

CHAPTER 2

PRACTICE MODELS AND LEGAL ORGANIZATION

Culture eats strategy for breakfast.

—Peter Drucker

LEARNING OBJECTIVES

- Describe the wide range of medical practice models.
- Characterize the relationships between physicians and healthcare institutions.
- Understand the duties and responsibilities of the practice manager.
- Appreciate the importance of the mission, vision, and values of the practice.

STRUCTURES AND ORGANIZATION

The healthcare portion of the US economy continues to increase due to population growth, the aging population, and other factors, all of which are discussed later in the text. This continued growth is one reason the US healthcare system needs transformation and reform.

Medical practices play an increasingly important role in this transformation as practices become integrated into the overall delivery system. As such, reform cannot occur without physician involvement. One change already taking place is a trend toward large, integrated practices (Adamopoulos 2014). Integrated practices are those that are part of

other organizations. In 2013, 26 percent of physicians identified themselves as employed by a healthcare organization (Jackson Healthcare 2013). Adamopoulos (2014) also noted a trend toward larger and more complex organizational practice structures. Multispecialty practices are growing, with the share of physicians in multispecialty practices having increased to 25 percent in 2014 from 22.1 percent in 2012.

These shifts bring new challenges for practice management professionals related to competitive pressures and the complexity of managing a large medical practice.

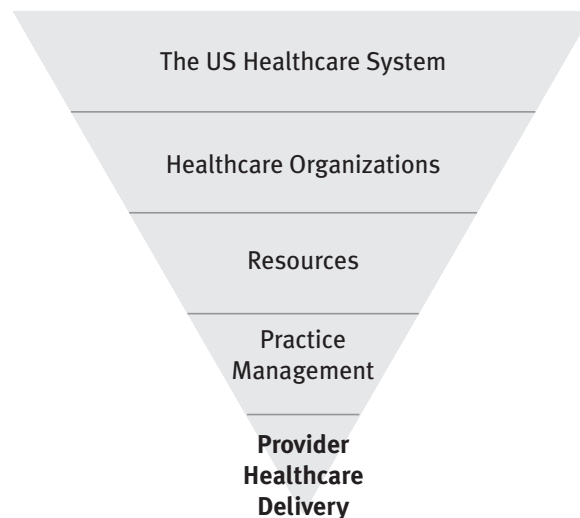
THE HEALTHCARE SYSTEM HIERARCHY

Before one can begin to address these challenges, one must understand the medical practice in the context of the overall healthcare system. As shown in exhibit 2.1, the medical practice plays a pivotal role in the US healthcare system because it provides continuity in the delivery of healthcare. Many, if not most, patients enter the healthcare system and are cared for at the individual provider level—often the medical practice—and are followed over time by the same practice. All aspects of the healthcare system rely on the direction of the physician to function and to trigger the use of resources.

MISSION, VISION, AND VALUES

A fundamental aspect of any organization, including the medical practice, is its governance framework, which includes the board of directors or trustees and senior management. As

EXHIBIT 2.1
The Healthcare
System Hierarchy



illustrated in exhibit 2.2, governance is guided by a mission, a vision, and values for the organization. This philosophical foundation provides a basis for strategic planning, which is a means of creating the goals and operational objectives of the medical practice. All aspects of decision making by the practice manager should be guided by the mission, vision, and values of the practice.

The mission of the organization is the reason it exists. The mission statement describes the overall purpose and intent of the organization. The vision of the organization describes the future state of the organization if it is successful in achieving its mission. The values of an organization indicate those beliefs the organization holds most dear and how it behaves as an entity in adhering to those values.

RELATIONSHIP OF THE PRACTICE TO ITS STAKEHOLDERS

Medical practices have many stakeholders—both internal and external to the organization. The effective medical practice is conscious of all of these relationships and carefully engages with them to carry out its mission. The practice manager and other practice leaders must understand the needs and concerns of all these constituencies and are critical conduits who

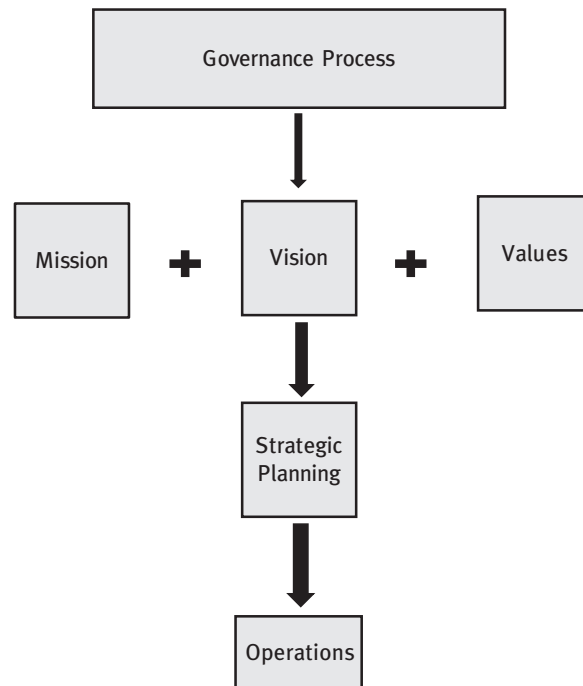


EXHIBIT 2.2

Mission, Vision,
and Values

must translate the input of the governing body and external stakeholders to the operational units of the practice. Exhibit 2.3 illustrates the interrelationships of different stakeholders in a medical practice.

GENERAL STRUCTURE OF THE MEDICAL PRACTICE

Exhibit 2.4 illustrates a functional structure for the medical practice. It demonstrates the relationship between the operational aspects of the practice, where care is provided to patients, and the internal and external functions that support practice operations and engage with the external environment.

TAXONOMY OF PRACTICE MODELS AND LEGAL ORGANIZATION

Practices are organized in a wide range of forms, from a small, individual or solo practice to a large, highly organized practice with hundreds or even thousands of providers (exhibit 2.5). In general, the larger the organization, the more structured, complex, and integrated it will be (Galbraith 2014).

