may feel difficult to implement due to the magnitude of change entailed; however, health systems can take manageable steps now to quickly realize meaningful returns while building the capacity for continued change. Specific actions to begin the journey include:

- **01** Identify
- **02** Test
- **03** Scale
- **04** Automate
- **05** Engage
Care model transformation has been on the to-do list of many health systems for some time. The instability of the current environment provides an opportunity to make changes which might be resisted in more stable periods. Many health system leaders have commented on their organization’s willingness to make significant changes over the past several months—changes that would have met resistance in the past, which slowed their adoption. Now is the time to act given the changes required from the harsh economic realities caused by COVID-19. More importantly, patients, providers and healthcare workers all recognize that change can help improve outcomes, value and experience for everyone. This is the time to bring provider enterprise transformation off the to-do list and make it part of the new reality.
About the Authors

Steve Levin
Director,
Academic Health System
Segment Leader
slevin@chartis.com

Steve Levin is a Director with The Chartis Group. He has over 35 years of experience as a management consultant to the healthcare industry. He is a nationally recognized expert in a number of areas pertaining to academic health system organization, governance, funds flow and strategy. He also has significant expertise with clinical program development, mergers and affiliations, and academic strategy. He has worked closely with the leadership of numerous universities and their academic health systems to help define their strategic direction and to help the leadership team to implement that direction over several years.

Mark J. Werner, MD
Director, Clinical Consulting and Chartis Physician Leadership Institute
mwerner@chartis.com

Mark J. Werner, MD, CPE, FAAPL is a Director with The Chartis Group leading Clinical Consulting, the Chartis Physician Leadership Institute and our work with the physician segment. In this role, Dr. Werner leads clinical consulting efforts across the firm focusing on: enterprise physician alignment and leadership, medical group performance, adoption and change management, performance innovation, population health, provider-payor relationships and the translation of strategy into clinical operations.

Michael Tsia
Principal
mtsia@chartis.com

Michael Tsia is a Principal with The Chartis Group. He serves as an advisor to executive leaders at leading academic health centers, children’s hospitals and community integrated delivery networks on numerous topics, including enterprise strategic and financial planning, provider workforce planning, payor-provider partnerships, and organizational economic alignment/funds flow. Mr. Tsia has been a leader in management consulting with The Chartis Group for over 10 years and regularly speaks on a variety of healthcare strategic planning topics. He also serves on the Board of Directors for Methodist Hospital of Southern California.
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