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Opportunity or Cost: Physician Leaders in Private Equity

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Abstract

What is the message? The goal of physician leaders in healthcare should be to improve the health of the population while providing a sustainable and fulfilling career for the clinicians and clinical support staff in a practice. The exponential increases in the spending to deliver healthcare has fueled the disruptive forces that are primarily aimed to increase scale, not necessarily to improve the health and wellness of patients, clinicians, and clinical support staff. This current state presents an opportunity for physician leaders in healthcare management.

What is the evidence? Over the last decades, private equity involvement in healthcare delivery and clinical practices has increased. While there is evidence demonstrating some negative outcomes in specific circumstances, it is important to understand the drivers of these negative outcomes in patient out-of-pocket costs, increased prices to payers, and health outcomes. The leadership and management structures of all healthcare institutions are likely to play a larger role in driving these outcomes, rather than the financial model itself.

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Introduction

At a recent gathering of prior joint-degree graduates from both the medical and business schools at my alma matter, I was struck by the message from the keynote speaker. The intimate gathering was the largest gathering that I had ever attended of MD/MBAs. The typical path of an MD/MBA graduate was to choose one of two paths – we either remained strictly clinical or crossed over to the other side to become mostly managers. However, in this setting, we had multiple joint degree graduates who had continued clinical practice while taking on leadership and managerial roles in our various organizations. The keynote speaker began his speech laying out the current issues in healthcare – ever increasing spending in healthcare, concerning burnout among clinicians and clinical support staff, plateauing clinical outcomes for chronic health conditions, patient frustration with the complexities of the system, and lack of improvement in various health equity indicators. As he continued on, I was awaiting his message for hope of change. I eagerly listened for the punch line where he would announce that physician managers had already begun cracking this code and reversing these trends. In this room, we had physician financial investors, physician chief executives of large companies, physician leaders of large healthcare networks, and physician leaders in academia. Surely, one of us would be commended for solving this enigma. However, the punch line in his speech never came. Were we all complicit in maintaining the status quo?

Trojan Horse

I was one of those physician executives in the audience. Since college, I have always been fascinated by the interplay of medicine and management after a personal experience led me to understand that the healthcare I received was at the end of the delivery chain – long after the succession of decisions by others who were not in the exam room. In my operations courses in business school, I remember learning about how managers were able to optimize performance on the production line (Spear & Bowen). It struck me that all levels of management of this manufacturing facility had a good understanding of what the functionality and quality of the final product should be, and thus, they were agile in responding to production challenges. From my experiences and education, I was convinced that most managers of healthcare practices and

institutions did not have a complete understanding of the complexities of healthcare delivery. In many ways, that is because of the complexity of the system. My goal was to bring my knowledge of the clinical scenarios, coding and reimbursement, patient behaviors, and clinical outcomes into consideration for decisions that are made by the leadership of healthcare practices. When classmates and other physicians would ask me about why I was enrolled in a joint degree program for medicine and business, I would respond that I saw myself as a Trojan Horse bringing clinical knowledge into the decision rooms.

After a decade, I am now in my current role as a Chief Medical Officer at a dermatology and plastic surgery group, a growing practice with about 100 clinicians. In this role, I work with the management teams on various operational, financial, and clinical initiatives. A critical component of my role is that I still see patients. I have maintained a general practice where I see patients of all types for medical, surgical, and cosmetic dermatology. Not only does my clinical practice allow me to understand the consequences of the policies, procedures, and technologies that we implement, but it also provides comfort to the practicing clinicians and the clinical staff to know that they have representation at the decision table. The non-clinical leadership team is also very receptive to having a physician on the leadership team. During our discussions, I learn as much from them as they do from me when we debate important issues that affect our clinic operations. This partnership has been very fulfilling as we have grown our clinical volume tremendously during my time in this company. Overall, I never needed to be a Trojan Horse in my current practice because my insights were welcomed in the discussions and decision-making. Some may be surprised that my practice is affiliated with private equity investments, but I am not.