EXHIBIT 2.3
Stakeholder
Relationships
of the Medical
Practice

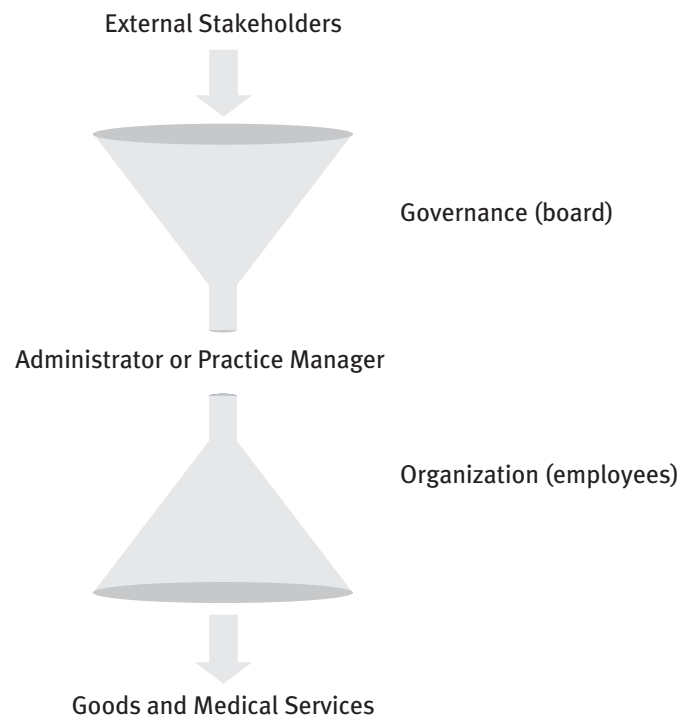
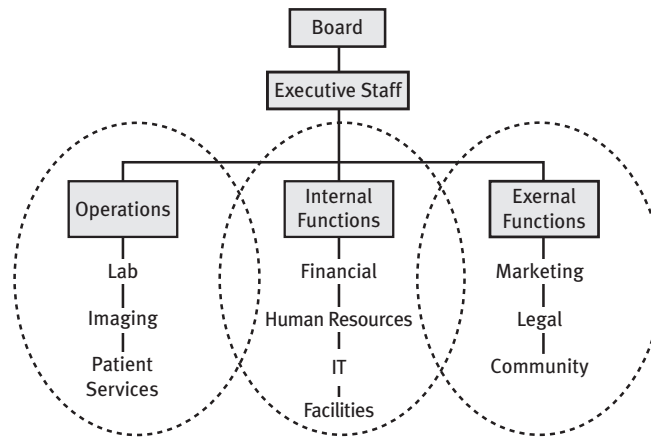


EXHIBIT 2.4Operational
Structure of the
Medical Practice

The degree to which a practice is integrated ranges from virtually no integration, as with the solo practice, to moderate integration, such as a group practice, which may include many providers and numerous specialties, to a fully integrated practice that is a wholly owned subsidiary of a healthcare delivery system or an accountable care organization (ACO). Integration of medical practices is discussed in terms of two dimensions. First is the issue of integrating business and administrative services, such as billing and marketing. Second is the issue of clinical services integration.

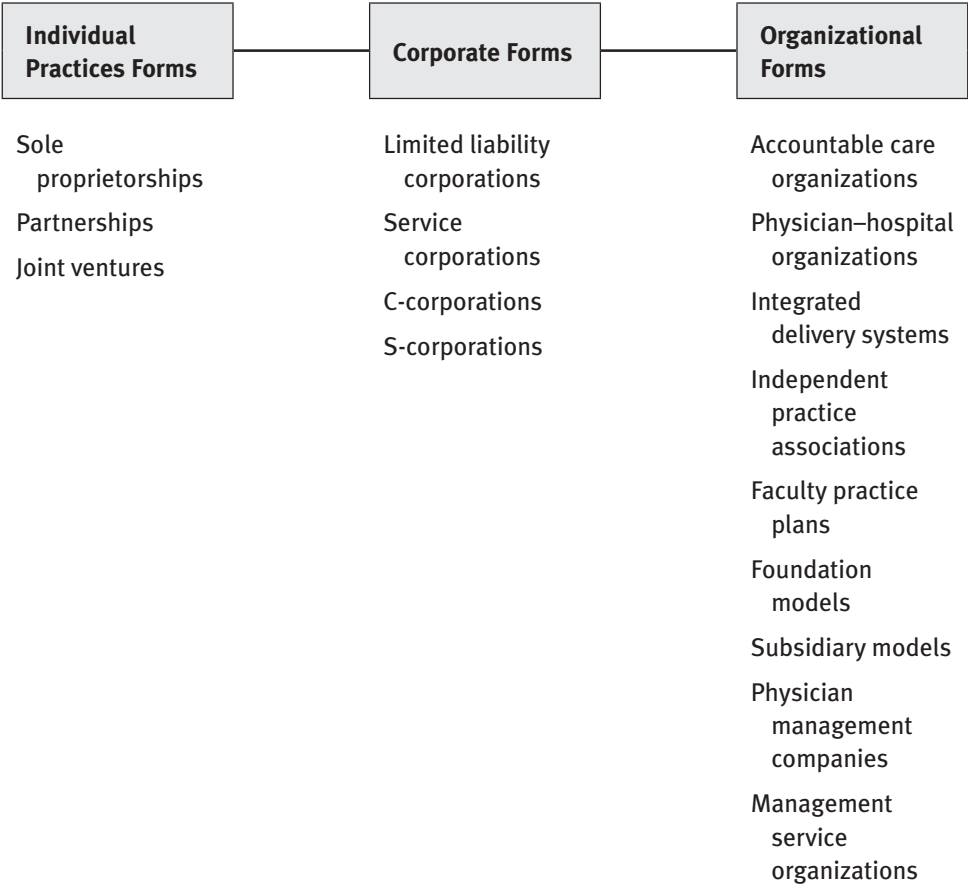
Two key characteristics of multispecialty group practices include that they are highly integrated, with a common governance and leadership or management structure, and they have a highly developed corporate system for managing finances and ensuring compliance with regulatory agencies. They differ greatly in operation and governance from solo practices, which are largely overseen by the practitioner who owns the practice. The specific differences are discussed in detail later in the book.

Practices may choose to integrate for any number of reasons. The most prevalent is the economies of scale achieved by pooling resources to carry out the necessary functions of the medical practice. One of the most important economies of scale to medical practices is the ability to manage the complex aspects of today's practice, including finances, the regulatory environment, and the increasing need for the practice to respond to the changing healthcare environment.

CHARACTERISTICS OF PRACTICE ORGANIZATIONS

Many important organizational elements must be considered when planning the form the medical practice will take. These factors include taxation, liability, the number of members,

EXHIBIT 2.5
Medical Practice
Taxonomy



Capital
Resources, usually cash, available to invest or use for operations.

ownership, extent of personal flexibility and autonomy allowed, transferability of ownership, **capital** formation, and vision (Wagner 2013). Practices that are sole proprietorships place individual responsibility on the individual practitioner to fulfill the financial, service, and other obligations of the organization. This form of ownership offers the advantage of control but holds the practitioner accountable for the entire operation.

Practices also may be formed as corporations, which, in the eyes of the law, are discrete entities (Showalter 2017). This status means that a corporation may enter into legally binding contracts, including debt obligations. In addition, because a corporation is seen by the law as an artificial person, it can be prosecuted for a variety of criminal behavior, such as fraud, wrongful death, and other criminal acts. It can be sued for negligence or liability,

can be licensed, and must pay income taxes. These features provide part of the appeal for a medical practice forming as a corporation because it may act as a single entity even though it may include many individual practitioners and areas of the organization that may carry out separate functions. Corporations generally shelter the individuals in the organization from its liabilities. The major exception to this protection in a medical practice is that the corporation cannot shield the individual practitioner from medical negligence and liability.

Corporations can be for-profit or not-for-profit. For-profit organizations have shareholders and pay taxes. Some advantages of the taxable corporate form over the not-for-profit include the following:

- ◆ Easier to set up
- ◆ More flexible in terms of governance
- ◆ Less regulation
- ◆ Can legally manage taxable income
- ◆ Less restriction on compensation arrangements

Two disadvantages of a for-profit entity are that they

- ◆ must pay income taxes to both the state and federal treasury when profitable and
- ◆ cannot seek tax-deductible donations for nonprofitable services.

