

Supporting and Promoting High-Performing Physician-Owned Private Practices: Voices from the Front Lines

White Paper

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Diane Rittenhouse, Tiffany Olszuk, Margaret Gerteis, Jan Genevro, Katie Hancock, Evelyn Li, Lindsey Carlasare, Carol Vargo, and Kathleen Blake

The American Medical Association
Professional Satisfaction and Practice
Sustainability
300 N. Wabash Ave., Suite 39300
Chicago, IL 60611

Mathematica
505 14th Street, Suite 800
Oakland, CA 94612-1475
Phone: (510) 830-3700

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I. Introduction

I feel like they could be doing more to help the independent groups... We are still a big part of health care out there. I mean I know we're sort of a dying breed, and some people look at us as kind of like a zebra that, you know, is not gonna be around much longer but...we are a very good example of how this type of a setup can be successful. I just think they should recognize that independent groups are still viable. We're still important.

— *Physician from a medium-sized multispecialty practice in the Midwest*

Physician-owned private practices, once the norm in the United States, are becoming less common. American Medical Association (AMA) survey data from 2020 confirmed a persistent downward trend in the percentage of physicians working in physician-owned practices, although it remains high at 49.1 percent, confirming the importance to the U.S. health system of this model of care and suggesting that extinction of this model would be highly disruptive (Kane 2021). The remaining private practices face immense administrative, financial, and clinical challenges in a predominantly fee-for-service environment.

A large body of research demonstrates that independently owned physician practices represent a distinct health care delivery model with specific advantages and disadvantages (Cuellar 2018). For example, evidence suggests that, compared with hospital-owned practices, physician-owned practices might be slower to adopt innovations such as health information technology (Rittenhouse et al. 2017) and care management processes (Rittenhouse et al. 2011). Yet total spending and quality measures—such as preventable hospital admissions, readmissions, and emergency department visits—for physician-owned practices are equivalent to or better than other models of practice (Burns et al. 2018; Casalino 2014; Casalino et al. 2018; Goldsmith et al. 2015; McWilliams et al. 2013; Pesko et al. 2018; Post et al. 2017; Whaley et al. 2021; Young et al. 2021;).

In this report, we describe findings from a qualitative study Mathematica conducted with the AMA to define, analyze, and assess the factors that create and sustain high-performing, physician-owned private practices. First, we describe our sampling strategy, recruitment, and interview approaches. Then, we describe our findings, which include (1) the nature of high-performing practices, (2) the advantages of private practice, (3) the threats and challenges associated with private practice, and (4) an overview of the changes physicians see coming to their practices in the future. We conclude with implications for research, training, policy, and practice.

II. Methods

A. Sampling strategy

We employed a purposive sampling approach to identify practices for recruitment. A purposive sample is a nonprobability sample selected using expert opinion based on the characteristics of a population and the objective of the study. Researchers who determine the parameters of the study select key informants and seek out people who will provide the information by virtue of knowledge or experience (Bernard 2001). This approach allows for identifying and selecting information-rich cases related to the subject of interest (Palinkas et al. 2015). Our sampling strategy consisted of the following steps:

- 1. Identify a pool of high-performing practices.** We identified a pool of high-performing practices using the 2017 Physician Compare Downloadable Databases, which are publicly available data sets on the Centers for Medicare & Medicaid Services website. We started with the Physician Compare National Downloadable File, which contains general information about individual clinicians, including demographic characteristics, address, phone number, specialty, and name of affiliated group practice. Because we were interested in small and medium-sized physician practices, we excluded practices with more than 15 physicians and practices composed entirely of non-physician clinicians. Next, we identified high-performing practices based on the 2017 Merit-Based Incentive Payment System (MIPS) final score for groups.¹ In performance year 2017, the score comprised three performance categories: (1) quality, (2) improvement activities, and (3) advancing care information (now known as promoting interoperability). Individual clinicians or groups with a MIPS Final Score of 70 points or higher (out of 100 points) were eligible for positive payment adjustments for an exceptional performance bonus. More than 700,000 physicians participated in MIPS reporting in 2017 and avoided a negative payment adjustment, and 44 percent of practices with 15 or fewer clinicians scored in the exceptional range (Navathe et al. 2019). Following the MIPS scoring methodology, we defined high-performing practices as those with a MIPS score of 70 or above.
- 2. Exclude system-owned practices.** We excluded system-owned practices from the pool of high-performing practices using data from the 2016 Compendium of U.S. Health Systems. Publicly available from the Agency for Healthcare Research and Quality, the compendium database provides a practice identifier linkable to Physician Compare data and an indicator for whether health systems own the practice as of December 31, 2016. The compendium database defines a health system to include at least one hospital and at least one group of physicians providing comprehensive care that are connected with each other and with the hospital through common ownership or joint management.

After completing the first two steps, we identified 3,526 high-performing candidate practices that had 15 or fewer physicians and were not owned by health systems (Exhibit II.1).

¹ The 2018 MIPS performance data were not available at the time of this study.

Exhibit II.1. Practice sample selection process

Sample selection step	Number of practices
Physician Compare National Downloadable File	1,136,841
Exclude large practices and non-physician practices	37,076
Limit to MIPS Final Score \geq 70	3,778
Exclude system-owned practices	3,526

MIPS = Merit-Based Incentive Payment System.

- 3. Determine desired mix of practices.** We stratified the pool of candidate practices to determine the desired mix of practice sizes and specialties.
- **Size.** We stratified the sample into solo (1 physician), small (2 to 5 physicians), and medium (6 to 15 physicians) practices. We chose to study small and medium-sized practices (1-15 physicians) because they represent the majority of independent practices in the United States and likely face different challenges compared to large practices (Casalino et al. 2016; Khullar et al. 2018). In addition, physicians in small- and medium-sized practices are more likely to be directly involved in the practice’s operations and business than are physicians in larger practices with more than 15 physicians.
 - **Specialties.** We focused on four common specialties: (1) primary care, (2) multispecialty, (3) cardiology, and (4) general surgery. We define a practice as primary care if all of its physicians were in either family medicine or internal medicine. We define a practice as multispecialty if it includes other specialties beyond family medicine and internal medicine, and at least one-third of its physicians are in family medicine or internal medicine.

Based on the stratified analysis, we determined a purposive sample consisting of 3 solo practices, 11 small practices, and 11 medium practices with the expectation that the number of practices in each size group might vary depending on the recruitment outcome. Within each size-specialty stratum, we prioritized practices that would help evenly cover all four U.S. Census regions (Northeast, South, Midwest, and West). We also considered rural locations (defined by the Federal Office of Rural Health Policy) to ensure a balanced sample of practices from rural and urban areas. To account for refusal to participate and nonresponse, we identified backup candidates for recruitment across the size-specialty strata and rank ordered them to prioritize those that exhibit characteristics of most interest to the study.

