Leadership in a Private Nephrology Practice: Autonomy Is More Than a Dream!

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Nelson Kopyt and Ravindra Bollu

Private practice is entering an era of diminishing reimbursement and increasing overhead associated with federally mandated payment reforms resulting in a need to move from the traditional fee-for-service to a value-based model, changes that place financial and organizational strain on nephrology practices. In addition, the changing geopolitical scene is one of mergers and consolidation of health care networks, which in turn are developing their own insurance plans or partnering with commercial payers. The new landscape will require the leadership of a private nephrology practice to vigilantly monitor and adapt to these changes for success. Our leaders must be mindful of the impact of these changes to foster the successful growth of an autonomous private nephrology practice in which there is opportunity for personal and professional growth of its members in their quest to provide quality and safe patient care.

Key Words: Private nephrology practice, Leadership, Autonomy, Alignment

Private practice is now entering an era of diminishing reimbursement and increasing overhead associated with federally mandated payment reforms resulting in a need to move from the traditional fee-for-service to a value-based model.[1,2] These changes will clearly place financial and organizational strains on any nephrology practice. In addition, the changing geopolitical scene has resulted in the merging and consolidation of health care networks (HCNs) who in turn are developing their own insurance plans or partnering with commercial payers. These entities are commonly purchasing referral practices adding further stress on independent nephrology practices. The new landscape will require close monitoring and associated adaptability to change by the leadership of a private nephrology practice to thrive and be successful. A consideration is merging into larger groups with hopes of increasing efficiency and negotiating power while reducing expenses. A successful outcome is dependent on the practice model used, the market, and group size. Simultaneously, our leaders must be mindful of the impact of these changes on other aspects of the practice as suggested by a recent report that physicians working in small primary care practices (2/3 solo practices) have lower levels of burnout than larger practices (13.5% vs 54.4%).[3] In this article, we present our thoughts about the development of a leadership model to foster the successful growth of an autonomous private nephrology practice that optimizes the environment for the personal and professional growth of its members allowing them to provide care for their patients as they feel appropriate.

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FORCES DRIVING THE CHANGING FACE OF PRIVATE PRACTICE NEPHROLOGY

Most nephrology practices began as small groups responsible for the care of 100 to 300 end-stage kidney disease (ESKD) patients distributed among 2 to 4 clinics. A typical work schedule integrated dialysis rounds, hospital rounds, and office hours. The revenue stream for these practices was a volume-dependent one. Nephrologists became comfortable and complacent with this model. The ever-increasing cost of total patient care has resulted in the design of new reimbursement initiatives such as the Merit-Based Incentive Payment System, end-stage kidney disease seamless care organizations (ESCOs), and accountable care organizations.[4] Participation in these programs has required practices to develop infrastructural changes adding to the increasing overhead costs to prevent costly penalties.

In addition to the challenges posed by changes in reimbursement and regulatory burden, concerns about a diminishing workforce are a common topic of discussion. Indeed, nephrology is an aging specialty with almost half of the community older than 55 years.[5] Even more disturbing is the decreasing number of new nephrologists in the recruitment pool with less physicians selecting nephrology as a career path.[6,7] Aging nephrologist may consider early retirement or moving to an employed model with a HCN or a large dialysis provider (large dialysis organization [LDO]) rather than face the challenges of maintaining an autonomous private practice. Many young nephrologists may not be prepared to develop the infrastructure and new programs required for alternative revenue sources to offset the decreasing reimbursement and increasing overhead expenses. Depending on their philosophy and risk adversity, young nephrologists may wrestle with these issues as they contemplate whether to remain in a private nephrology practice. Many are finding an employed model a path of least resistance. Others have left the specialty to become hospitalists where their salary and work schedule may be more enticing. Nephrology practices of the future must adapt to the

professional and personal growth needs of these young nephrologists to successfully maintain practice autonomy.