Not-for-profit, or tax-exempt, organizations are established under section 501(c)3 of the Internal Revenue Code. They, too, carry distinct advantages and disadvantages (IRS 2017). Some advantages of not-for-profit over for-profit organizations include the following:

- ◆ They are allowed to solicit tax-deductible donations.
- ◆ They may enjoy a more positive public image.
- ◆ They do not pay taxes to the state or federal treasury as long as the organization operates within the tax-exempt guidelines.

Disadvantages of not-for-profit status include the following:

- ◆ Additional paperwork is required to apply for tax-exempt status.
- ◆ Not-for-profit organizations are required to follow Internal Revenue Service regulations regarding tax-exempt organizations.

- ◆ They are required to have a board of directors that has community representation.
- ◆ All of their financial transactions must be performed at arm's length, meaning insider dealing is prohibited.
- ◆ Compensation arrangements may be restricted.

A common scenario in today's healthcare environment is one in which practices are owned by large healthcare entities such as a hospital or healthcare system. These larger entities may be for-profit or not-for-profit. In the case of for-profit hospitals or healthcare systems, they may be privately held or publicly traded organizations; the latter form means that the shareholders may be any individuals or entities that wish to buy shares in the organization.

AFFILIATION VERSUS EMPLOYMENT MODELS AND THE CORPORATE PRACTICE OF MEDICINE

The extent to which medicine may be practiced is dictated by each state, either by statute or by other means such as licensure. These rules are generally codified in state regulations known as corporate practice of medicine doctrines. These doctrines prohibit a corporate entity from owning practices and directing medical practitioners to eliminate the control of medical care by those not trained or motivated to provide care in the best interest of patients. Many states prohibit any ownership of a medical practice by nonproviders for the same reason. At one time, these rules placed limits on physicians being employed by corporations or selling their practices to hospitals and other healthcare entities. In roughly the past decade, these laws have been clarified to lift many restrictions on the employment of providers (Michal, Pekarske, and McManus 2006).

The employment of physicians or affiliation of physician practices with other healthcare entities takes different forms, as described in the paragraphs that follow.

THE EMPLOYMENT ARRANGEMENT

The most straightforward is the employment arrangement. In this arrangement, the physician or provider becomes an employee of the organization, and often the working arrangement is detailed in an employment agreement. Exhibit 2.6 lists some features of an employment agreement.

Benefits and Compensation

Benefits and compensation provisions specified in the employment contract include the salary the provider is to receive and how that salary is calculated; many practices use formulas

Benefits and Compensation	Restrictive Covenants	EXHIBIT 2.6 Key Features of an Employment Agreement
Salary	Perfect Performance	
Nonsalary Terms	Contract Terms	
Ownership/Partnership	Termination Provisions	
Outside Activities	Tail Insurance	
Job Requirements	Nonassignability	

to determine compensation (discussed in more detail in a later chapter.) The contract also includes important nonsalary benefits, such as the following:

- ◆ Vacation pay
- ◆ Health insurance
- ◆ Disability insurance
- ◆ Pension or retirement savings **account**
- ◆ Allowances for meetings and entertainment **expenses**
- ◆ Car allowances
- ◆ Continuing education benefits

In addition, the contract often specifies practice accoutrements that the provider receives, such as cell phones, office furnishings, and other equipment or accessories.

Ownership

Some private practices offer physicians the opportunity to purchase an ownership stake or to become a partner in the practice. Such terms are typically detailed in the contract or included by reference in a separate agreement that specifies how the provider becomes an owner. Inclusion by reference is an important concept in contract law. Contracts that reference a document, such as a policy, essentially make the referenced document part of the terms of the contract. All the parties to the contract must be clear on what terms from the document are incorporated into the contract to avoid future disputes and misunderstandings.

Many practitioners engage in entrepreneurial activities such as book writing, software development, and other types of medical enterprise. The employment contract should specify the terms and conditions under which these activities are permissible and to what extent, if any, the benefits from these activities belong to the contract holder. Such provisions are

Account

A record of financial transactions; usually refers to a specific category or type.

Expense

An expenditure that is chargeable against revenue during an accounting period resulting in the reduction of an asset.

often overlooked in contracts and can lead to misunderstanding and difficulties when the issue arises post facto (after the contract has been signed).

The job requirements may also be delineated in the contract. These may entail working hours, the location at which the practitioner is expected to work, the number of days per week that the provider will be available to practice, the amount of call coverage to be taken, and the method for distributing call coverage among the practitioners.

Restrictive Covenants

A controversial area of contracts is the restrictive covenant. This provision sets certain parameters usually related to future working restrictions if the provider leaves the practice. Simply put, it restricts the practitioner from engaging in the practice of medicine for a certain period of time in a certain specified distance from the previous practice. In some states, such provisions are prohibited; in other states, they are discouraged but legal. In states where the restrictive covenant is permissible, the covenant is almost always bound by certain reasonableness standards. The first standard is the length of time that the restrictive covenant may be in place: The shorter the time, the more enforceable the covenant may be. The second standard considers how far the practitioner must move to be compliant with the covenant. Obviously, a restrictive covenant that prohibits practice in an entire region or state is unreasonable and would be found unenforceable by a court of law.

In many cases, the restrictive covenant calls for “perfect performance,” meaning the provision can only be satisfied by doing what is specifically stated in the contract. In other cases, the restrictive covenant may offer a buyout provision, allowing the practitioner leaving the practice to pay a certain sum to negate the restrictive covenant. Regardless of the provisions, the practitioner must understand the nature of the restrictive covenant and be willing to abide by its terms.

Terms of the Contract

Contract terms are always stated in the contract. They include length of the contract, under what state laws the contract is governed, whether arbitration will be used as a method for settling disputes, and any other conditions related to how the contract is administered.

Effective contracts also include a termination process or termination provisions. These clauses specify how the parties to the contract will conduct themselves once the contract has expired and how the contract can be otherwise terminated. Contracts can typically be terminated for failure to perform by either party. For example, if the practice refuses to pay the provider, the provider has a claim of nonperformance under the contract. Conversely, if the provider fails to provide medical care as specified under the contract, the practice has cause to terminate the contract. Some contracts simply expire. In this case, decisions must be made to determine how medical records are handled and any continuation of benefits

or access to practice resources. Any restrictive covenant usually survives the expiration of the contract, meaning it is enforceable after the contract has ended.

Tail Coverage or Extended Reporting Endorsement

One aspect of ending the practice relationship involves the provision of tail coverage for malpractice insurance. This coverage extends insurance protection to the provider for all prior occurrences of alleged or actual malpractice that occurred while employed by the practice. These policies can be expensive; therefore, the contract should specify who is responsible for purchasing tail coverage. The practice almost always requires that malpractice tail coverage be purchased by the practitioner (see also chapter 4).

Nonassignability Clause

Most provider employment agreements contain a nonassignability clause. This provision simply states that the contract may not be assigned to another individual, in essence allowing someone else to take the provider's place in the practice. Although this limitation may seem obvious, the clause is an important part of the employment agreement.