B. Recruitment and participating practices

Starting with the 25 high-priority practices in our purposive sample, we used online searches and informational telephone calls to identify the medical director or most senior clinician in charge at each practice. After identifying the physician leader from each practice, we initiated formal outreach via a letter of invitation describing the purpose and objectives of the research, its voluntary and confidential nature, the reasons for our interest in their practice, and terms of participation. We offered \$300 compensation as an incentive to participate in a one-hour telephone interview. We followed up with each practice by phone until we determined the practice was ineligible for the study ($n = 4$), it accepted our invitation to participate ($n = 25$), or it declined to participate ($n = 8$). The study director also categorized some practices as dead leads ($n = 20$) after calling multiple times with no response.

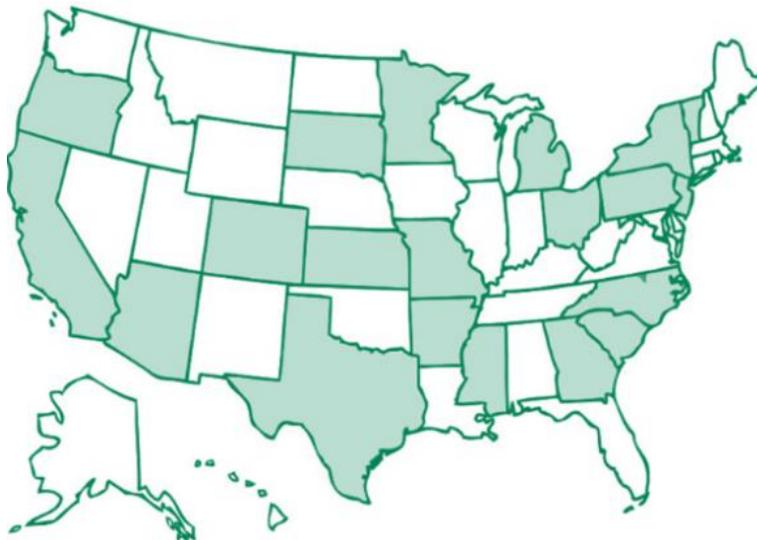
We recruited 25 practices to participate in the study and interviewed 25 physicians from 24 practices. We could not interview one medium-sized cardiology practice because of challenges the practice faced related to the COVID-19 pandemic. In total, we interviewed 3 solo practices, 7 small practices, and 15 medium practices. Exhibit II.2 summarizes our outreach efforts to practices and shows the total number of participating practices by specialty and practice size. In all, 12 of the 24 practices were in primary care, 3 were multispecialty, 3 were in cardiology, and 6 were in general surgery. In addition, 8 of the 24 practices were in rural areas. The participating practices spread across 20 states (Exhibit II.3).

Exhibit II.2. Summary of practice recruitment by practice specialty and size

Primary care				Cardiology			
	Contacted	Interviewed	Rural		Contacted	Interviewed	Rural
Solo	5	3	1	Solo	0	0	0
Small	9	4	3	Small	7	0	0
Medium	9	5	3	Medium	11	3	0
Total	23	12	7	Total	18	3	0

Surgery				Multispecialty			
	Contacted	Interviewed	Rural		Contacted	Interviewed	Rural
Solo	0	0	0	Solo	0	0	0
Small	5	3	0	Small	2	0	0
Medium	3	3	1	Medium	6	3	0
Total	8	6	1	Total	8	3	0

Exhibit II.3. States represented in the sample of high-performing physician-owned private practices



C. Interview approach

Between September and December 2020, Dr. Rittenhouse and Dr. Gerteis conducted one-hour virtual interviews with each participating physician-leader, and a research associate took notes.

For each interview, we used a uniform semi-structured discussion guide covering topics such as characteristics of the practice, its patients, and the market; business operations and management; approach to quality improvement and quality management; practice culture and leadership; and factors contributing to the sustainability of high-performing physician-owned private practice (see Appendix B for discussion guide).

We audio-recorded all interviews except one to supplement detailed handwritten notes, and all audio tapes were professionally transcribed.

D. Data analysis

We analyzed interviews using a conventional approach to content analysis to identify emergent themes. We coded transcripts independently without the use of qualitative software. Subsequently, members of the Mathematica research team met regularly to reach consensus on topics, identify discrepancies, refine concepts, and develop emerging themes. Quotes provided in this report exemplify these themes.

E. Limitations

Because this is a qualitative study with a small purposive sample, some findings might not be generalizable to all independent physician-owned primary care, multispecialty, or general surgery practices. In addition, we used MIPS scores to identify high-performing practices. MIPS scores are one indicator of performance but might not reflect all aspects of quality that are important to understanding high-performing practices. For example, MIPS scores might not accurately capture a practice's office culture. Some practices might institute policies or initiatives that go beyond what MIPS requires, and others aim to meet the minimum requirements for a positive payment adjustment. Finally, the MIPS score file that we used to select high-performing practices for the sample was from 2017. Although these data were the most recent information available to the public at the start of the study, a few of the practices in the sample might no longer meet the MIPS score criteria for a positive payment adjustment.

III. Findings

Here, we report the findings from our interviews with physician leaders of 24 high-performing physician-owned private practices across the country. In each section, we include a sample of exemplar quotes from physician leaders to further illustrate key findings.

A. Overview of high-performing private practices

1. High-performing private practice is not one size fits all

Governance structure and staffing models varied widely across practices, and no single model emerged as a best practice. Practices grew organically over time, and key decisions about governance structure and staffing models were largely personality-driven or specific to time and local geographic and market context. One key driver of high performance was choosing physician partners.

a. Governance structures varied widely

The governance structure varied widely across practices. For example, some practices had partnership arrangements in which all partners had an equal voice and input in decision making, and others had formal leadership roles with the equivalent of positions such as chief executive officer, chief financial officer, chief operating officer, or chief information officer. Many practices assigned leadership roles to physician partners based on their existing skill sets. A few practices had rotating leadership structures or other arrangements such as contracts with management entities to hire and manage office staff. In all practices, physician partners met regularly to discuss administrative, clinical, and financial matters, though the frequency of these meetings and attendees at the meetings varied. For example, some partners met twice per month with only physician partners, and some met weekly with administrative staff.

We all play a part in managing, discussing, and deciding on everything from new equipment to purchase to whether we should build an office, to whether we should cover this hospital or that hospital. So, no one in particular has any more power than others from a voting standpoint. And we will defer to each other—for example, I do a lot of the [information technology], networking, computing, and management, so some of the others will defer to me. And I will defer, for example, the financial aspects to those who are more interested and talented in that region and so forth. Everything is voted on pretty flatly at this point by the six of us.

— *Physician from a medium-sized cardiology practice in the West*

We have a very talented [chief executive officer] who is very involved with the various organizations and medical management... He's still beholden to the eight partners, but he has a fair amount of autonomy in what he does in the practice. And yeah, he's been terrific. He's been with us for three or four years now. We've had shifts in the senior management team as far as practice managers, and our [chief executive officer] as the practice has grown, and revenue has increased. We needed people with enhanced experience in computer and revenue stream, and the financial aspects of the practice.