Status quo

Consolidation has been the big theme in healthcare in recent decades (Moses, et al., 2013). Over time, other private payers have increasingly become more consolidated (Robinson, 2004) (Levinson, Godwin, Hulver, & and Neuman, 2024). Clinicians have responded by similarly consolidating to enable scale for purchasing power, payer negotiations, and patient coordination (Kimmey, et al., 2021). In fact, there has been consolidation at all levels of healthcare delivery – clinic supplies, pharmaceuticals, medical equipment, technology and applications, health information exchange networks, etc. There has been both vertical and horizontal integration and consolidation. Moreover the complexity of the administrative burden in healthcare has increased

(Zegers, et al., 2022). These forces are powerful and have promoted the entry of third-party solutions that aim to simply the complexity primarily for one stakeholder in the delivery chain, while furthering the complexity for all the others. This consolidation was occurring even before private equity growth in healthcare (David, Simon, & White, 2002).

I witness the effects of the healthcare delivery complexity daily in my clinic. A recent patient interaction highlighted the effects of the presence of all these misaligned stakeholders in healthcare delivery. A young woman came to see me for treatment of her worsening psoriasis. She had been diagnosed with psoriasis for over a decade but was never able to obtain consistent treatment due to periods of uninsurance as she changed employment. When she was finally consistently insured, she was covered under the state Medicaid plan which most private practice dermatologists do not take due to severe underpayment and other administrative burdens. She now transitioned into a managed care plan, which few private practice dermatologists accept. Upon clinical presentation, she had over 15% of her body surface area covered in psoriatic plaques. Due to her skin color, there was an additional 20% of her body surface area with dark patches, post-inflammatory hyperpigmentation, which stemmed from the lingering effect of the psoriasis after inflammation. The main reason why she presented to me was that the itching had become unbearable, and it kept her up at night. To prescribe a biologic medication that was both safe and effective for her, I had her fill out a patient assistance form while in clinic since many patients need some financial assistance to obtain the drug. I prescribed the medication to a national pharmacy that offers a solution to larger practices to perform prior authorizations, which saves time for our clinical staff. The patient's insurance responded that the biologic medication was a non-covered drug on her plan, thus she was underinsured. Several members of my team spent about three cumulative hours on the phone with numerous electronic health record messages that became increasingly difficult to follow. They were eventually able to get her coverage for the drug through the pharmaceutical company based on compassionate care. This level of effort for one episode of care for one patient is not sustainable. A major reason why it was possible was that I was part of a consolidated dermatology practice that was able to absorb the low reimbursement by her managed care plan, create centralized prior authorization departments, and forge partnerships with larger national pharmaceutical companies and pharmacy chains. This would neither be possible in a smaller practice due to limited resources, nor in a larger multispecialty or academic group as dermatology operations would not be prioritized over primary care or higher spending specialties.

It is worth noting that I played an instrumental role in forging those partnerships with the national pharmaceutical companies and pharmacy chains because I understood the needs and frustrations of my clinical teams. Their frustrations are my frustrations. Overall, the status quo is not sustainable for patients and clinicians.

Innovation

In my current role, I am constantly solicited by third parties about solutions for scheduling, patient communications, patient access, marketing, among others. Their pitch is often that they are 'the' innovative solution to make my company operate more efficiently. Few of them are truly innovative; instead, they are hoping to replace personnel in the company. Most of the innovative companies face hurdles to fit into the already complex web of the healthcare delivery system. For example, a patient communication platform must seamlessly integrate with the practice management system for scheduling, the billing system (internal and third party), the electronic medical record, and the post-visit patient communication system. Any deficit in the integration will create more layers of complexity and additional resources to patch the inadequate interface. For example, if the system does not integrate well with the electronic medical record, clinicians and clinical support staff would need to create accessory pathways or workarounds to reconcile the patient's messages with information that is accessible at the time of the visit.

Technological innovation in health delivery is stymied by the lack of interoperability, transparency, accountability, and reward. Healthcare delivery system innovation is equally hampered by the need for scale and the unclear reward system. Certain delivery models are inherently fraught with tension – value-based care delivery models are inevitably going to decrease spending by eliminating or reducing the earnings of one or more players in the delivery chain. Even notable technology, logistics, and finance entrants into healthcare delivery have not garnered as much success as was initially envisioned (Hensley, n.d.). It appears that disruptive innovation in healthcare is extremely difficult to attain (Hwang & Christensen, 2008).

