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How physician-finance partnerships pave the way to higher-value care

To succeed under value-based payment models, healthcare organizations must replace siloed perspectives with shared goals. Physician and finance executives can help each other think more globally.

AT A GLANCE

- The pursuit of higher-value care requires clinical and finance leaders to avoid operating in silos and instead combine their expertise to reimagine care delivery and operations.
- Finance leaders can help physician leaders learn how to access information, participate in the budgeting process and develop a business plan.
- Physician leaders can help their finance counterparts by supporting systematic thinking about value and identifying realistic opportunities for cost savings in the clinical realm.

In the past few years, a growing number of physicians have taken leadership roles in hospitals and health systems. Given that value-based care is a team sport, this is a positive trend. Yet conflict between physicians and finance executives can arise because of their respective knowledge gaps and differing perspectives and work styles.

To work together effectively, finance executives and physician leaders need a better understanding of each other's strengths. They also need to recognize how they can help each other leverage their distinct skills to build a strong value-based care delivery organization.

Collaboration between clinical and financial leadership produces the following personal and organizationwide benefits:

- Avoids time wasted in conflict
- Lowers leadership turnover
- Improves patient outcomes
- Reduces costs

How finance leaders can support physician leaders

Today's physician leaders are more likely than those in earlier eras to have received some finance training. However, most physicians still come to new leadership roles with a knowledge gap.

It is imperative that chief medical officers (CMOs) and other physician leaders understand how to read and interpret basic financial reports and

spreadsheets. Finance leaders also should help physician leaders understand the following concepts of effective financial and clinical decision-making.

Finance leaders can't lead without information. As a discipline, financial management has honed systems and processes to collect and report information on revenue and expenses. That same rigor needs to be applied to managing utilization and quality metrics under value-based care programs.

Finance leaders can support physician leaders by using their expertise to provide relevant and timely data, ensure the data is accurate and consistent across periods of time and deliver that information to the right people at the right time in a meaningful and understandable format.

In addition, finance can help physician executives leverage the emerging "science" of data visualization to manage value-based care programs. For example, the ability to look at large quantities of data for entire populations over time is critical to detecting opportunities for improvement in utilization and quality metrics, and to identifying systemic or common reasons for deviations from national benchmarks.

The budgeting process is a balance. The hospital budgetary process and fiscal cycle are foreign to most new physician leaders. Finance leaders can help physicians understand the impact on revenue and expenses of factors such as:

- Market demand
- Market share
- Payer mix
- Utilization
- Inflation
- Regulation
- New risk-based contracts

Physician leaders also should understand the fundamental objective of the budgeting process. Most healthcare organizations either must cut something from the previous year's allotments to make room for new initiatives or have a plan to increase revenue from new services. Some hospital functions and programs lose money; others produce a margin. For the entity to survive, the financial positives *must* outweigh the negatives.

For every clinical program under budgetary review, however, physician leaders require enough lead time to assess effectiveness and then correct course or prepare staff for change. Budgetary work requires leaders to be creative and make difficult choices that should be informed by business objectives.

Every program must have a business plan. Whether or not a program is expected to generate a margin, the CMO and all service line leaders need to express their clinical proposals in rigorous business terms. If no revenue is expected from a

4 principles to help leaders see eye-to-eye on community-benefit programs

Most hospitals, particularly faith-based not-for-profit institutions, support charitable medical services that are not fully reimbursed. However, it is common for physicians to misunderstand the meaning and role of *community benefit* within hospital financial management.

To collaborate effectively, physicians and finance leaders should base decisions on a shared set of principles:

1. Charitable programs should not be confused with programs that are intended to be financially self-sustaining. An outpatient cardiac clinic that cannot break even is a failed program, not a charitable outreach.
2. Poor management that leads to a loss should not be excused by reclassifying the program as "community benefit" after the fact. The designation should be done prospectively and approved all the way up to the board level.
3. The degree of loss should be predicted as closely as possible. Even if physician leaders expect a loss on a program that is run for community benefit, accurately quantifying expected losses is critical to overall financial management.
4. Even charitable programs that lose money can lose less money when managed well. The goal is not to wring additional revenue out of charitable programs but to establish the financial balance that makes community benefit available in the first place.