— *Physician from a medium-sized cardiology practice in the West*

We do something that we've been told by a number of consultants can't work except it does work. Forever, we were a three-headed hydra with one of us managing [human resources], another managing the physical plant, and I managed the fiscal plan. And it worked. And we

could fight with each other, we could scream at each other, we could curse. And then we could go play golf and go drink a beer together. And that worked. And as we grew, we established more roles for more people that we brought in. And now all partners in the practice are part of the management team.

— *Physician from a medium-sized primary care practice in the Northeast*

So, we have the luxury of being best friends, additionally, which is a huge blessing in our lives in a difficult job and world. We probably talk a couple times a day and we operate together when we can, and we just talk things through and figure it out. There's no formal structure, I would say that I take the lead in the practice. I'm just a little more type A.

— *Physician from a small general surgery practice in the Midwest*

Many physicians emphasized that selecting physician partners for the practice is one of the most important contributors to running a successful private practice. Several compared the partnership dynamics to a marriage, and many emphasized the need to hire physicians who see the practice as a long-term commitment.

The four of us are not best friends, but beginning a practice is like a marriage. So, you have to be as honest as you can and communicate with each other. You don't have to like each other really well. You just have to work together. And I think that's worked for us to that we understand each other's pros and cons, we work within those constructs.

— *Physician from a small family medicine practice in the Midwest*

Finding the right person is the hardest thing, I think, in running a practice. The right person that's going to come and stay and be a 22-year employee and be there for the duration... It's super expensive when a doctor or a surgeon comes to a practice and then leaves—for both sides... You're covering their overhead for quite a while before they're productive enough to cover their own overhead. So, you want them to be successful.

— *Physician from a medium-sized general surgery practice in the Midwest*

b. Staffing models varied widely

Most physicians said that they had low physician turnover in their practice. On the other hand, physicians said that medical assistants and front-office staff tended to turn over more frequently.

I think when you can have a private practice like ours, where we have people who [have] good business minds but still are concerned about providing care for people first and making people feel like they've received good care and they've had compassionate care, if people are part of something like that, I think it makes them want to stay in a place like this.

— *Physician from a small multispecialty practice in Midwest*

They're my family. I mean it—not blood, but I treat them as family. We have great working conditions, we have a great environment—just physically, emotionally, mentally. I treat them well financially. You know, I've had good mentors in the past, and they said if you're going to be successful or good, you surround yourself with good and successful people... So, we surrounded ourselves with excellent staff, nursing staff, billing staff, secretarial staff, and we're just one happy family. I have never fired one person in my office. And very proud to say that.

— *Physician from a small general surgery practice in the Northeast*

Almost all practices, regardless of specialty, employed advanced practice providers, such as nurse practitioners and physician assistants, but their roles in each practice differed. For example, some rounded on patients in hospitals, nursing homes, or outpatient settings, and others managed wound or walk-in clinics. The nursing staff in each practice also differed. Most practices employed licensed vocational nurses, but one employed only registered nurses. Some larger practices had the capacity to support additional staff, such as health educators, social workers, and dieticians.

Larger practices had dedicated business management staff, which enabled physicians to focus more on clinical care.

So, the administrative team, obviously, they kind of oversee the day-to-day operations in terms of the finances and the money coming and going and so forth, so, we're, you know, for the most part, able to focus on our medical practices.

— *Physician from a medium-sized multispecialty practice in the Midwest*

However, in solo and small practices, physicians tended to take on more administrative responsibilities.

You're everything. You're the provider, you're the physician, you're the manager, you're the human resource person, you're the computer technician. Everything falls on your head...

— *Physician from a small family medicine practice in the South*

There're a few little things that you'd need almost an admin for, but we've just really picked those up. We just do them. So, we open the mail, and we do a few little things here and there.

— *Physician from a small general surgery practice in the Midwest*

2. High-performing private practice means delivering high quality health care and running a successful business

Nearly all private practice physicians we spoke to indicated that, to them, high performance means simultaneously delivering high quality health care and running a successful business.

a. Delivering high quality health care means excellent physicians and excellent outcomes

Nearly all interviewees placed strong emphasis on the excellence of the individual physicians in their practice. Excellence was described in a traditional qualitative sense: using informal assessment of clinical judgement by their physician colleagues; establishing a reputation in their community; getting along well with physicians, staff, and patients; and going the extra mile for patients by, for example, actively tracking down lab results and being accessible to their patients. Excellence was also measured more formally using available data on clinical standards and outcomes of care.

I think that independent practice...really is driven by quality providers. If you have providers who care about providing for people, they're mindful of the business side of it. And hopefully, they're mindful of the business side of it because they realize that's a means to an end of providing better care.

— *Physician from a small multispecialty practice in the Midwest*

To be successful as a private practice surgeon, you have to...be skilled and have good rapport with patients and physicians, so your practice grows. Whereas that is not necessarily as important if you're in an owned practice where you have a guaranteed feeder source, and

the administrator is telling their primary care doctors they have to refer their patients to this group of doctors because they own them.

— *Physician from a medium-sized general surgery practice in the Midwest*

We're extremely patient-centered, extremely available, hiring the best doctors we could hire, and practicing the standards. We expect everybody to meet the standard of care. The world of medicine now actually tells you what you have to do. It no longer accepts the idea that you're a physician and you absolutely know what you're doing... And so, there really is a standard of care for A1C, there really is a standard of care for blood pressure, there really is a standard of care for immunizations. We've always demanded that of ourselves...

— *Physician from a medium-sized family medicine practice in Northeast*

All physicians indicated that the fee-for-service environment does not provide direct financial motivation for high quality care. Instead, physicians expressed personal and professional motivations for delivering high quality care, such as being seen as the go-to practice for other physicians in the area and doing what they think is best for patients, physicians, and society.

Success is also determined on how we are viewed in the community, in terms of our reputation there, how our patient outcomes are... We ended up taking on and investing the time in creating a mission statement, vision, values, and posting those so people knew that we wanted to have this be our corporate culture, so to speak. We've taken intentional steps to make sure that people know our practice.

— *Physician from a medium-sized primary care practice in the Midwest*

[A successful private practice physician is] someone whose primary motivator is not money... You can definitely make a very comfortable...very good living, being in solo or private practice, but if your primary motivator is doing something for the revenue stream, I think you're gonna get burned. [The important] criteria: Is it good for the patient? Is it good for the provider? Is it good for society? I think [you've] got to follow those rules.

— *Physician from a solo practice in the South*

b. Running a successful business requires market knowledge, strategy, and change management

Physicians also described how running a successful business requires an understanding of the local health care market and strategic management to adapt to changes in the marketplace. Several physicians emphasized the need to pursue innovation and be on the leading edge of technology, especially in relation to using electronic health records (EHRs) to their full capabilities and managing the data necessary to support quality-based payments.