Managing and disrupting from within

I remember when I was interviewing to be a physician manager in various healthcare delivery settings. While I considered multiple roles, I distinctively remember two roles – one in an

academic center, the other at a physician-owned private practice. An academic center was going to appoint me to a “quality” role, which was intended to be a stepping stone into hospital administration leadership. I was explicitly warned that the path to becoming a key decision maker meant waiting for the current leaders to decide to retire or move on. Furthermore, a major requirement of the role would be research. I probed the team on why research was necessary for an operational and managerial role, but the answer I was given was not satisfactory to me. At another interview with a physician-owned large private practice, I was welcomed to participate in the management of the practice and to lead growth initiatives. However, the only caveat was that I had to do it on my own time without any explicit compensation. Partnership would be discussed after two years. Roles where I would have more management duties would likely affect my clinical practice, which I thought was crucial to being a physician leader.

After much deliberation with mentors, coaches, colleagues, and family, I accepted the role at my current company, where I am both a clinician and an executive who sets the clinical strategy and quality goals. What drew me to the company were the people, the excellent reputation, the explicit promise of high-quality dermatologic care, and the embedded structure of physician leadership. In some circles, private equity affiliated practices are often accused of placing profit over clinical care. However, the freedom of the management structure encourages efficiency and creativity in the clinic and hospital setting. The structure also encourages innovators in other fields to engage in healthcare by providing accessible incentives in the complex healthcare landscape. To be a sustainable healthcare company, one must prioritize patient outcomes, patient experiences, clinicians’ satisfaction, and teammate satisfaction.

Since joining, I have worked with the management team on multiple projects to create accountability for patient access with the call centers, improve the success of electronic health record implementations by ensuring that clinical workflow designs are captured in the initial launch; improve efficiency of the prior authorization process by understanding which portions of the workflow can be outsourced to an external party; improve the hiring and training processes of clinical staff to enable continued clinician productivity; increase accountability in the revenue cycle and billing departments to understand how to efficiently capture value for the work that the clinicians are already performing; engage payers to educate them about the value of community dermatologists; and much more. compared with other dermatology practices. Our team was much more nimble during the COVID-19 pandemic, resuming patient care within one

to three weeks after the March 2020 shutdown. We were able to get back to scale much faster than the dermatologists in academic or multispecialty groups since we were much more agile.

Anecdotally, my experiences may be different from some other private equity-affiliated dermatology groups. Some of the dermatologists in these other groups complain about productivity quotas being placed on them that do not account for the clinician's skill or a patient's complexity. Other groups have put in place cost-saving but burdensome systems, such as eliminating a clinical triage team and passing all patient messages directly to the clinicians. This practice contributes to physician burnout (Ratanawongsa, et al., 2008). Research has also shown that private equity affiliates may result in increases in a patient's costs and the share of non-physician clinicians in the practice (Bruch, 2023) (Singh Y, 2022). A common theme that I see in these other private equity models is that there is an explicit lack of a physician leader in the group's decision-making room. We need more insight into understanding the impact of the leadership team on the critical measures and key indicators of a successful healthcare delivery system.

Concluding remarks

Private equity affiliations enable healthcare practices to scale, and they provide managerial flexibility to innovate. Whether healthcare delivery systems choose to capitalize on that opportunity is up to the leaders of the delivery system – in particular, the presence of a strong physician leader is crucial to understanding whether the practice will focus on any of the quintuple aims of healthcare delivery (Nundy S, 2022).

Overall, I do not regularly think about my company's affiliation with private equity. I am grateful for the opportunity to provide access to patients who would otherwise be underserved because of the scale that we have created.

I think back to the keynote speech at the joint degree gathering of MD/MBA alumna. While I will never know the speaker's intentions of his address on the misaligned incentives and the resulting issues in the U.S. healthcare delivery system, I choose to see his speech as a call to action. It is a call to action to the physician leaders who are in positions where they do not have the ability to use their training and clinical expertise to change the system from within. We need more physician leaders who still practice clinically within the systems that they lead. With this,

some of them will truly be able to capitalize on opportunities to innovate and improve the health and wellness of our patients and our clinical teams.

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