A Look Back,

A Look Forward

Reflections on 72 years of GPJ

By Tom Flatt

Group Practice Journal (GPJ) started as *Bulletin*, a publication of the American Association of Medical Clinics, in 1952. It consisted of notes and transcripts from Annual Sessions (now our Annual Conference), commentary, and letters. By 1958, it was renamed *Group Practice*, and content included some articles and advertising. As the association grew and evolved into AMGA, so did *GPJ*. Through all the changes, *GPJ* remained a vital resource for sharing best practices and strategies for successfully running physician enterprises. Thought leaders regularly commented on issues affecting their groups. We still struggle with some of these issues, and it's interesting to see how our thinking has evolved.

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Patient Experience

With the rise of capitation and population health initiatives, there was a corresponding concern about engaging patients. Many groups focused on improving the patient experience to foster trust and engagement, including a leader in the field, Cleveland Clinic. In the March 2014 issue, James I. Merlino, MD, chief experience officer and associate chief of staff, and Delos "Toby" Cosgrove, MD, president and chief executive officer, Cleveland Clinic Health System, shared their insights into creating a scalable approach to patient engagement. They offered this advice, which still rings true today.

The patient experience is about how our patients flow through our systems. We need them to receive safe, high-quality care in an environment of maximum satisfaction. Understanding that collectively these points are interconnected and represent the experience of care will enhance the delivery of healthcare and ensure that patient's journey through our systems is seamless.

Our success at achieving this requires us to align our organizations with the patient and make improving and sustaining the patient experience a top strategic priority. We believe that healthcare will not work any other way, and our success will enable us as leaders to drive better value.

In our system, much work remains. We are nowhere near to where we want to be, and every day we struggle with sustainability of our results and efforts. Despite this, creating a great patient experience is the right thing to do for our patients, our organization, and our industry.

Are there other strategies and tactics? Certainly! We are not consultants or a business trying to do work for hospitals. We are just hospital leaders describing what we did and are continuing trying to do to figure out ways to improve what we do for our patients—a performance we need to give together. It is our collective challenge as leaders.

We are both surgeons and clearly understand the importance of paying attention to detail. Delivering great healthcare is all about consistency and details. Delivering a great patient experience is no different. Patients pay attention to details as well. These are the tactics that drive our organization, and we believe the results support what we have done. Some ideas were borrowed from other hospitals and leaders, many lessons were learned from industries outside of healthcare, and occasionally we created something unique. At the end of the day, please remember one thing: We are just like you, working to improve the experience we deliver to our patients!

Culture

Creating and sustaining culture are core elements of a successful physician enterprise. In February 2013, 2012 Acclaim Award recipient HealthPartners contributed an article based on their submission, "Triple Aim 2.0: Designing Culture and Care to Support Better Health, Better Experience at a Lower Cost." They offered some keen insights on culture and change management.

HealthPartners believes organizations wishing to implement a dramatic organizational change need to follow the key elements below to redesign the care process and achieve Triple Aim results.

- **A clear vision.** A clear, shared vision among the board members and senior leaders cascading throughout the organization is essential. Progress toward the vision requires setting ambitious goals and transparently reporting results.
- **Cultural change.** The cultural change required to succeed with team-based medicine is considerable. The organizational culture needs to embrace standardization and reliability and to act every day on the belief that the center of the care is the patient.
- **A Triple Aim focus.** Measuring progress on all three elements of the Triple Aim simultaneously is a powerful way to keep an organization on track.
- **The right leadership structure.** HealthPartners' leadership system pairs an administrative leader and a physician leader in each area. The two manage their areas as a team, agreeing on all decisions before any changes are made. This unites administrative and clinical points, so together, they see the whole picture.
- **Teamwork.** The Triple Aim 2.0 vision works, in part, because the teams are operating in new ways to have individuals working to their full capabilities, to huddle and design care together, and in new roles and new communication processes.
- **Design principles.** In order to practice design with intention, apply design principles across the system: reliability, customization, access, and coordination. The EHR is essential, but it is not sufficient on its own to drive change.
- **Involvement of patients and families.** It really changes the focus of the discussion and enhances the care design to have patients involved.