Have a strategic plan, have a business model. Follow that through, but also be nimble enough to course-correct. What we've learned is, you can't force something to happen, sometimes you have to react to what comes at you in this type of business rather than trying to make things happen themselves, but I think for private practices, practice groups, they need to have a strategy. They need to have a good business plan and a good business model to succeed.

— *Physician from a medium-sized general surgery practice in the West*

I think to be successful, you have to be adapting to the environment as it's occurring, or better yet predicting where you think things are going to be.

— *Physician from a medium-sized primary care practice in the Midwest*

Well, the first thing is I would say is...let technology be your friend. Try not to hate your EHR, but make the EHR work for you. So, one would just realize that the world is techie today, so, you know, deal with it, cope with it, just push that angle and then align yourself whether it's an [accountable care organization] or [clinically integrated network] or some of these other [entities]... because I think going forward...you're going to have to have [technology and relationships with networks] if you want to keep shared savings or capitation or these per member per month payments. Fee-for-service I think, is going away, and honestly, it probably does need to go away. So, you're going to have to be able to get those savings to stay in business.

— *Physician from a small primary care practice in the South*

You must be adaptable to the point of being ahead of change. Stress of the [electronic medical record], value-based care, quality improvement...a lot of them couldn't adapt [to] those changes, and they had to sell or close... Some are able to adapt to changes.

— *Physician from a small primary care practice in the South*

Oftentimes, people say to me, don't sweat the details or don't sweat the small stuff... I mean, in any business, to be successful, the margins are not great, so you do have to sweat the small stuff... You have to innovate, you have to make changes quickly, you have to adapt, and you have to have the right personnel that you hire to help you do that.

— *Physician from a medium-sized primary care practice in the Northeast*

In addition, all providers expressed that hiring personnel, including physician partners, with business acumen is necessary to run a successful business. They also emphasized the need to keep overhead charges low to stay financially viable and to ensure that all staff provide excellent customer service. When asked what business skills are essential to run a successful practice, a few physicians commented on skills that they taught to residents or think would be helpful for residents to learn. Physicians mentioned (1) an understanding of core technical business principles, such as human resources management, accounting, billing, contracts, marketing, and outreach; (2) an understanding of financial principles, such as mortgages, depreciation, and loans; and (3) an understanding of how to work with outside consultants and network within the broader community. They also stressed the importance of knowing how to understand and market their value to other organizations and the community.

I would have a course and divide it up. And some of it needs to be [human resources], which is the absolute worst thing, just the hardest thing to do, but you need to know about that. You need to understand what the laws are, as far as hiring and firing. You need to understand how to read a balance sheet, how to balance your checkbook. You have to understand money in and money out, you have to understand, perhaps mortgage, and how to have property, what insurance means for your property, what depreciation means...how to get a loan, what it means to have a loan, how to work with a bank, how to work with consultants...how important it is to have a good attorney and have a good accountant and not scrimp on that—how to use those people. So, I think you could probably do a semester-long course.

— *Physician from a small primary care practice in the Midwest*

You're very valuable as a physician, and the business of medicine is certainly lacking in education of the young doctors. I mean, most doctors really don't know the business of medicine, how to talk about contracts, what their real value is.

— *General surgeon from a medium-sized practice in the Midwest*

B. Advantages of private practice

1. Independent practices offer benefits for physicians and patients

Physician leaders spoke highly of private practice, emphasizing the many benefits of private practice for both physicians and patients.

I love my job. I don't have a job, I have a hobby. I don't have a practice, I have a family. I really mean that ... And my other partners that went to corporate America, I know for a fact that they can't say the same...I couldn't do it. I couldn't drink the Kool-Aid. It's magical, because I give quality care 24/7.

— *Physician from a small general surgery practice in the Northeast*

There's a sense of pride... that I'm employing seven individuals and a sense of ownership and actively being involved in the community versus sort of passively being involved in a community. If you want to support the local football team, you just write a check and support the local football team, or if you want to do free sports physicals, you just sort of do it. And so, there's definitely a pride, and that's a key factor for me.

— *Physician from a solo primary care practice in the South*

2. Physicians in independent practices value their autonomy and flexibility highly

All physicians stated that the primary advantage for physicians of working in private practice is autonomy. Many emphasized the decision making power they have as a physician-owner. For example, most physicians pointed out that they could make decisions as quickly or nimbly as they desire, which made decisions related to hiring, firing, equipment management, business hours, and other business essentials less taxing. Furthermore, to most physicians, autonomy meant less bureaucracy. Many physicians mentioned that a significant advantage of being in private practice was not having to go through various subcommittees or a distant parent company to make decisions. Several physicians also observed that being in private practice enabled them to have a more flexible work schedule. Autonomy, independence, and flexibility appeared to be important components of respondents' conceptions of work-life balance.

... If we try something, and it doesn't work or it's slowing down the patient care or flow or just anything, our joke is we just get the four of us together with our administrator, and we don't have to form three committees and study it for six months to realize we need to change something that could really impact how we're doing things. So, we like to think that we can be nimble.

— *Physician from a medium-sized primary care practice in the South*

...We can continue to do what we think is right and not necessarily what the hospital system feels is the way we should approach a problem... They have people making decisions that aren't necessarily clinicians and telling you that they don't have the money to support this program, but the hospital [chief executive officer] is making a million dollars a year... I don't want you to think that they're telling you everything you have to do with every patient, but it just allows us to do things that use our judgment and, you know, it's less one-size-fits-all.

— *Physician from a small cardiology practice in the Northeast*

And over the years, a big piece of it was just being able to be moms and have our schedule the way we wanted. We just completely shifted our schedules to accommodate what we needed to do for kid life, which for a surgeon is a pretty great to be able to do that.

— *Physician from a small general surgery practice in the Midwest*

I think independent groups tend to be more flexible and can get things done more quickly.

— *Physician from a medium-sized cardiology practice in the West*

3. Physicians see accessible, relationship-based care as an advantage for patients

Many physicians thought that patients were not aware that their practice was privately owned. Some commented, however, on features of the practice that might give patients a sense that the practice is not owned by a large corporation. For example, several physicians mentioned the easy accessibility of their practice, continuity of care when seeing providers, and the ability to establish close relationships with physicians as opposed to feeling like a number moving through a health care system.

I think that—we know that we've had some patients that have had bad experiences with employed physicians. We know that the reason that they had that bad experience is because of the employed model and the employed decision making. I don't know if the patients are savvy enough to understand that. Some probably are, but you know, I don't know if it's evident in patients, if they really understand the difference in employed versus private practice.

— *Physician from a medium-sized general surgery practice in the West*

They come to me because they know that they'll see maximum two providers, that they don't have to tell their story over again. It's funny how much, how often I hear the idea of like, you know, your parking lot is small, it's really like walking two steps.