A consistent trend toward hospital acquisitions of physician practices and a dramatic increase in physician employment was recently demonstrated by the Physician Practice Acquisition Study.[8] For nephrology, this will be market dependent. In our community, 1 of 2 practices was acquired by a large hospital network, whereas the other remained independent. The benefit of acquisition by a hospital includes assurance of a stable referral base as well as avoiding the need to address infrastructure needs for an ever-changing regulatory burden. The cons include the fact that nephrology practice patients may be viewed as cost centers and likely to result in less revenue flow from shared savings programs as other specialties. Contract negotiations may benefit larger revenue generators. LDOs have expressed increased interest in partnering/acquiring nephrology practices allowing access to analytics and capital/infrastructure for growth and to meet the needs of increasing regulatory burden. Coincident with these benefits is the relinquishment of control of the practice to the LDO and adding a layer of bureaucracy to the management and control of the practice. These are all fluid states as it is not clear how aggressive hospitals will be in acquiring nephrology practices in the future, in some areas hospitals are in the process of divesting from acquired nephrology practices, and some LDOs may have stopped acquiring practices.

CLINICAL SUMMARY

- The autonomous nephrology practice is facing increasing pressures transitioning from a fee-for-service to value-based model associated with increasing overhead and diminishing reimbursement.
- Leadership in these practices will require the skill set to optimize the quality and value of care while simultaneously developing alternatives to traditional revenue streams to maintain viability.
- Understanding the intricacies of alignment with HCNs and LDOs will be a prerequisite for a successful leader.
- The ability to listen, adapt, change, and evolve in this period of transition can lead to a viable and successful autonomous nephrology practice.

CHALLENGES FACING NEPHROLOGY PRIVATE PRACTICES

Importance of Moving From Volume-Based to Value-Based Strategies

Increasing reliance on population health strategies will command a greater use of analytics and data mining. Electronic medical record (EMR) providing clinical data and claims data from network-owned commercial payers will allow for real-time analysis regarding the impact of practice changes in quality and value of care. Nephrology leaders must learn how to effectively use these data to simultaneously enhance the quality and value of their practice as well as meet the needs of the HCN with which they are aligned. Effective use of data will assist the practice in optimizing quality requirements mandated through federal legislation and alternate payment models.

The high cost of CKD care is a global problem commanding a multifaceted approach to population health care.[9,10] Initiatives will need to include the early recognition of CKD potentially directing more referrals to a nephrology practice to assist in the care of those patients with progressive disease earlier. The transition to value-based medical care will tend to shift treatment of these patients to the outpatient setting increasing the need to develop practice-related programs to handle this influx of patients. Partnering with HCN patient-centered medical homes to optimize this care will increase the value of the nephrology practice to the larger HCNs. Nephrology leaders must assure development of a strong infrastructure to optimize outpatient transition of care from CKD to ESKD improving value and cost.

Alignment With Global Health Systems

Historically, private nephrology practices worked simultaneously in multiple HCNs within their communities. Health care reform and emphasis on value-based health care models have intensified the competition between these networks.[11] Networks from diverse geographic areas are merging into larger health care organizations (HCOs) and developing relationships with commercial payers or their own commercial insurance product. As these HCOs grow, the model evolving is to acquire and own multiple practices.[12] Alignments have intensified competition between network-owned and private nephrology practices. If not managed well, this trend could possibly result in the demise of an independent practice. Difficult decisions made by leadership regarding network alignment will be required for autonomy. Support provided by each HCO will require careful review. The private nephrology practice aligned with an HCO must be prepared to provide whatever services are required to foster a strong and successful relationship.

Alignment With Dialysis Organizations

Among the many challenges facing future leadership is the ability to understand and develop relationships with their LDO. LDOs have developed the capacity to support a private nephrology practice in many aspects of infrastructure and management. These relationships will become especially important if the ESCO opportunity is successful and flourishes as an alternative payment model in our patients with ESKD. Alignment with the correct LDO also opens the possibility of developing a joint venture relationship in a hemodialysis unit or access center. These also have to be reviewed critically with the ever-changing world of reimbursement guidelines such as is occurring recently with access centers and ambulatory surgical care centers.[13] The resources available to the large LDOs regarding logistics and analytics will also provide opportunity regarding potential areas of change, which may be needed to ensure viability and progression to a stronger independent practice. These relationships will require a

leader who is sophisticated and accomplished enough to manage restrictive covenants, obligations, and debt service for the practice as well as potential for conflict of interest adversely affecting patient care and global health care costs.