Some Final Details About Employment Contracts

For a contract to be enforceable and considered legally binding, it must contain these five elements (McKendrick 2012):

- ◆ An intent to enter into an agreement.
- ◆ An offer.
- ◆ Acceptance of the offer.
- ◆ Consideration, which means, in the case of an employment agreement, economic benefits, such as a salary, in exchange for services rendered to the practice.
- ◆ A legal capacity to enter into the agreement. Although unlikely in the case of a provider service agreement, a minor cannot enter into a legally binding agreement.

In addition to these five elements, the subject matter of the contract must be of a legal nature. This component is particularly important in the area of medical services because of the many private inurement rules and anti-kickback provisions that exist in the regulatory environment of the medical practice (see chapter 4 for details). If the contract contains

requirements to break the law, it cannot be enforced. Notably, although contracts are usually enforced and governed by specific state laws, federal issues arise related to Medicare, Medicaid, and regulations that govern the practice of medicine.

Severability clauses may be important elements as well. In some states, if any provision of the contract is held to be unenforceable, the entire agreement is unenforceable. In other jurisdictions, only the offending clause is voided. Contracts may also contain language that requires the parties to negotiate a resolution to any clause of the contract that is found unenforceable or illegal to bring the contract into compliance. This is an important consideration in today's healthcare environment, as laws and regulations change so quickly that an acceptable activity may become illegal due to policy changes, requiring those aspects of the contract to be changed or eliminated.

The development and execution of an employment agreement in the medical practice require expertise in state and federal law. Often, this is an area for which the practice seeks outside counsel to be certain these important documents are handled correctly.

AFFILIATION AGREEMENTS WITH OTHER ORGANIZATIONS

In an affiliation agreement, the practice signs a contract with another party, typically a healthcare entity, to provide certain specific services under a contractual arrangement. A major difference between an affiliation agreement and an employment contract is that under an affiliation agreement the provider remains an independent contractor and continues to own and manage his or her practice. Any restrictions on the practice are enumerated in the affiliation agreement.

Affiliation agreements vary widely and may involve the provision of specific medical services, educational affiliations, and management services. Such agreements are often entered into because one or both parties do not wish to become fully integrated but see a need for specific services to be delivered and some level of cooperation to do so (see, e.g., Blum 2013).

CULTURE AND ORGANIZATION

Culture is defined as the beliefs, customs, practices, and behaviors of a particular group (*Merriam-Webster* 2016). Simply put, culture dictates how an organization conducts business, what it values, how it gets things done, and how it views itself. The culture of an organization defines how it treats its members and what behaviors it expects from them. Culture is a powerful force; as Peter Drucker is widely said to have stated, “Culture eats **strategy** for breakfast.”

The relationships between practitioners and institutional providers, such as hospitals and healthcare systems, have often been strained because of the significant cultural differences between the parties. Almost by definition, medical practices have been less formal and are what Robbins (1990) refers to as professional collegial organizations. In these

Strategy

The science of business planning whereby an organization plans its approach to achieving its goals.

organizations, the primary producer is also the owner and governs the organization. Often the cultures of the two healthcare segments clash and create management problems that must be addressed by the medical practice (Schein 2016).

Part of the problem centers on expectations of each party being established prior to the acquisition or affiliation. A cultural fit survey is essential to determining compatibility, as is having a clear understanding of what each party wishes to accomplish as a result of the combination of the organizations. As exhibit 2.7 shows, culture dictates virtually every aspect of the organization by influencing

- ◆ organizational structure and governance;
- ◆ mission, vision, and values;
- ◆ goals, tasks, and incentives;
- ◆ performance and the expectations of people in the organization; and
- ◆ information systems and other operational infrastructure.

Culture is both codified by formal policy and procedure and imbued by informal means through the behavior of its members. The more the culture is aligned with positive

**EXHIBIT 2.7**

Culture Affects
All Aspects of the
Practice

behavior, the more effective the organization is. For example, if organizational leaders say they value and expect courteous treatment of others but allow disrespectful behavior to go unchallenged, they degrade the culture (Drucker 2006).

ACADEMIC MEDICAL CENTERS AND PHYSICIAN PRACTICE MANAGEMENT

About 400 of the more than 5,500 hospitals in the United States carry the special designation of academic medical center (AMC) (AHA 2017). AMCs are typically members of the Association of American Medical Colleges (AAMC) and its subsidiary, the Council of Teaching Hospitals (AAMC 2016). As are other hospitals, they also are often members of the American Hospital Association (AHA). An AMC has an organizational structure that is different from other for-profit or not-for-profit solo or multispecialty practices.

The number of AMCs and their associated medical practices, as with most health-care organizations, grew rapidly after World War II when federal funding for medicine was greatly increased. Specific factors in this growth include the following:

- ◆ The advent of the third-party payer following World War II
- ◆ The introduction of Medicare and Medicaid in 1965, which stimulated research and allowed for the application of the resulting technologies in the treatment of many more patients
- ◆ A great increase in the expectations of the US healthcare system by patients
- ◆ The creation of many new medical specialties that focused on the treatment of complex illnesses

Physician practices often are involved with AMCs, so practice managers must be knowledgeable of several elements of this important healthcare organizational structure. AMCs are typically integrated in the teaching and research functions of the medical schools at major research universities. They often offer unique and highly specialized medical services requiring the availability of physicians with specific training in complex areas of medicine. Examples are Level I trauma services, transplantation services, and the use of sophisticated diagnostic technology such as positron emission tomography scanners. Physicians who practice in AMCs are often involved in teaching and research functions.

Making generalizations about how physician practices associate with AMCs is difficult. The physicians in the practice may be employed as faculty to provide clinical services; the practice may be affiliated by contract as previously discussed, fulfilling specific needs of the AMC; or the practice may be wholly owned by the AMC. One important distinguishing characteristic related to the medical practice in an AMC is that it is often mission based, and as a result, less emphasis is placed on productivity as a function of patients seen, or

relative value units produced. Productivity may include such aspects of medical activity as research, time devoted to teaching, presenting at conferences, and other scholarly endeavors.

ACCOUNTABLE CARE ORGANIZATIONS

One of the most influential developments in determining the structure and organization of medical practices is the ACO. These healthcare delivery constructs are a central feature of the Affordable Care Act (ACA) of 2010 (McCanne 2010) and, in many ways, are defined more by what they do than by their structure. In general, an ACO is a group of providers who share responsibility for a population of patients regarding the quality, cost, and coordination of their care. Two notable features of ACOs are that they can

- ◆ be any a combination of group practices, practice networks, hospitals, or hospital-employed physicians and providers and
- ◆ be joint ventures, with the proviso that they must be able to receive and distribute payments.

All members of the ACO do not have to belong to a single entity; they can be bound by a contract. However, an ACO must include physicians in its membership (AAFP 2016).