— *Physician from solo primary care practice in the South*

I worked for the hospital for three years. And it was great, but you know, you take care of somebody, and then you discharge them, and you never see them again... And [now] to have patients that I've seen for 20 or 25 years—you know, I saw a guy yesterday [whose parents] I took care of... I've got a couple where I've got three generations now.

— *Physician from a medium-sized primary care practice in the West*

C. Threats to private practice

1. Administrative work creates significant burdens

Many physicians commented on the difficulties of balancing clinical responsibilities with administrative work, such as coding and prior authorizations. One reported that the administrative burdens became so overwhelming that the partners decided to sell the practice to a hospital system.

And now, it's gotten to a point where the complexities of it or the MIPS and the wellness visits and all this other stuff, that you just feel that you're I guess corrupt to be successful, that you have to chase certain ways of doing medicine... But the bottom line is that for survival that we just keep whichever way that [the Centers for Medicare & Medicaid Services] blows the wind, that process, and we have to go chase it down and try to do it the way that it's reimbursed to make some living.

— *Physician from a solo practice in the Midwest*

My business partner and I kinda turned the management of the practice over about 10 years ago to the younger staff, and it just got overwhelming for them to try to take care of coding and insurance and staff problems. And so, they negotiated with a hospital system to buy us out and that will take place [next month]... It just got too hard to practice. We could never set up a practice like we did [40 years ago]—too expensive, too complicated, too hard.

— *Physician from a medium-sized primary care practice in the Midwest*

I think the interference by insurance companies requiring a lot of work to authorize testing, constantly changing formularies—formularies now that you try to prescribe a generic medicine and it comes back for a prior authorization—just ridiculous...dealing with payer bureaucracy is certainly a major struggle.

— *Physician from a small primary care practice in the West*

2. Low and declining payment rates threaten practice viability

Another threat to private practice, according to the physicians we interviewed, was declining payment rates from insurers. Many physicians commented on declining rates from Medicare, Medicaid, and commercial insurers over time as well as drastic differences in how independent physicians are paid compared with physicians employed by health systems. In many cases, system-employed physicians were paid higher rates for delivering the same services as private practice physicians because they were affiliated with a system. Many physicians commented on how these types of arrangements threaten their ability to remain financially viable.

One of our real struggles is with the commercial payers not paying us enough, because they're paying so much to the hospitals or this hospital. That's a bit of a struggle. We would probably not be able to survive if we were...out in rural [area] where there is a very much higher percentage of Medicaid. We wouldn't be able to survive. You can't survive on just Medicaid. All the [Federally Qualified Health Centers] around us are subsidized for [Medicaid]. It's their best payer. The hospital gets subsidized by a huge difference in commercial rates. We don't get subsidized by anyone.

— *Physician from a medium-sized primary care practice in the Northeast*

...The margins are so tight that when you're just one or two physicians trying to survive, it's hard. It's just very hard. So...unless they change the way we are paid ...primary care's at the bottom of the barrel as far as payments. I don't see primary care remaining independent. I think primary care is...going to have to be where they're joined up with somebody with deeper pockets, who preferably is going to appreciate what primary care can do.

— *Physician from a medium-sized multi-specialty practice in the South*

The main reason [we decided to sell the practice to a health system] is all the administrative aspects. A combination of increasing requirements by insurances, which makes us incur a lot more overhead along with the decrease payment from insurances, as well as Medicare and Medicaid. So, the gap between the amount of money that we as a practice have to spend to be able to serve the patient versus the amount of money that we get paid by the insurances, it keeps getting smaller and smaller and smaller until it pretty much becomes virtually impossible to run a practice.

— *Physician from a small general surgery practice in the South*

Many private-practice primary care physicians earned supplemental income by serving on hospital boards or as directors of nursing homes and accountable care organizations (ACOs). Many surgeons invested in

surgicenters or other health care centers and took on additional or more complex call coverage. Furthermore, many physician leaders regardless of specialty owned their building as an investment.

I have a pretty good salary [from] the nursing homes, as medical director. And so, that's a basis for part of my income.

— *Physician from a solo primary care practice in the Midwest*

One thing that we did, we're not a high dollar practice. So, the money that we actually make in our practice is not a huge amount and would probably not be enough for most practitioners. And what we've been able to do is be owners in surgery centers, which has supplemented our practice income or our personal income.

— *Physician from a small general surgery practice in the Midwest*

3. Lack of negotiating leverage puts practices at a disadvantage

Most physicians expressed frustration with navigating contracts with insurers. They often felt they were at a disadvantage compared with system-owned practices. For example, many practices felt they didn't have the resources to renegotiate contracts or felt they were not being heard by insurers. A few attempted to negotiate contracts on their own but made little progress, so they proposed partnering with an outside entity for support or hiring additional personnel dedicated to contracting. Physicians also acknowledged that these types of supports require funds that many small practices don't have.

Private physician practices confront nearly insurmountable disadvantages when negotiating with insurance companies. Every year, the insurance companies are able to increase their rates to patients and their families, but the primary care physician is fortunate to stay "even" as we are unable to collectively bargain for better reimbursements.

— *Physician from a medium-sized multispecialty practice in the South*

We have almost no bargaining power with the big insurance companies right now... A few years back, I hired a consultant to contract with me, and she was received with quite a bit of a consternation from the United Health Care. They hated her, and we were able to make some headway with a couple of companies back then. The next time we tried to negotiate, we got nothing, and I don't think our rates have changed in many years. So instead of us pursuing our commercial contracts to get another presenter to embattle with them every year, we kinda went toward the Medicare advantage direction.

— *Physician from a small primary care practice in the West*

... You pretty much have to partner with somebody because you have to have somebody helping you with insurance contracts. If you're just one person trying, you can, you don't have time to negotiate with all these 20 or 30 entities to get a good contract... I think it depends on where you choose to set up your practice and what is available to you there. I am not aware of [any national] programs that you can join that assist with this, but there might be, I'm just not aware of them, where you could be affiliated with an organization that also can help you with your contracting.

— *Physician from a small primary care practice in the Midwest*

A year or so ago, we decided to hire someone to look through all of our contracts and renegotiate all of our contracts. We realized that had not been done for some time. And I would say that one big hurdle for a small practice is getting their attention and making them feel like they need to even talk to you and redo your contracts. It took a fair bit of doing, it

took a little bit of money, but I think it was definitely [worth it]. It probably cost about \$8,000 or \$10,000 to do, but it was money well spent... We renegotiated all our fee schedules with the major commercial payers. So, that was one little thing we did in the last year, and I think that's a hurdle for smaller practices is to do be doing that.