A leader who can create programs aligning the practice with an HCN and an LDO may enhance the quality of care for our patients through the development of the seamless care of these patients across the boundaries of outpatient, inpatient, and clinic care. These strong relationships evolving between the nephrology practice, the HCN, and an LDO can also evolve into another entity, the patient-centered nephrology neighborhood.[14,15] This will require the development of a complex infrastructure and interfacing the EMRs of the nephrology practice and the patient-centered medical homes/HCNs. The lack of interoperability in the current environment constitutes a palpable barrier to achieving this.

Maintaining Financial Viability

Maintaining financial viability while transitioning from a fee-for-service into a value-based model with increasing need for population health is a major challenge. Traditional revenue streams once driven by outpatient dialysis patient care and inpatient billings are shifting to outpatient CKD care. Optimizing CKD care to slow the progression of disease, from a health care policy perspective, will reduce inpatient care needs and cost. However, this will simultaneously have a negative impact on practice revenue. The tenant that working harder is rewarded with enhanced income is now fading. Patient relationships are important and rewarding; however, we must not become so myopic as to assume that the rewards of patient care will always outweigh our desire (and need) for fair renumeration for one's efforts. This will eventually lead to conflict at the individual and group level once a point of diminishing return in a practice is reached.

To adapt and survive these revenue stream changes amid ever-increasing overhead costs, our future leaders must be creative in their consideration of alternative sources. Potential opportunities include joint ventures with LDOs and HCNs, clinical research, telehealth/telemedicine, involvement in alternative payment models of care, and access centers. Adding an access center may improve the financial (depending on the impact of ever-changing reimbursement guidelines) and the quality objectives of the practice. It also supports the ESCO objectives to curb the costs of ESKD patient care by limiting unnecessary hospitalizations. Enhancing revenue can also come from traditional routes such as expansion into underserved areas and expanding the practice's workforce through the use of allied health care practitioners.

Practice overhead costs are skyrocketing largely because of the escalating health care insurance costs for employees and the need to improve infrastructure. Increased informational technology (IT) demands will be required to meet the needs of an increasingly complex EMR for merit-based incentive payment system and Medicare Access and Children's Health Insurance Program Reauthorization Act reporting.[16] Many small practices will not be able to afford these costly services, and leadership must anticipate these needs that will increase costs even further and plan accordingly. Decisions will be required to proceed with the legislatively mandated reporting requirements or absorb the penalties associated with not reporting. Some practices are making the decision that accepting the penalties may be more cost effective than developing the infrastructure.

The isolationist philosophy of multiple small practices may no longer be a viable model as we move into the future. Recognizing opportunities to forge alliances with like-minded practices in the same or disparate geographical areas may allow for the unification of infrastructural aspects of a practice, such as billing, human resources, IT, health care insurance (allowing the possible consideration of self-insurance), retirement plan management, malpractice, office space, as well as legal and accounting services. The centralization of these services has the potential to propagate significant savings in an independent practice whose overhead can be as much as 50% to 55% of total revenue. Development of a full-time IT department and enhanced infrastructure support for development of analytics to track quality indicators may improve standards of care for the patients as well as the marketability, growth, and prosperity of the practice. These capabilities along with an increasing geographic footprint for the practice will also allow for the negotiations of improved contracts including perhaps at-risk contracts with payers. There are various models to consider ranging from a complete merger to the development of an infrastructure where each practice functions as an independent business unit under one corporate umbrella to address all the aforementioned unified benefits. The latter model allows for the least impact on the cultural and geopolitical aspects of each of the merging practices. Leadership must decide which direction is optimal for their practice to minimize the possible pitfall of accumulating increased costs, complexity, staff, and administrators.