The ACO works with insurers, the largest being Medicare, to achieve improved health outcomes. Specifically, they seek to accomplish the following goals, referred to as the Triple Aim (IHI 2017; see chapter 10):

- ◆ Improve population health
- ◆ Improve the patient experience
- ◆ Reduce total cost of care

Most of the arrangements between the payers and the ACO involve incentives for reducing cost such that the ACO receives payments if agreed-on targets are met. A central aspect of the ACO is to provide enhanced preventive care; therefore, the care delivered by ACO primary care providers is central to the success of the ACO.

Although more sophisticated in some respects, the ACO is reminiscent of the health maintenance organization (HMO) because it places a heavy emphasis on wellness and prevention as a health and economic strategy and focuses on primary care. HMOs are prepaid or capitated health insurance plans for which the patient (or his or her employer) pays a fixed fee each month instead of paying for the cost of each service received. These are delivered by providers who are under contract with (or are employees of) the HMO. ACOs provide incentives for shared savings, making prevention a hallmark of the concept. Patients and providers both benefit, in theory, through attentive patient management,

improved outcomes, and reduced cost. In addition, economic opportunity accrues for the physicians, hospitals, and other provider organizations that are part of the ACO.

The ACA established an ACO for Medicare providers called the Medicare Shared Savings Program (MSSP) as part of reforms to the Medicare delivery system. The MSSP is intended to improve outcomes and increase the value of care by rewarding ACOs that “lower their growth in health care costs while meeting performance standards on quality of care and putting patients first” (CMS 2017). Additional ACOs are being developed with commercial insurance carriers, and as of January 2015, the total number of ACOs was 744 (Muhlestein 2015). All 50 US states now have at least one ACO.

CLINICAL INTEGRATION

Clinical integration is receiving much more attention than in the past as an alternative care delivery model concept. More than a type of organizational structure, integrated delivery systems (IDSs) seek to provide integrated clinical services. Specifically, the clinical integration model aims to provide care to the patient in a longitudinal (or long-term and coordinated) manner without necessarily having all of the providers of care reside in a single entity.

Joining or developing an IDS requires the following elements to be in place:

- ◆ Collaborative leadership
- ◆ Involved governing body
- ◆ Compliant legal structure
- ◆ Effective payer strategy
- ◆ Culture change
- ◆ Aligned incentives for physicians
- ◆ Value-based compensation
- ◆ Program infrastructure
- ◆ High performance
- ◆ Network physician leadership and support
- ◆ Clinical programs
- ◆ Disease programs
- ◆ Care protocols
- ◆ Clinical metrics
- ◆ Population health management

- ◆ Technology infrastructure
- ◆ Health information exchange
- ◆ Disease registries
- ◆ Patient longitudinal record
- ◆ Patient portal to enable engagement

Considering the longitudinal nature of clinical integration, the model focuses much more on developing procedures geared toward achieving excellent outcomes than relying on organizational structure to maximize the benefits. The clinical integration model is an approach to solving the problem of fragmented care. The essential features of clinical integration are as follows (Strandberg-Larsen et al. 2010):

- ◆ Providing care across the continuum of services
- ◆ Improving individual care outcomes
- ◆ Improving the health of all of the patients served by the organization (population health)

Clinical integration can be accomplished by contracting with other providers; merging with other practices or being acquired by a health system; or having all the clinical care providers agree to established protocols of care, which provides for a more seamless continuum of care for the patient and greater economic synergy.

PATIENT-CENTERED MEDICAL HOMES

The patient-centered medical home (PCMH) is a concept introduced by E. H. Wagner in 1998. Unlike many of the approaches pervasive in the healthcare field today, such as more efficient treatment, better drugs, and new care modalities to care for the sick, the PCMH is focused on prevention and early intervention for patient care. This focus is especially appropriate for the chronically ill, as early intervention can delay a worsening condition and prevent the emergence of further complications and other consequences of the **chronic illness**, such as kidney failure in diabetic patients. The PCMH helps ensure continuity of care and offers expert guidance in navigating the healthcare delivery system by serving as the starting point for all of a patient's medical concerns. Any physician practice can become a PCMH by adhering to the following six principles and standards, which form the basis for certification by the National Committee for Quality Assurance (NCQA 2016, 2017):

- ◆ Patient-centered access: The practice must be able to provide needed care 24 hours a day.

Chronic illness

Diseases characterized by one or more of the following criteria: they are permanent; leave residual disability; are caused by nonreversible pathological alteration; require special training of the patient for rehabilitation; or require a long period of supervision, observation, or care.

- ◆ Team-based care: All members of the practice must be engaged in providing the patient with needed information and meeting the cultural and linguistic needs of the patient.
- ◆ Population health management: The practice must collect data for population health management purposes.
- ◆ Care management and support: The practice must support evidence-based guidelines for prevention and for acute and chronic care management.
- ◆ Care coordination and care transitions: The practice must track and coordinate tests, referrals, and care transitions.
- ◆ Performance measurement and quality improvement: The practice must use data and experience for purposes of continuous improvement.

Physician practices that are interested in becoming a PCMH should reflect on the following questions before beginning the process:

1. Does the practice value the patient as an active participant in his or her own healthcare?
2. Is the practice able to develop and maintain an ongoing personal relationship with the patient for achieving continuity of care?
3. Can the practice lead a team of professionals, inspiring and empowering them to fulfill the mission of the medical home concept?
4. Is the practice able to establish solid professional relationships with other physicians, particularly those who specialize in different fields, to secure specialized care for patients?
5. Does the practice believe in the concept of prevention of disease and illness and a holistic approach to medicine?
6. Is the practice able to help the patient navigate the complex field of healthcare?
7. Is the practice open to patient feedback and to seeking quality improvement based on that feedback to ensure that patient expectations are met (and in some cases exceeded)?
8. Does the practice embrace technology to support patient communication, care, and education?
9. Is the practice prepared to adopt the needed workflow and process modifications? Does the practice have adequate staff (in both number and skill) to manage the increased accessibility to its patients (increased volume

of e-mails and after-hours phone calls)? Does the practice have adequate information technology (IT) staff to manage video chat capabilities and mobile health applications?

10. Does the practice have the IT infrastructure to support the services offered by a PCMH? Does it have an electronic health record system (EHR) in place? Is the EHR interoperable with the rest of the community healthcare providers, such as hospitals, rehabilitation centers, and other medical practices?
11. Does the practice staff have adequate training to provide health coaching? For example, are they experienced with techniques such as motivational interviewing? Does the practice have the capacity to organize disease-specific support groups? What behavioral or mental health services will it offer its patients?
12. What kind of care teams will the practice provide its patients? What specialists and care providers will make up these care teams? Do they have adequate relationships with other providers who are willing to join the PCMH?
13. Is the practice prepared to assess process and outcome improvements? What performance measures will it use to track its progress?
14. Does the practice wish to become a certified PCMH? If so, has it chosen a national accrediting body through which to apply for certification?
15. Is the practice currently financially stable enough to take on the **risk** of shifting to the value-based purchasing model of the PCMH?

Not enough practices ask these important questions as they begin to develop a PCMH. As with so many decisions in the healthcare world, mind-set is everything. Practice leaders must have a deep understanding of what the practice wishes to accomplish and how best to implement the effort.