— *Physician from a small general surgery practice in the Midwest*

4. Recruiting physicians is costly and challenging

Recruitment was a universal challenge among the practices we interviewed, with the exception of a few practices in highly desirable geographic areas with rapid population growth. Many physicians expressed difficulty recruiting new physicians because of the financial costs associated with recruitment, and a few turned to hiring their own family members to fill positions. Some tracked potential recruits for years until they joined the practice, and some did not have the funds to support outreach for recruitment, onboarding for new physicians, or new physicians' salaries. Others expressed concern about hiring physicians who did not have strong ties to the community because of the costs associated with onboarding and subsequent losses from turnover.

In addition, many physicians underscored the hiring disadvantages their practices experienced compared with system-owned practices. In many scenarios, recruits were attracted to higher pay and enhanced benefits that they could receive from working for a system. Physicians also commented on how health systems tended to have greater resources to advertise for positions or woo recruits. Despite the widespread recruiting challenges among practices, some physicians felt that their connections to residencies were promising avenues for recruitment.

The margins are so small in reimbursements for clinics, primary care clinics... that most times, I have to take money from established providers to help recruit and invest in new providers to keep the clinic viable.

— *Physician from a medium-sized multispecialty practice in the South*

It's not to say we haven't tried to recruit, but thinking about it now, a lot of these conversations we had with people was, you know, they were getting big offers from other places. For instance, I interviewed this gal, and we were even gonna hire her...and what we could offer her to join the practice was in the \$350K to \$400K range, which ain't too bad, but she is like, "Oh gosh, I am getting offered \$600K at this place in rural Kentucky?"... They were gonna pay off student loan debt and all this other stuff.

— *Physician from a small general surgery practice in the South*

Because we have so much trouble recruiting doctors, we've hired mid-levels...Our most fertile [recruiting] ground...is people who have worked for hospital systems and hate it.

— *Physician from a medium-sized primary care practice in the West*

...We do quite a bit of work with medical students and with residents, as well. And we definitely use that as a recruitment tool.

— *Physician from a small multispecialty practice in the Midwest*

A handful of physicians commented on how education debt is a major factor for potential hires when deciding whether to pursue private practice. According to some physicians, recent graduates' education debt is often so overwhelming that they cannot invest their time or scarce dollars in private practice.

I think some of the current graduates coming out of med school are in so much student debt, that idea of going out on a limb, you know, with three of your buddies and even if you just rented the space [is daunting]. I mean I could see that bit because I was able to come out of school with very little debt, you know, and even though we borrowed money to start our solo practice it wasn't [nearly] as daunting as what I hear from some of the med students nowadays.

— *Physician from a medium-sized primary care practice in the South*

Many physicians also commented on the attitudes and skills of recent physician graduates. From the perspective of some physicians, many recent graduates do not have the interest or technical abilities to run a successful private practice. For example, many physicians commented on recent graduates' tendency to gravitate toward shift-based work, preferring minimal call responsibilities, predictable schedules, few or no business worries or risk, and potentially lower administrative burden. This perspective on work–life balance, which is characterized by boundaries and predictability, differs from the perspective of work–life balance espoused by many respondents, which was rooted in autonomy and flexibility.

The current generation of primary care physicians are unwilling or unable to put the time or effort required to build a private practice, and are more interested in the employment models [that] allow them a nine to five, Monday through Friday workweek, with weekends off.

— *Physician from a medium-sized multispecialty practice in the South*

On the other hand, some physicians indicated that there are opportunities to improve medical school or residency training to generate more interest and enhance clinical and business skills. For example, a few physicians commented on how there might be a lack of interest in private practice because there is not much exposure to it during medical school and residency. Other physicians commented on a lack of exposure to core clinical or business skills necessary to succeed in private practice.

Even our local residents who are trained in the family medicine residency program don't even look at us often times because they never see us. The local residency programs don't rotate their residents through any private practices at all. They don't even know that they exist or that that opportunity is out there for them. Now one thing I started doing was one day a year a family medicine senior resident comes out to the practice just to see what a private practice is. It's an animal they've never seen. It's rare for them, and their message in the big hospital is that private practice is dead, and everybody is employed. But it's not true, and so we've actually had some success having some of them come to the practice. Once they see it they're like, "Oh, I didn't know that this was an option," and one of our docs actually sort of came out of that.

— *Physician from a medium-sized primary care practice in the Northeast*

Some of the younger people coming out of these training programs are used to working at a university setting where there's hundreds and hundreds and hundreds of doctors around them and the concept of going to a smaller group with, you know, kind of an independent group... I don't think they're being told in their training programs that that's a good option. I don't want people to think that young doctors are being told not to go into groups like ours, but I think they're used to these large entities, these large organizations.

— *Physician from a medium-sized multispecialty practice in the Midwest*

And [medical students are] usually pretty astounded (when they rotate through the clinic), because they're used to going to some of the bigger, other clinics where they're bought and

the doctors aren't as happy. So, the ones that we have are usually pretty astounded and, you know, kind of talk about it being a breath of fresh air and everything.

— *Physician from a medium-sized primary care practice in the South*

We actually, I think, have cheaper care and better outcomes, and our physician-owned hospitals show the same thing. We do cheaper surgery at our physician-owned hospital, significantly cheaper surgery with better outcomes. Our infection rate is way lower. And our patient satisfaction—we are the only five-star hospital in the state year after year, the physician-owned one. So, I think sending that message to new doctors [is important]—the education about the business of medicine is sorely lacking in med schools and residency...

— *Physician from a medium-sized general surgery practice in the Midwest*

5. Practices lack the resources necessary to collect and analyze meaningful data

Several practice leaders commented on how difficult it is to collect and analyze population-based data or manage their high-risk patients via registries or other systems without additional resources.

You just run out of hours in the day to [collect and analyze data]. And if you're doing that, you're not seeing patients, so you're not bringing in income. And maybe it takes somebody with a little higher view of things, to look down and say, "These practices could go up and could do better if they at least get some data, why don't we help them get some data and show them and they'll be even better?"

— *Physician from a small family medicine practice in the Midwest*

We've actually talked about some of these programs in our electronic medical record, which is eClinicalWorks. [It] has the capability for that and we've thought about it a number of times, but it just seems like our nursing staff's been very busy and it would probably mean hiring somebody else and... I think we've just, with our staff, we've just been too busy to do that in the right fashion, and it's too bad, because we think it can make a difference. But we just haven't had the bandwidth.

— *Physician from a medium-sized cardiology practice in the Northeast*

I'm constantly getting communications from outside vendors, and others who want to help us better manage our high-risk patients, and data, and all this stuff... But like, "Well, wait, how do we pay for this?" And they are like, "Well, risk-based contracts." I said well, "We don't have any risk-based contracts." So, without risk-based contracts, it's very hard to pay for all this, because you need some upfront money to hire care managers.

— *Physician from a medium-sized primary care practice in the Northeast*

6. EHR systems and updates are costly and not adequately supported

Many physicians from small practices mentioned the exorbitant cost of purchasing and updating an EHR to help collect and analyze meaningful data. They also commented on the lack of support they received after the purchase.