The New Look of Leadership in the Nephrology Practice of the Future

Leaders of a practice must be effective time managers to balance the responsibilities associated with providing leadership with those of patient care and leisure. Some practice leaders receive protected time or extra money for these positions, although this can be controversial and divisive in a practice. None are ideal solutions; time spent in patient care is reimbursed at a greater rate than administrative salaries, making protected time not cost effective. Given the growing pressures associated with changes in the overall health care landscape, the historic traditional approach to management of a nephrology practice has become an unsustainable strategy for both the long-term survival of the practice as well as the personal and professional growth of its members. Future leadership will need to adapt and evolve to succeed.

As defined by Ackoff[17] (the father of systemic thinking), leadership is a creative pursuit concerned with teaching

new ideas that improve the current state. He further emphasized that the importance of leadership is to promote doing the right thing by creating a vision or roadmap for the future. Ackoff stressed in his teachings that a leader must inspire others to work together to achieve this goal, understanding that this takes transformative change, which often cannot be achieved without abandoning the status quo. Thus, the new breed of leaders must be flexible rather than rigid in their thought processes to inspire others to work together as an interactive team. These new leaders can encourage team participation in practice affairs and foster future leaders through the development of leadership training programs.[18] A leader with these attributes will become important if the practice is to evolve and grow into a self-sustaining entity. A leader's ability to cultivate trust and operate in a transparent manner is a major attribute for a successful outcome. Above all else, however, the key driving force for the success of the practice must continue to focus on quality of care and enhancement of patient safety and satisfaction without losing sight of the financial viability of the practice.

Developing the Future Nephrology Practice Leader

Leaders in a private nephrology practice must evolve and participate in a rapidly changing landscape of regulatory and payment models, ever addressing the need to satisfy regulatory requirements without compromising our true priorities, such as spending precious minutes with each patient. With the current transformations in health care, as leaders, we must broaden our accountability past clinical outcomes, to the financial viability of a practice.

Adaptation will be the new mantra of a successful nephrology practice leader in these transformative times of health care reform and transition from a traditional fee-for-service to a value-based model. Excellent communication skills will be of paramount importance, and the ability to foster trust not only within a practice but also between practices will be required to achieve successful and desired outcomes. Transparency will be key to a leader's success.

Future leaders will require a thorough knowledge of the interests and strengths of all practice members and the ability to incorporate them into the areas of management best suited to each one. A team approach will be needed for the successful nephrology practice to survive. As with any group of individuals, internal differences and variations of management styles will be a challenge to even the most astute of leaders. Open honest dialog will be needed to synchronize the direction and desires of all members to optimally achieve a desired goal. A successful leader must actively listen to members and incorporate good ideas. Input from membership will become all the more crucial to the viability of a practice.

Nephrology practices, now more than ever, need a nephrologist at the helm. This would allow a finger on the pulse of not only what is needed to assure the success of the practice but also the continued improvement in the quality and value of the patient care provided. The nephrologist leader will blend an understanding of the business requirements for success with the simultaneous optimization of patient care, one of the ultimate purposes of a nephrology practice. To propagate this success, it will be imperative for all members of the practice to participate in management roles at different levels and hopefully ignite a spark of interest in becoming a future leader of the practice. This can be accomplished by the development of leadership skills through mentoring programs encouraging members to assume leadership assignments on committees and projects as well as rotations through the practice's board for stimulation and growth as future leaders of the practice.

CONCLUSION

The current transformations occurring in health care mandates leaders to broaden their accountability beyond clinical outcomes to the financial viability of the nephrology practice. Nephrologists are trained and reared on the ever-changing landscapes with regard to the art of practice and providing care for our patients. The ability to adapt to change and evolution is inherent in our nature and will be beneficial in the development of our future leaders. The greatest challenge leadership will face in the autonomous nephrology practice will be the enticement of young developing physicians to follow a career path into nephrology. As future leaders emerge from this diminishing pool of nephrologists, they must be taught the skill sets to interact with HCNs and dialysis organizations. The primary directive remains the optimization of quality and value in the lifesaving care of the vulnerable patients we, as nephrologists, serve.

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