Risk

The possibility of loss, inherent in all business activities. High risk requires high return. All business decisions must consider the amount of risk involved.

Additional Considerations Related to Medical Homes

The overall promise of the PCMH is that it helps frame a medical practice's approach to offering value-based care. One way it does so is by allowing the practice to seek simplification for a complex environment. The payment system that drives practice management encourages incremental improvement efforts, bolting on process after process, procedure upon procedure, making systems difficult to work with, rather than taking the time to think through the value that each process adds and how it operates.

Consider waiting time. The scheduling structure in medical practices is largely dictated by the reimbursement system. Practices have determined that they need to see a certain number of patients in a given amount of time to break even or be profitable as a business. Regardless of the individual patient's needs, the practice may schedule an elderly

or disabled person for the same 15-minute appointment length given any other patient when, realistically, the elderly or disabled individual requires more time and attention.

With modern data analytics processes, however, medical practices could match appointment times with the specified needs of the patient, including his or her demographic characteristics, giving older patients or those with complex medical issues more time than patients with relatively straightforward and simple problems. The PCMH is often a prominent feature of the ACO because it aligns well with the goals and strategies of reduced cost through better, more coordinated care.

INTEGRATED DELIVERY SYSTEMS

Although a detailed discussion of IDSs is beyond the scope of this text, a brief discussion is relevant to the physician practice because practices are often part of an IDS. Essentially, the IDS can be either a horizontally or a vertically integrated healthcare organization. Vertically integrated organizations increase their reach by adding similar service lines, such as hospitals, whereas a horizontally integrated organization increases in reach by adding related but different service lines; for example, a hospital organization might add physician practices. IDSs are generally characterized as being a large organization capable of providing a variety of services to their patients. An IDS may include any or all of the following services or entities:

- ◆ Hospital services
- ◆ Physician services
- ◆ Ambulatory care services
- ◆ Surgical centers
- ◆ Urgent care centers
- ◆ Nursing homes
- ◆ Palliative and hospice care facilities
- ◆ Home health care services
- ◆ Pharmacy services
- ◆ Telemedicine services
- ◆ Telehealth services

Some IDSs also include an insurance arm, thereby providing the financing of care as well as the provision of services. Although IDSs have similarities to ACOs, they are not the same model. In essence, all ACOs are likely IDSs, but not all IDSs are ACOs.

PROS AND CONS OF INTEGRATION

All structural forms have pros and cons, and this maxim is true of integration. Some advantages of participation in an IDS are as follows:

- ◆ Economies of scale can be leveraged.
- ◆ Patient care decisions can be improved through the coordination of care across affiliated providers.
- ◆ Cost-effectiveness is more likely to be achieved.
- ◆ Patients may be better served with an increased scope of service.
- ◆ A larger financial base may afford a practice more access to capital.
- ◆ More specialty staff with greater expertise may be hired.
- ◆ Competition erodes, as little antitrust activity in healthcare has been seen in the past two or three decades.

Disadvantages of integration are the following:

- ◆ Friction among physicians may emerge because, as a function of their training, many tend to work better independently than they do as part of a team in large, integrated organizations (Groopman 2008).
- ◆ Decisions are made differently in larger integrated practices than members are typically accustomed to, requiring an adjustment for some providers.
- ◆ Seamless integration of information systems is needed and often difficult to achieve.
- ◆ Standardizing processes and workflows to reduce variation is often resisted by practice physicians and can be difficult to achieve.
- ◆ Changes in policies must be reconciled. This can be a difficult process, and it may be costly because government regulations may require enhancement of the benefits package of the acquiring organization to comply with nondiscrimination rules, such as pension and health benefits (IRS 2016).

Increased complexity is another issue that often arises with increasing organization size and scope. By definition, medical care is complex, and it is often delivered on an individualized basis. This factor makes streamlining processes and organizational structures difficult, and streamlining also tends to reduce innovative activities due to environmental uncertainty. This uncertainty leads to unintended consequences, unpredictability, indecision, and lack of clarity of goals (Star 2013).

Asset

Item of value owned by a business. May be a physical property, such as a building; a physical object, such as a stock certificate; or a right, such as the right to use a patented process.

MERGERS AND ACQUISITIONS

Tremendous growth has been seen in recent years in the size and scope of medical practices, as noted earlier in the chapter. This growth is usually accomplished in one of two ways: by “organic growth,” which constitutes additions to an existing practice by recruiting new members, or through mergers and acquisitions. A merger is a transaction that creates a new, single entity from combining two or more previously single organizations. An acquisition occurs when one organization purchases the **assets** of another entity. In the case of an acquisition, the acquiring organization usually remains intact.

One danger that can arise from a merger or an acquisition is illustrated in exhibit 2.8: the creation of too many silos for patients to navigate. Healthcare professionals often see their work as a series of discrete activities, each under separate control. The patient or the patient’s family view healthcare activities differently; they see their encounter with the practice as a single event and part of an overall experience. When mergers or acquisitions take place, the practices involved need to fully integrate all parts of the new practice to avoid silos. Keeping the patient experience in mind helps practice leaders improve the functioning of their medical practices.

While drawbacks to mergers and acquisitions are evident, especially in terms of culture issues, they allow a practice to grow quickly and may also allow it to acquire new services and prevent the duplication of services that can lead to an oversupply and potential overutilization.

These activities require great care and expertise. As shown in exhibit 2.9, numerous details must be resolved to ensure a successful transaction.

EXHIBIT 2.8

Rearranging How
We Think About
Care

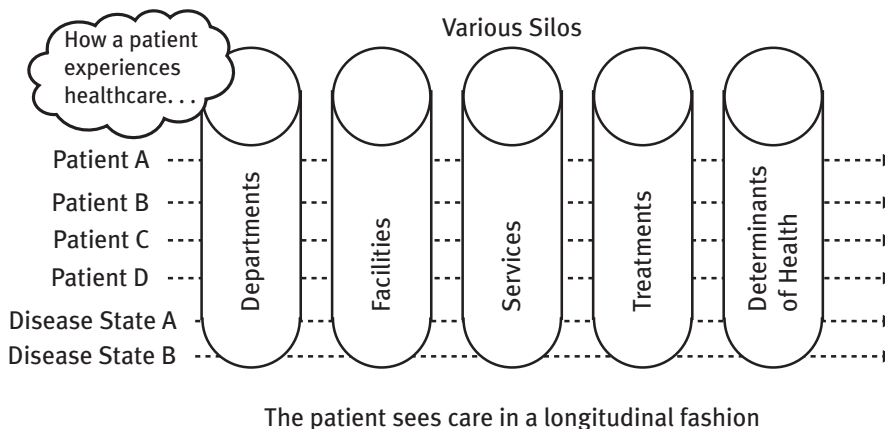


EXHIBIT 2.9

Merger Checklist

PREMERGER ASSESSMENT

- Review each practice's finances.
- Review employee payroll and benefits for each practice.
- Review coding practices.
- Review fee schedules.

NEW PRACTICE ENTITY

- Partnership or corporation?
- Professional association?
- Effective date of merged operations?

ASSETS THAT WILL BE CONTRIBUTED TO NEW ENTITY BY EACH PRACTICE

- Hard assets (will be leased from existing and new entities).