I think the big thing will be a seamless EHR, you know, the EHR we have at current is kind of the budget one. Ten years ago, we paid about \$40,000 for the software. Probably it does a fair amount of the job, but you know, at one point we reached out to [the hospital system], once we thought of Epic. Epic is the EHR system, I think one of the best in the county. So, you know, when we reached out to them to see how [to become] part of the Epic EHR...they

mentioned something about it, maybe about 10 times what we pay now for EHR. That was, you know, purely undoable.

— *Physician from a small primary care practice in the South*

And that is another thing that makes it very difficult for a private practice, because unless you have something subsidized, you are not able to get to the big names. One of them is Athena, and it is very expensive for us to do it, and the other big name is Epic. Epic is pretty much something that as a private practice it's extremely difficult to reach unless you belong to a branch of a hospital and the hospital's willing to subsidize you to have that medical record system.

— *Physician from a small general surgery practice in the South*

7. Feelings of professional isolation are common

Many physicians mentioned feeling isolated in independent practice and expressed the desire to network with other physicians around the country who lead similar high-performing physician-owned private practices.

I'd love it if [the AMA] said, "Hey, we can hook you up with some group in Milwaukee or Chicago or whatever. We can get you talking back and forth so that maybe together you can try to, if there's issues you're having, you can get some advice from other independent groups out there." ...That would be the one thing that I think if they could help us a bit more with that, I would love to see that.

— *Physician from a medium-sized multispecialty practice in the Midwest*

In a world where there are very few private practices, we are a private practice that still goes to the hospital. We are a private practice that is a single-specialty private practice. And we are a private practice that works out of one site. There [are] not a lot of...[family medicine practices] around the nation that I know of, there's just not a lot of us. And that doesn't mean that they don't exist other places... We have trouble finding them.

— *Physician from a medium-sized primary care practice in Northeast*

You know, there're cardiologists who are independent, urologists who are independent, so it's a really sort of diverse group of doctors who are independent. I mean, that they have a commonality in certain aspects, but from the standpoint of like [evaluation and management] codes they're on like completely different pages, and for a lot of other key terms that we usually think of when we're talking health care and health care policy. And it is hard to bring a united voice, as we tend to typically talk through our [specialty societies]...

— *Physician from a solo primary care practice in the South*

8. Mentoring is critical for recent graduates and solo physicians in isolated settings

Several physicians emphasized the need for mentoring of recent graduates to help them build their practice and contribute to the business. In medium-sized practices, senior physicians mentor junior physicians. Solo practice physicians do not have this same benefit. Mentoring is especially important in surgery, because recent graduates might not be ready to work completely independently. One physician also described the challenges associated with mentoring new graduates in small or rural locations.

These surgeons that are young and coming out (of residency), if they end up in a small town without good mentorship, they start making bad decisions after a year or two because they

don't have someone to bounce it off of. And we've seen multiple surgeons go backward, literally, and start making decisions that they probably wouldn't have made coming right out of training.

— *Physician from a medium-sized general surgery practice in the Midwest*

Our job is to make sure that you succeed in practice here. So, the new owners that we just brought on, we did help mentor them along the way and made sure that their receipts, or revenue that they're generating was going to be sustainable.

— *Physician from a medium-sized primary care practice in the Midwest*

D. Looking forward

1. Primary care is moving toward value-based payment

Fee-for-service was the dominant payment mechanism across all practices that we interviewed, and many physicians talked about adapting their business and clinical practice style to meet those demands.

You have to watch your dollars, and you have to constantly battle to try and change your practice style to what is being reimbursed. And then, so you feel like there's gamesmanship about how to survive as opposed to saying, "Look, all I want to do is practice medicine."

— *Physician from a solo primary care practice in the Midwest*

We were unable to increase our margins with the insurance companies, so we chose to increase our patient volume by hiring nurse practitioners, incorporating them into our clinic practice. This allowed us to increase visits of established patients to the clinic.

— *Physician from a medium-sized multispecialty practice in the South*

Some physicians expressed interest in value-based payment, but those models were not available in their market. A handful of primary care physicians in select regions participated in value-based payment arrangements that resulted in direct financial rewards for high quality care. These physicians suggested that practices embrace these arrangements as "the way of the future."

Change is always kind of hard, and initially, we were, you know, skeptical about it a little bit. But now...I think we're getting comfortable with the whole kind of quality outcome thing and very happy to continue doing that.

— *Physician from a medium-sized multispecialty practice in the Midwest*

The payments we're getting for quality are pretty big. And so...that's something we've really worked on growing, you know, over the last number of years. And we're trying to even grow that even further if we can, because I think you're gonna be putting energy and into the sickest patients... And that's what these programs allow us to do, and if they pay you a little better to spend more time with them, and you know, code things properly and see them twice a year, and all the things that they like you to do, then it's—I think it's a win-win, you know, for the payers, the government, and the doctor. Especially the patients.

— *Physician from a small primary care practice in the West*

2. The role of ACOs and independent physician associations (IPAs)

Many physicians indicated that they explored relationships with IPAs, ACOs, or similar entities, but the results of these partnerships were mixed. A few physicians said these organizations were not common in

their market, or their patient population was not large enough to support joining an ACO. Many practice leaders said the financial costs of joining or risks associated with participation were not worth the rewards. A few practices discussed specific activities the organizations were able to help with, such as enhancing the practice's data capabilities or recommending a reputable telemedicine company. Many primary care physicians valued the savings achieved from ACO arrangements. Primary care physicians also emphasized their preference for physician-led primary care-focused ACOs.

We started participating in an ACO. Unfortunately, they had savings, but their savings were not high enough for them to pay us. So, we were kind of disappointed.

— *Physician from a medium-sized multispecialty practice in the South*

I do think the ACO is going to help improve the bottom line. The other ones, you know...there was really no financial gain with any of the other initiatives that we did.

— *Physician from a solo primary care practice in the South*

The bottom line is [IPAs] don't do much. Our first IPA we were in 20 years ago was effective. They got us better contract rates, they directly contracted with insurance companies and then, apparently, that became illegal... The consultant I'm working with now, he's very skeptical about IPAs, and I can see why, because they charge fairly high rates...and they don't always provide much. A lot of doctors, especially, I think specialists are in them because they feel like if they don't belong to the club, they might be pushed aside and maybe they'll lose contracts or something.

— *Physician from a small primary care practice in the West*

The ACO's software is a lot more user-friendly, and you can really slice and dice the data in an easier way. You can prioritize high-risk patients versus low-risk patients. So, for example, right when COVID started, they created a COVID work list of 200 patients that would be most vulnerable if they acquired COVID, so we contacted them first to make sure they're okay.