Adapted from the 2012 Acclaim Award Application of HealthPartners submitted by Beth Waterman, RN, MBA, chief improvement officer.

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Workforce and Delivery Models

Advanced practice clinicians (APCs) are now a huge part of the delivery of ambulatory care in most medical groups. This was not always the case. In the December 2013 issue of GPJ, *Ragan Cohn, CAE, director of communications and public relations for the National Commission on Certification of Physician Assistants, penned "Growing Demand, Shrinking Revenues: The PA Solution," which detailed how to effectively use physician assistants (PAs) to solve some access issues.*

A growing number of practices offer PAs a base salary plus an "at risk" portion of compensation, often based on productivity measures. "Giving PAs 'skin in the game' early on—even at a low level—with a portion of productivity-based compensation will make them aware of their productivity and position them to contribute to the practice at the highest levels," said Randy D. Danielsen, PhD, PA-C, author of *The Preceptor's Handbook for Supervising Physicians* and dean of the Arizona School of Health Sciences at A.T. Still University. "Physician assistants don't want to be viewed as hired help just there to facilitate the physician's work. These are highly educated, highly skilled professionals in their own right who should be viewed and treated as such."

He suggests that "compensation" is a formula that includes not only cash and financial benefits but also time off, respect, and valuing of the individual's skill set. Patricia Cook, MD, FACP, retired internist and former medical director of the U.T. Southwestern PA Program, advises physicians, "Have PAs play a significant role in the practice. Take advantage of that second—and hopefully different—skill set, and view the PA as an extension of yourself. Foster and celebrate the differences between you, and partner with the PA in the improvement and expansion of care your group is able to provide."

The provider shortage is a serious issue, but the PA profession is stepping up to bridge the gap, improving access to high-quality, affordable healthcare as members of physician-PA teams. "As practices deal with the challenges and opportunities afforded by healthcare reform, the PA is ready, willing, and able to partner with physicians to help us emerge on the other side of the implementation process with better practices, greater work-life balance, and healthier patients," concluded Dr. Cook.

Population Health/ Employee Health

AMGA members identified the obesity epidemic early and began to plan interventions. Some of their work is reflected in the Obesity Care Model Playbook, developed through an AMGA Foundation Best Practices Learning Collaborative. Aurora Health Care® developed weight management programs, and in April 2014, Amy S. Confare, BS, integration analytics manager, Aurora Health Care, and Steven H. May, PhD, director of behavioral medicine, HMR Weight Management Services Corp., shared their efforts to create a weight management program for their employees. Their strategies are still relevant today.

Most employers are concerned about the health of their employees, rising healthcare costs, and the increasing impact of obesity on these costs. A range of weight-management options for employees may be necessary, including intensive programs that demonstrate effective outcomes. Those programs yielding clinically important weight loss may be essential to reach health and economic objectives. Aurora Health Care implemented an intensive medical weight-loss program in a clinic and remote model, both of which support employee access and utilization. Adding incentives by linking wellness objectives to employees' health insurance premiums was critical to increasing participation and impacting a greater portion of the employee population. Basing incentives on participation may be possible with a data-driven weight-management program that can demonstrate substantial outcomes.

The remote program alone, delivered here as Healthy Solutions at Home, provides clinically relevant weight loss offering a useful option for those companies that may not have the infrastructure for, or proximity to, a clinic-based program.

Aurora Health Care is integrating HMR, both clinic and remote programs, throughout its healthcare system as well as offering both treatment options to insurance plan partners. Given the access to medical supervision, the clinic program is particularly well-suited to employees with comorbid conditions or more complicated medical histories, while the remote program can be made available to employees across a wide area.