Physicians can provide practical insight on not only where patients go out-of-network for care but also why they do so and what collaborative solutions can be applied.

proposed investment, the CMO must be clear about the range of potential loss.

Ideally, all physician leaders will have a basic understanding of return on investment (ROI), net present value (NPV) analysis and internal rate of return (IRR). Minimally, physicians should be paired with a finance staff member who is proficient at creating formal business plans that include market analysis, marketing plans, expense projections and pro forma financial statements.

The pro formas should be bracketed to present worst-case, expected and best-case scenarios. The CMO or service line leader should be prepared to defend each point of the business plan and to modify it based on input.

The finance department can support this process by helping physician leaders commit to predictions in numeric terms and quantify expected outcomes and collaborate to put forth and vet their best estimates.

How physician leadership can support finance

The shift from volume to value has prompted many finance leaders to deepen their understanding of clinical care delivery. However, physician leaders still need to help their finance colleagues understand opportunities to increase healthcare value and value-based revenue. The following opportunities stand out.

Supporting systematic thinking about value. Some activities that lose money in isolation contribute positively to the enterprise. For example, it is well documented that hospitals lose significant money on employed physician groups in terms of practice operations.

Considered in the context of the entire organization, however, an employed physician group can generate substantial ROI. Physician employment creates opportunities to better coordinate and manage patient care, which can help reduce medical spend and the overall cost of care. Under a value-based contract, the resulting shared savings would be additional revenue for the organization.

Physician leaders are needed to identify, evaluate and manage similar opportunities. For instance, an organization might propose hiring a nurse care coordinator to manage a registry of patients with congestive heart failure. As a human resource, the nurse has a finite cost to the hospital. But when considering ROI, the organization may struggle to predict precisely how many unnecessary hospitalizations the nurse's efforts will prevent. Physician leadership is critical to working out the impact on outcomes and the revenue projections for such investments.

Calculating fee-for-service (FFS) revenue involves a simple formula of *rate times volume*. In a fee-for-value (FFV) environment, the financial impact of an initiative is much harder to predict because effects are estimated on an actuarial basis and small numbers of patients lead to greater statistical variability. Physicians can help reduce this variability by identifying the strongest relevant research, maintaining focus on the most promising clinical interventions and providing disciplined assessment of outcomes.

In this way, physicians can help finance executives deal with the challenges of a mixed-payment model. It is easier to maintain business as usual and merely subsidize Medicare and managed care losses with FFS profits. However, when finance leaders work with the CMO and other physician leaders to agree on principles (e.g., "right care, right place, right time"), they can devise an

internally consistent business model that reconciles the conflict between FFS and FFV payment and creates a path to success in the value-based environment.

For example, a health system might pursue an ambulatory strategy that increases access by expanding hours and enhancing services at its urgent care facilities. This approach would reduce unnecessary emergency visits and inpatient admissions, thereby cutting FFS revenue on the inpatient side.

However, in addition to increasing ambulatory revenue, this shift potentially would reduce the variable costs associated with unneeded services. It also would increase capacity for services (such as procedures) that generate margin. Physician leadership is key to operationalizing this business model.

Practical suggestions for a productive working relationship

As finance executives and physician leaders respond to the demands of value-based care, they may run into roadblocks to forming a strong partnership. Leaders can overcome these issues by taking a positive approach to combining their divergent skills and perspectives.

Cultivate professional empathy. Both parties should seek to understand the motives and constraints of their leadership partners.

Finance leaders are typically cautious by nature and fiscally conservative. Physician executives, meanwhile, may have a higher tolerance for risk and a stronger sense of patient advocacy.