— *Physician from a solo primary care practice in the South*

I think we brought in the last year almost \$400,000 just in revenue from the ACO just through the performance of the ACO. Just my practice, one provider...[the ACO] did a wonderful job, and I'm learning a lot about how I should do things better, and that's what we're doing. And see, [it's] because it's physician-led, it's not corporate-led.

— *Physician from a solo primary care practice in the Northeast*

IV. Implications for Research, Training, Policy, and Practice

Empirical evidence suggests that physician-owned private practices deliver quality that is equal to, or better than, practices owned by systems. In our study, we found that the leaders of high-performing physician-owned private practices are a distinct subset of physicians who place a high value on autonomy and independence in medical practice. These physicians care deeply about their practices and the roles they play in their communities as healers and as small business owners. They feel privileged to do work they find meaningful. That said, they tend toward feeling isolated, and many said they wished they had more contact with other like-minded physicians. Some had a difficult time seeing a future for solo, small, and medium-sized physician-owned private practices. A few saw their only options as suffering under the administrative burdens and low payment rates or selling their practice to a larger entity with deeper financial reserves. Other physicians we interviewed were driven to succeed. They were strategic in the way they managed change, adapting to value-based payment mechanisms, new technologies, and new practice models. Overall, the physicians we interviewed were highly professional and intrinsically committed to delivering high quality care. They were also doggedly determined to succeed in private practice and very responsive to financial incentives and to peer comparison data when available.

Engaging leaders of high-performing physician-owned private practices requires an approach that builds on their strengths and works with them to overcome challenges. Independent practice leaders would welcome changes that “level the playing field” in their communities and are open to advice from knowledgeable sources if this guidance creates opportunities for them to achieve high-quality clinical outcomes and financial success. Here, we recommend ways that researchers, professional organizations, IPAs, ACOs, medical educators, accreditation organizations, and policymakers can support leaders of physician-owned practices.

A. Health services researchers

More research is needed to further clarify the value and sustainability of small physician-owned practices, especially in underserved urban and rural communities. Only a few studies compare these practices with system-owned practices with respect to clinical quality and cost. We found no studies that compare physician-owned and system-owned practices from the patient perspective. Other questions to be considered include the following: To what extent are high-performing physician-owned practices currently meeting the health care needs of people across the United States? What will happen to health care access and quality, patient satisfaction, and the cost of care over the next decade if many or all of these practices close or are purchased by larger systems? If these practices remain open, how can they be supported to successfully deliver high-performing care? Who will serve in these practices as the older generation of physicians retires?

B. Professional organizations, ACOs, and IPAs

Physicians who remain in independent practice face immense administrative, financial, and clinical challenges in a predominantly fee-for-service environment. Larger entities like professional associations, ACOs, and IPAs are well situated to help small and medium-sized physician-owned practices in several ways. First, innovative solutions are needed to help solo and small physician-owned practices contract for network access, timely receipt of performance data, and sustainable and fair payment rates. Solutions could include access to education and training on the business of running a practice for physicians in training; coaching for contracting success, including being able to forecast the cost to the practice of

delivering contracted services; or providing access to contracting consultation services to which members could subscribe for assistance. Physician practices could also benefit from learning how to establish a “kitchen cabinet” of trusted advisors, comprising, for example, legal, banking, real estate, marketing, and other experts.

Second, purchasing groups composed of and serving physician-owned practices could facilitate EHR system acquisition and implementation along with new technology updates and optimal use. Offerings could include low- or no-interest loan programs, partnering with major EHR vendors to offer discounts on software and technical support for members, and securing funding to establish the Primary Care Extension program (see below). In addition, these entities could assist practices with the infrastructure investments, both human and financial, required to provide patient-centered and cost-effective care that reliably delivers high-quality outcomes. Finally, these organizations could provide physician leaders with opportunities to connect and network with other like-minded practice owners to overcome feelings of isolation—for example, convening and supporting learning communities and linking practices with others of similar in size and specialty.

C. Medical educators or accreditation organizations

Small and medium-sized independent practices are significantly disadvantaged when recruiting new physicians. If the physician-owned practice model is to survive, medical students and residents need to be exposed to it during their education and training. Medical schools, residency programs, and community-based physician-owned practices should develop relationships to provide clinical rotations, electives, and mentoring experiences for trainees. Federal graduate medical education funding programs that limit off-campus clinical rotations may need to be revised. Undergraduate and graduate medical education programs could include business courses in their health systems science curriculum, much of which would be applicable to all practice models. Topics addressed could include strategic planning, change management, budgets, contracts, finance and accounting, and human resources. Continuing medical education in practice management and business development would provide support for all physicians, especially those in small physician-owned practices.

D. Policymakers

Policymakers have a significant role to play in determining whether the physician-owned practice model will survive. First, policymakers must prioritize efforts to decrease administrative burden on practices. Opportunities include streamlining coding and billing requirements across all sites of care, as was done for outpatient evaluation and management visits as of January 1, 2021, and achieving multi-payer alignment on quality metrics, a stated objective of the Core Quality Measures Collaborative. Second, it is important to promulgate policies that create equitable opportunities for success for small physician-owned practices relative to practices owned by hospitals, health systems, commercial payers, and private equity groups. For example, higher payments are made to system-owned practices, Federally Qualified Health Centers, and rural health clinics for the same services delivered by physician-owned practices (Post et al. 2021). Third, physician recruitment for small physician-owned practices could be promoted by expanding educational loan repayment opportunities for physicians that choose to go into independent primary care practice, especially in underserved and rural communities. Innovative approaches include combining loan forgiveness with requirements that recipients acquire business skills, participate in time-limited mentorship by established practices, or commit to serve a community for a specified number of years. Partnering with local business and elected leaders to recruit and retain physicians also warrants exploration, and the lessons learned through these efforts should be shared.

Primary care, in particular, would be substantially aided by funding of the [Primary Care Extension Program](#) (Phillips et al. 2013). This federal program, authorized but not funded, is modeled on the U.S. Department of Agriculture's [Cooperative Extension Service](#), which has successfully spread innovations to farmers throughout the country over the past century (U.S. Department of Agriculture n.d.). The program would employ regional practice improvement consultants who could support and coach practices as they update and use new EHR technology, implement telehealth, and learn to function under new payment methodologies. Consultants would provide tailored assistance to help practices provide essential services, such as integrating behavioral health care and connecting to and coordinating care with community services.

V. Conclusion

The landscape of physician practice in the United States has shifted dramatically since reliable data were first obtained in 1983, with implications for patient care, the physician workforce, health outcomes, and communities (Kletke et al. 1996). The still large number of physicians who provide care in a physician-owned practice, either as owners or employees, suggests that the number of people who rely on these practices for care is also high. Therefore, for the foreseeable future, physician-owned practices will be an integral part of the health care ecosystem. This qualitative study suggests that the success of this practice model cannot depend only on dedicated physicians and care teams but also requires the commitment and collective efforts of policymakers, educators, professional organizations, and other entities to remove obstacles and create equitable opportunities for success.

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