Value

AMGA members have long been leaders in moving to value, and AMGA was instrumental in crafting the legislation that created Accountable Care Organizations under the Affordable Care Act. In the February 2012 article titled "Adopting the High-Value Accountable Care Model for Integrated Group Practices," early vanguard Mayo Clinic offered advice on moving to value. Robert E. Nesse, MD, chief executive officer, Mayo Clinic Health System; Douglas Wood, MD, medical director of value analysis for the Center for the Science of Health Care Delivery; Robert Chase, chair of the Department of Contract and Payor Relations; R. John Presutti DO, medical director of contract and payor relations; and Shirley A. Weis, BSN, MM, chief administrative officer, Mayo Clinic, shared their experiences and insights.

The concept of high-value care and the accountable care model for its implementation gained prominence in American medicine following the passage of the Patient Protection and Affordable Care Act of 2010 (PPACA). Replacing the fee-for-service

reimbursement model with a new one that would incent high-quality care at a lower cost appeals to many provider groups, professional societies, and consulting groups.

However, healthcare providers have been hearing for some time about new systems of care that promise higher quality and lower costs. Experience taught us that some were fads and most did not have sufficient impact on our current delivery system. Therefore, prior to making a decision about repositioning a medical practice to accept accountability for high-value care, it is important to understand the forces that led the Federal government and other payers to support implementation of accountable care as the vehicle for value-based care.

The status quo of healthcare in America cannot be sustained. There will be fewer dollars for care, while the population requiring it will increase. The future effectiveness of healthcare requires us to design and deliver better quality, safety, and service at a lower cost. It is core to a medical group's mission and values to improve performance and support the patient's best interests. We also know that future quality and safety performance will be transparent to the public.

Integrated medical groups, cooperative practice arrangements, advanced information technology and management tools, and expertise in management of population health are all in place or in development throughout the country, and integrated group practices are well established in many regions. These groups are positioned to develop accountable care models. The challenges and requirements of accountable care call for full integration of primary and regional care with tertiary and quaternary care to develop the expertise necessary for care delivery to a population of patients over time.

If medical groups do not participate in new care models due to their disappointment with current rules and the political environment, they will miss an opportunity for health reform that can support the interests of their practices and their patients. Many groups have a coordinated practice, electronic medical records, an aligned financial model, and an established governance model. What they often lack are reliable partners who can work with them to incent and reward value. This issue can be addressed. Engaged and aligned provider groups have a chance to develop a successful, high-value approach to accountable care that will serve the country well, regardless of the future challenges of national healthcare reform.

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Mergers and Acquisitions

Over the past decade, we have seen much integration, with many groups merging or becoming a part of a larger system. Near the beginning of this trend, David A. Ettinger, JD, of Honigman Miller Schwartz and Cohn's Antitrust and Trade Regulation practice, began writing for GPJ*, sharing his experiences in merger litigation. In June 2014, he shared his insights in "The Decision Is In: Expect Jump in M&A Challenges," insights that still ring true today.*

Two years ago, I wrote an article that appeared in this *Journal* entitled, "Planning for Antitrust Reviews of Practice Acquisitions and Mergers."[1] That article addressed the antitrust issues arising from physician practice mergers and acquisitions (M&As). Now, the first litigated antitrust case in this area, *Saint Alphonsus Health System, et al. v. St. Luke's, et al.*, in which I represented one of the successful plaintiffs, has been decided. The St. Luke's decision establishes an important precedent and has received broad national attention.

As a result, antitrust challenges to physician transactions will likely be more frequent in the future. The St. Luke's decision also provides important lessons for any physician groups considering significant M&As.

The St. Luke's case concerned an acquisition of a 41-physician practice in Nampa, Idaho (just outside of Boise), called Saltzer Medical Group. Saltzer was the largest and oldest independent medical group in Idaho and by far the leading group in Nampa. The buyer was St. Luke's Health System, the largest health system in Idaho, based in Boise. St. Luke's already employed several hundred physicians and had acquired more than 20 physician practices over the previous several years.