Accounts Receivable (A/R):

- What amount will be contributed?
- How will remainder of physician A/R be accounted for?

Inventory and Other Assets**NEW PRACTICE'S ASSUMPTION OF DEBT OF EACH PRACTICE****Review physician's existing debts:**

- Accounts payable.
- Notes and other payables.
- Lease obligations.
- Defined benefit plan.

FORMULA FOR COMPENSATION OF THE DOCTORS (USUALLY BASED ON PREASSESSMENT)

- Physician collections and shared and allocated overhead.
- Fixed compensation plus bonus.
- Bonus based on percentage of collections.
- Bonus based on percentage of net production.
- Equal compensation for all physicians.
- Fixed compensation plus percentage of net production.
- Percentage of net production.
- Compensation formula for nonowner physicians.

OPERATIONAL ISSUES

- Call schedule.
- Billing/collection policies.

(continued on next page)

EXHIBIT 2.9Merger Checklist
(continued)

- Computer system (hardware and software to use).
- Appointment scheduling, including systems to schedule.
- Office forms.
- Medical charts.
- Superbill.
- Fee schedule.
- Notification of insurance carriers of new entity, if applicable.
- New group provider number.
- Banking (and banking contact).
- Insurance:
 - Group health, life, and disability.
 - Malpractice.
 - Office contents.
 - Other.
- Office hours, all locations.
- Telephone numbers, all locations.
- Purchasing function, establish controls and systems.
- Professional assistance.
- Choose practice's accountant.
- Choose practice's attorney.
- Establish and wire for computer networking.
- Other operational issues.

ASSESS HIDDEN COSTS TO MERGE

- Nonproductive time (lost patient billing).
- Marketing costs.
- Professional fees to merge.
- Moving costs, if applicable (schedule moving assistance).
- Malpractice tail premium.
- Cost to equalize fringe benefits.
- Cost to develop common operational policies.
- Possible facility costs.
- Buyout of existing leases.
- Additional leasehold improvements.
- Write-off of unproductive or abandoned assets.
- Other hidden costs.

PERSONNEL

- Determine practice's administrator and related employment contract.
 - Review current compensation of employees and existing benefit plans.
 - Decide which employees stay and which may have to leave.
 - Write or update employee manual.
-

- Establish new fringe benefits.
- Establish job duties for each employee.
- Technicians to be assigned or pooled?
- Identify potential employee conflicts.
- Establish annual office and clinical personnel job assessment and evaluation program.

EXHIBIT 2.9

Merger Checklist
(continued)

FACILITIES

Review current lease obligations of each practice:

- Office leases.
- Equipment leases.
- Determine if offices will consolidate into one location.
- Decide how specific equipment will be used in the practice.
- Review issues related to physician ownership of office building, if applicable.
- Establish lease formula for existing equipment and equipment to be acquired.

MANAGING PHYSICIAN

- Who will be managing physician? (or)
 - Establish “office of managing physician.”
- Decide on duties of managing physician vs. administrator:
- Manage day-to-day operations.
 - Supervise employees.
 - Supervise billing/collection activities.
 - Ensure that all insurance as required by the group is paid and maintained.
 - Acquire fixed assets for less than \$[dollar amount].
 - Authorize contracts on behalf of the group not in excess of \$[dollar amount].
 - Maintain bank accounts.
 - Make sure all tax returns are prepared and filed on time.
 - Make sure all licenses are renewed.
 - Supervise payment of accounts payable.
 - Implement business decisions of the group practice.
 - Call to order regular meeting of the physicians.
 - Serve as liaison with community hospitals, referral networks, other medical practices.
 - Other duties.
 - Will managing physician be compensated? If so, how much?
- How will managing physician be elected each year?
- Vote of the physicians.
 - Annual rotation.

PRACTICE’S RETIREMENT PLAN

- Will there be a new plan? What features will it include?
- Decide what to do with current plan(s).

(continued on next page)

EXHIBIT 2.9Merger Checklist
(continued)

- Choose retirement plan administrator.
- Choose investment counselor.

NEW NAME OF THE GROUP PRACTICE

- Adopt name of one of the practices or decide on name of the new practice.

SPECIFIC PHYSICIAN CONTRACT ISSUES

Voluntary withdrawal by owner:

- Required notice [number of days or months].

Involuntary termination of an owner:

- Death.
- Owner's right to practice medicine in the state is suspended, revoked, or canceled.
- Owner loses privileges to any hospital at which the practice regularly maintains admission privileges.
- Owner fails to follow reasonable policies or directives established by the practice.
- Owner commits acts amounting to gross negligence or willful misconduct to the detriment of the practice or its patients.
- Owner is convicted of a crime.
- Owner breaches the terms of his or her employment agreement.
- Physician becomes uninsurable for medical malpractice coverage.
- Disability of an owner:
 - Owner becomes and remains disabled for [number] months (six months?).
 - Continued compensation to a disabled owner:
 - How long?
 - How much? (Based on a percentage of receivables collected over [number] months.)
 - Permanent vs. temporary disability.

Physician fringe benefits:

- Vacation.
- Sick leave.
- Effect on compensation if physician chooses to take extra time off for vacation, continuing medical education (CME) study, etc.
- Expenses (CME, etc.)—dollar allowance.
- Time off (regular afternoon) during week.

Malpractice tail-end premium:

- Who pays in event of owner's withdrawal?

BUYOUT OF AN OWNER

Address these events requiring a buyout:

- Death.
- Disability.
- Retirement.
- Withdrawal from the practice.

How will ownership interest be valued?

- Appraisal.
- Fixed formula.
- Deferred compensation (payout a percentage of patient receivables).
- Will a goodwill calculation be required?

Payout of ownership interest:

- Death:
 - Insurance proceeds.
 - How much insurance to obtain.
 - Proper structure for “key man” insurance.
- Disability, retirement, withdrawal:
 - Installment payments or lump sum.
 - Interest rate for installment payments.
 - When will installment payments begin?

Admission of a new owner:

- Required vote.
 - Required net production dollar volume.
- How to value buy-in amount:
- Appraisal.
 - Fixed formula.
- Installment payments, interest rate.

DISSOLUTION OF THE GROUP PRACTICE

- Required vote of the current owners.
- Method of dissolution.

MAJOR DECISIONS BY THE GROUP

- Majority or unanimous approval?
- Hiring and firing of personnel.
- Amending practice fee schedule.

EXHIBIT 2.9

Merger Checklist
(continued)

(continued on next page)

EXHIBIT 2.9Merger Checklist
(continued)

- Purchase of fixed assets in excess of \$[dollar amount].
- Adopting or amending retirement plan.
- Any expenditure in excess of \$[dollar amount].
- Designating of changing signatories on group bank accounts.
- Borrowing money.
- Entering into lease contracts.
- Offering ownership to a physician (probation or trial period).
- Terminating a physician's ownership.
- Withdrawals from group bank accounts.
- Negotiating and settling claims against the group practice.
- Determining which expenses of the individual physicians should be paid for by the group practice.
- Dissolution of the group practice.
- Purchase of insurance.
- Sale of group practice assets.
- Time intervals to reevaluate owner physician compensation formula; management group assignments; nonowner physician compensation formula.
- Other.