Physicians are also natural problem-solvers, assessing a situation quickly to find a diagnosis and move to a course of treatment. This approach can create problems if it means pushing change before the organization is ready, but it also injects important energy into critical initiatives.

Create supportive structures. Finance leaders should establish standing meetings with their physician counterparts to address matters of mutual concern. For example, the CFO and chief medical officer might set up a monthly meeting to review KPIs and value-based initiatives. Regular meetings allow financial and clinical leaders to get to know each other personally and find common ground.

Taking this idea one step further, healthcare organizations should consider adopting a dyad leadership model. Under such a model, an administrative executive and a clinical executive are designated co-leaders for a key function, strategy or initiative. Since all finance decisions influence the clinical aspects of the business and vice versa, this approach ensures no one feels like they are making decisions in a silo.

At times, finance-physician partnerships will require conflict resolution. Professional coaching and mentoring can help teams develop the skills to navigate these issues when they occur. All leaders benefit from learning to avoid taking a defensive posture and instead focus on processes and solutions that create the best shared outcomes.

Pay attention to soft skills. Accustomed to sitting behind the steering wheel, physicians may struggle to settle into a team approach where others have the same or more authority. A formal physician leadership program can help physicians enhance their self-awareness, learn better communication skills and begin to master critical conversations.

Finance leaders can also benefit from soft-skill interventions in the context of their partnerships with physicians. The focus of this training tends to be on emotional intelligence, leadership agility and a people- and results-oriented management approach. The training can lead to more-effective meetings, better working relationships and calm handling of critical issues.

Identifying realistic cost-saving opportunities. Physician leaders are essential to pinpointing the drivers of clinical waste that undercut margins under FFV payment. For example, they can identify overutilization that occurs when evidence-based protocols are not followed, or duplication of services that results from poor clinical communication.

Finance staff and physician leaders should work together to make sure cost reductions outpace revenue reductions, including by alleviating avoidable inpatient days, unnecessary utilization and readmissions, and hospital-acquired conditions. Addressing the costly impact of variability in care and operational processes requires a team-based approach. For example, physicians could lead a multidisciplinary effort to avoid over-testing in the inpatient environment.

Supporting value-based contracting. Physician leadership is essential to every aspect of planning and executing value-based contracts.

Negotiation is one key area. Before system leaders can commit to a value-based contract, they must have an accurate understanding of costs and opportunities within an attributed population. Physician involvement is key to identifying realistic opportunities to optimize population health, an essential part of negotiating a sustainable contract.

Regarding revenue cycle management under FFV, wherein clinical-risk scores can drive payment, physician leaders need to work with the medical staff to ensure that clinical documentation fully captures diagnoses. Physicians and finance leaders should collaborate to develop a shared understanding of the drivers of risk adjustment (e.g., the CMS-HCC model) for an assigned population, along with how clinical-risk scores will impact revenue.

Finally, there is the concept of patient "keepage." In initiatives to optimize outcomes and control costs, physician leadership is essential to creating clinical programs that keep patients engaged in the system. This effort especially is important to keeping attributed patients in-network, where appropriate care most readily can be managed. Physicians can provide practical insight on not only where patients go out-of-network for care but also why they do so and what collaborative solutions can be applied.

Lofty goals are within reach

When physician-finance partnerships succeed, the cost savings can be significant. Potential outcomes also include less time wasted in conflict and lower leadership turnover.

Ultimately, as finance executives and physician leaders develop more cohesive working relationships, healthcare organizations will be in a stronger position to achieve what has come to be known as the Quadruple Aim: lower costs, healthier populations, better patient experiences and better professional experiences for clinicians and staff.[a] ■

a. Bodenheimer, T., and Sinsky, C., "From Triple to Quadruple Aim: Care of the patient requires care of the provider," *Annals of Family Medicine*, November/December 2014.

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