My client, Saint Alphonsus Health System, is the second largest health system in the Boise area. Saint Alphonsus operates a hospital in Nampa, which depends substantially on referrals from Saltzer Medical Group. Saint Alphonsus experienced significant referral losses from physician groups after they were acquired by St. Luke's and feared the same would occur after a Saltzer acquisition. For this reason, among others, Saint Alphonsus opposed the acquisition.

The Court held that the transaction was unlawful.[2] Judge B. Lynn Winmill

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found that the acquisition of Saltzer was the latest in a series of acquisitions by St. Luke's that had already allowed St. Luke's to raise prices. "Between January 2007 and January 2012, St. Luke's acquired 49 physician clinics in the Treasure Valley and at least 28 physician practices in the Magic Valley. ...[B]y 2012 St. Luke's had three of the top five highest paid hospitals [in Idaho]." He therefore predicted further price increases were likely as a result of the Saltzer acquisition.

The Court concluded that the transaction would likely result in higher prices not only for primary physician care, but also for ancillary services such as lab and diagnostic imaging. According to the Court, "St. Luke's own analysis projected that it could gain an extra $750,000 through hospital-based billing from Saltzer from commercial payors for lab work and $900,000 extra for diagnostic imaging."

The Court found that higher prices were in fact one of St. Luke's goals. It referenced a document written by St. Luke's Regional Medical Center's CEO that "under [a] heading of 'Price Increase' was a bullet point stating 'pressure payors for new/directed agreements.'"

Lessons Learned

Judge Winmill's decision certainly provides encouragement to healthcare providers who believe that transactions in their local markets may be anticompetitive. It also provides very important lessons for providers seeking to conduct healthcare transactions. These include:

- There's no simple "healthcare reform" defense where significant antitrust concerns are present. Judge Winmill found that the goals of healthcare reform can be achieved without acquisitions.
- Competitors, payers, and employers play significant roles in the antitrust process. The key witnesses in the St. Luke's case were several of the area payers (including Idaho Blue Cross) and the largest area employer, Micron. The lawsuit filed by Saint Alphonsus and Treasure Valley illustrates that in a hospital/physician transaction, competing hospitals that may stand to lose referrals or lose network access to the acquired physicians may also have substantial antitrust claims.
- A transaction resulting in a high market share will be presumed to be unlawful, and it will be difficult to present evidence that rebuts this presumption. If the merging parties possess a combined 50% share, this will exceed the level at which FTC presumes transactions are anticompetitive.
- The critical antitrust question is likely to be the size of the geographic market in which the physicians compete, since that finding will drive the market share calculation. The St. Luke's decision helps establish that markets in which PCPs compete are likely to be very local because of patients' strong desire for convenient access to routine care. Therefore, the first step the merging parties should take in assessing antitrust risk is their combined share of the local areas they serve.
- The analysis may be very different for many specialties since patients may be willing to travel substantially greater distances for specialty care, especially for specialties they do not routinely utilize. In other cases, I've successfully argued for broad geographic markets for urology and cardiology, although these determinations strongly depend on the facts of the particular case.
- As in every antitrust case, the St. Luke's decision turned in significant part on the merging parties' own documents. Critical admissions in a memo or even an email can sink an antitrust defense.
- Two kinds of transactions can raise antitrust issues: those involving two competing physician groups and those involving a hospital and a physician group. A hospital/physician transaction will raise the most serious antitrust issues only if the hospital already employs competing physicians in the relevant market, so that the transaction eliminates existing physician competition.
- In hospital/physician transactions, it is important that physicians obtain their own expert antitrust counsel. If the transaction ultimately fails on antitrust grounds, the greatest loser may be the physician group, whose operations may have been "in limbo" during a long investigation and potential litigation. Total reliance on the assurance of hospital counsel that antitrust issues will not be a concern can be a big mistake.