PROMOTION OF THE NEW GROUP PRACTICE

- Develop marketing strategy.
- Budget costs for marketing implementation.

THE "GREAT DOUBLE CROSS"

Psychologist and author Wayne Sotile discusses one of the most compelling issues weighing on the minds of medical group practice members. That issue is the "great double cross." Sotile asserts that the physician has always enjoyed the admiration of society and the promise of a comfortable living in return for providing care to patients—and that status is changing. Now-perpetual reductions in reimbursement are leading to ever-declining financial rewards, and lawsuits and the increasing scrutiny of physicians' practice of medicine have eroded the esteem many physicians feel. In addition, they are required to devote more time than in the past to charting in the EHR and performing other non-patient-care duties, further separating patients from physicians. The result has been a continued decrease in satisfaction with the practice of medicine (Sotile and Sotile 2002). Of those physicians currently in practice, 36 percent plan to retire in the next ten years, and only 58 percent of physicians are satisfied or very satisfied with their practice. They are also less likely to recommend medical practice as a profession (Jackson Healthcare 2013).

One important function of a practice's governance structure is to help restore and maintain practice satisfaction and address issues of burnout (see chapter 8). In addition,

practice leaders must deal with a whole host of other issues in today's modern healthcare era, including the following:

- ◆ Decisions about the ownership structure
- ◆ New providers and their contractual relationship with the practice
- ◆ Practice relationships with outside entities
- ◆ Duties and contributions of the practice manager
- ◆ Physician involvement in practice management
- ◆ Provider relations
- ◆ Emerging model of healthcare delivery

Part of the practice leader's job is to manage the important relationships among physician practice stakeholders. We return to these and other issues in the chapters ahead.

DISCUSSION QUESTIONS

1. What is the purpose of the mission, vision, and values of the medical practice?
2. Who are some of the stakeholders of the medical practice?
3. What are some of the operational, internal, and external functions of the practice?
4. What are the components of organizational culture that affect the medical practice?
5. Describe some of the key organizational forms that include medical practices.

REFERENCES

- Adamopoulos, H. 2014. "10 Key Healthcare Transaction Trends." Published February 7. www.beckershospitalreview.com/hospital-transactions-and-valuation/10-key-health-care-transaction-trends.html.
- American Academy of Family Physicians (AAFP). 2016. "Accountable Care Organizations." Accessed May 31. www.aafp.org/practice-management/payment/acos/sell.html.
- American Hospital Association (AHA). 2017. "Fast Facts on US Hospitals." Updated January. www.aha.org/research/rc/stat-studies/fast-facts.shtml.

- Association of American Medical Colleges (AAMC). 2016. "Council of Teaching Hospitals and Health Systems (COTH)." Accessed June 1. www.aamc.org/members/coth.
- Blum, B. A. 2013. *Examples & Explanations: Contracts*, 6th ed. Alphen aan den Rijn, Netherlands: Aspen.
- Centers for Medicare & Medicaid Services (CMS). 2017. "Shared Savings Program." Modified January 18. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/shared-savingsprogram/index.html?redirect=/shedsavingsprogram.
- Drucker, P. F. 2006. *Classic Drucker: Wisdom from Peter Drucker from the Pages of Harvard Business Review*. Boston: Harvard Business Review Press.
- Galbraith, J. 2014. *Designing Organizations: Strategy, Structure, and Process at the Business Unit and Enterprise Levels*, 3rd ed. San Francisco: Jossey-Bass.
- Groopman, J. 2008. *How Doctors Think*. New York: Houghton-Mifflin.
- Institute for Healthcare Improvement (IHI). 2017. "The IHI Triple Aim." Accessed April 24. www.ihl.org/engage/initiatives/TripleAim/Pages/default.aspx.
- Internal Revenue Service (IRS). 2017. "Exemption Requirements - 501(c)(3) Organizations." Updated January 26. www.irs.gov/charities-non-profits/charitable-organizations/exemption-requirements-section-501-c-3-organizations.
- . 2016. "A Guide to Common Qualified Plan Requirements." Updated October 28. www.irs.gov/retirement-plans/a-guide-to-common-qualified-plan-requirements.
- Jackson Healthcare. 2013. "Filling the Void: 2013 Physician Outlook & Practice Trends." Accessed April 22, 2017. www.jacksonhealthcare.com/media/191888/2013-physiciantrends-void_ebko513.pdf.
- McCanne, D. 2010. "How Does the Affordable Care Act Define ACOs?" Published October 28. <http://pnhp.org/blog/2010/10/28/how-does-the-affordable-care-act-define-acos>.
- McKendrick, E. 2012. *Contract Law: Text, Cases, and Materials*, 5th ed. Oxford, UK: Oxford University Press.
- Merriam-Webster Collegiate Dictionary*. 2016. "Culture." Accessed March 2. www.merriam-webster.com/dictionary/culture.

- Michal, M. H., M. S. L. Pekarske, and M. K. McManus. 2006. "Corporate Practice of Medicine Doctrine 50 State Summary." New York: Center for Advanced Palliative Care.
- Muhlestein, D. 2015. "Growth and Dispersion of Accountable Care Organizations in 2015." Published March 31. <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2>.
- National Committee for Quality Assurance (NCQA). 2017. "NCQA Patient-Centered Medical Home: Improving Experiences for Patients, Providers and Practice Staff." Accessed April 22. www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf.
- . 2016. "Patient-Centered Medical Home (PCMH) Recognition." Accessed March 5. www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx.
- Robbins, S. P. 1990. *Organizational Theory: Structure, Design, and Applications*, 3rd ed. Upper Saddle River, NJ: Prentice-Hall.
- Schein, E. 2016. *Organizational Culture and Leadership*, 4th ed. San Francisco: Jossey-Bass.
- Showalter, J. S. 2017. *The Law of Healthcare Administration*, 8th ed. Chicago: Health Administration Press.
- Sotile, W., and M. Sotile. 2002. *The Resilient Physician: Effective Emotional Management for Doctors & Their Medical Organizations*. Chicago: American Medical Association Press.
- Star, P. 2013. "Law and the Fog of Healthcare: Complexity and Uncertainty in the Struggle over Health Policy." *Saint Louis University Journal of Health Law and Policy* 6: 213–28.
- Strandberg-Larsen, M., M. Schiøtz, J. Silver, A. Frølich, J. Andersen, I. Graetz, M. Reed, J. Bellows, A. Krasnik, T. Rundall, and J. Hsu. 2010. "Is the Kaiser Permanente Model Superior in Terms of Clinical Integration? A Comparative Study of Kaiser Permanente, Northern California and the Danish Healthcare System." *BMC Health Services Research* 10 (91): 1–13.
- Wagner, E. H. 1998. "Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1): 2–4.
- Wagner, S. L. 2013. "Organization and Operation of Medical Group Practice." In *Physician Practice Management: Essential Operational and Financial Knowledge*, 2nd ed., by Lawrence Wolper, 45–83. Burlington, MA: Jones & Bartlett Learning.