Antitrust challenges to physician transactions will likely be more frequent in the future.

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References

1. David A. Ettinger. 2012. Planning for Antitrust Reviews of Practice Acquisitions and Mergers. Group Pract J 2012; 61: 10.
2. St. Alphonsus Medical Center-Nampa, Inc. v St. Luke's Health System, Ltd., 2014 WL 407446 (D. Idaho).

Health Equity

Access and health equity have long been concerns of AMGA members. In 1999, Edward B. Noffsinger, PhD, began contributing to GPJ *with his models for shared medical group appointments, the Drop-In Group Medical Appointment (DIGMA) model developed in 1996 at Kaiser Permanente and the Physicals Shared Medical Appointment (PSMA) model developed in 1971 at the Palo Alto Medical Foundation. He wrote extensively in our publication as he implemented the models at groups around the nation. In the July/August 2013 issue, in "Reaching Out to the Poor, Disenfranchised, and Underserved: Testing the Limits of Group Visits," he shared how these models were able to address health inequities in various marginalized populations.*

Homeless Vets

One DIGMA that I felt would test the limits of the model and have a high likelihood of failure was designed for homeless veterans on the East Coast. Much of recent social perceptions of these patients would likely be distinctly negative, with people often looking down on them as they panhandle or urinate in public areas. Many of these patients have limited coping skills plus mental health, substance abuse, and PTSD issues—and most would likely be used to handling their problems alone. For these reasons, I felt that homeless vets would not be favorably disposed toward receiving their medical care in a large and highly interactive group visit format.

Therefore, I went to a Veterans Health Administration (VHA) facility on the East Coast and assisted in setting up a DIGMA for homeless vets. What I found was that, far from being the failure that I had anticipated, this "Homeless Vets DIGMA" was not only a success but also an absolutely touching and heartwarming experience for all—including me. These patients were extremely appreciative of the care we were offering them. Time and again they expressed how they simply could not believe that anyone would care enough to reach out and provide them with such a high-quality healthcare experience.

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—Edward B. Noffsinger, PhD

Street-Involved Aboriginal People

This finding was replicated when I was asked to come up to Canada for what they called a "DIGMA for Impoverished, Street-Involved Aboriginal People"—another application of the DIGMA model that I felt would be at high risk for failure. As was the case with homeless vets, this turned out to be a very touching, successful, and heartwarming experience. It was hard for me to believe that people could actually live out on the streets in northern British Columbia during the middle of winter—yet, sadly, they were doing so. Conditions were very harsh for these unfortunate souls, most of whom had serious substance abuse problems. To be culturally sensitive, we started this group off with a smudging purification ceremony led by a tribal elder. It was indeed a privilege to hear this wise man speak of how he "had learned in the circle that we are not meant to be alone. That we are meant to share our sorrows, hopes, sufferings, and joys with one another."

Our culturally sensitive gesture opened the DIGMA on an exceptionally warm note. It made it easier for these otherwise quiet and reserved patients to begin talking, to open up, and to share their health issues with the medical staff as well as each other. Not only were their unique medical needs individually addressed in turn, but the heartfelt support shared between patients (and between patients and staff) was palpable and truly touching.

In the Alaskan Bush

Having found that the so-called high-risk "Homeless Vets DIGMA" and "Street-Involved Aboriginal People" SMAs actually turned out to be highly successful, I was even more resolute about making yet another attempt to determine the limits of applicability of the DIGMA and PSMA models. The most improbable group I was able to conceive of at that time was "digital rectal examinations for elderly hermits living in the bush of Alaska," conducted by a young female urologist. Although I had previously implemented successful DIGMAs and PSMAs in urologic practices with high levels of patient satisfaction (despite the sensitive nature of many of the issues discussed), I felt that socially isolated, elderly hermits would not take well to this setting.