

Practice Models in Dermatology

August 2020

Introduction

The purpose of this white paper is to describe current trends toward consolidation in dermatology and help members understand the different practice models that are emerging in this evolving climate. This impact can be seen, not just with the type of practice models, but on dermatologists that support those models. The field of dermatology, along with the rest of medicine, has experienced a transformation in the way that practices are organized and owned. Many dermatologists are moving from solo practice to group practice in response to increased administrative burdens related to electronic health records (EHRs) documentation, billing requirements and prior authorizations. Meanwhile, many larger organizations, including hospitals and academic medical centers, and those backed by private equity are moving into the dermatology market, buying up practices and creating large groups. These forces are converging to drive significant consolidation in the market.

Part 1: Why does the consolidation trend exist?

Although the effects of consolidation can be observed across other areas of medicine, dermatology in particular has experienced a more rapid contraction due to a variety of factors.

Increased medical specialization, administrative burden, contractual relationships, and government oversight have over time gradually contributed to the movement of dermatologists from solo practices into single and multispecialty groups (1). The movement to larger practice environments has been viewed by some dermatologists as a way to manage increased administrative burden and reduced payment. For example, while the costs of health care are going up every year (6), the requirements of multiple payers and government regulations are often increasingly complicated and burdensome to track. Other challenges include competition from large groups, as well as providing oversight of office space, equipment, supplies, and personnel (7). Joining a larger practice or working for a larger entity can provide physicians with resources for integrated technology, branding, and practice management (5).

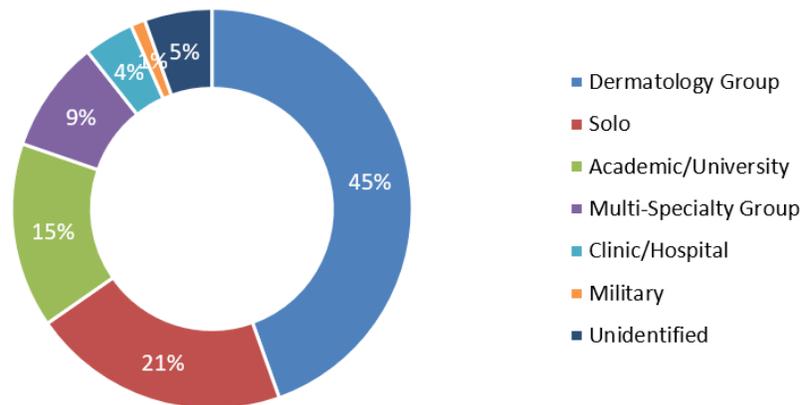
However, practice consolidation has skyrocketed over the last decade with private equity entering the health care marketplace. Private equity is defined as either capital invested directly into private companies, or capital used to purchase public companies, with subsequent loss of publicly held status (2). In 2011, there was just one private equity investor in dermatology (3), but between 2012 and 2018, 184 dermatology practices were acquired by 17 private equity investors (4). Investors are attracted specifically to dermatology's fragmented market, where no single practice or organization has enough influence to move the industry in a given direction, and elective/cash pay services allow for direct-to-consumer marketing and unique practice branding (5).

Some dermatologists find these new practice environments too restrictive with respect to autonomy, particularly when determining a patient's course of treatment or how to run their practice. According to 80% of dermatologists, autonomy in treatment decisions was at the top of their list of what made them happy in their jobs (8). These dermatologists may find a need to consolidate in order to reduce administrative burden but may go about doing so in a different manner by forgoing formal consolidation and instead setting up a small dermatology-only group practice or a virtual group.

This publication explores the spectrum of practice models, including solo, multispecialty, group, and academic; public, private, and private equity-owned; and the implications of working in each setting for individual dermatologists as well as the field of dermatology in this changing health care environment.

Part 2: An overview of prevailing dermatology practice models

US Members in Practice Settings
12,070 Dermatologists



Source: 2020 Member Profile

Solo Practice

In 2019 about 21% of dermatologists were solo practitioners (39). Preserving full ownership over a practice has both pros and cons. This model requires one owner to make all decisions for a small business. A main advantage of ownership is full autonomy and control of future growth and strategic planning. This includes the number of patients scheduled and how much time to allocate to each visit, choices that impact patient care and work/life balance (9). However, the stressors of competition, reporting quality standards, compliance with increasing regulatory and payer demands, in addition to general practice management upkeep, can add up to more than a full-time job, requiring a very different set of skills than those achieved with medical training. Regulatory changes are made every year and reporting requirements are updated accordingly (10). Staying up to date on these changes and developing systems can be a daunting task that often requires support of a highly paid manager. Dermatologists in a solo practice, on average, report seeing about 132 patients in a 4-day work week (11).

Some solo dermatologists have found that consolidating can offload some of the day-to-day back office responsibilities, allowing focus on patient care. Joining forces into a small or larger group practice will require a new balance of priorities and duties. Ideally, everyone involved in the group will take the opportunity to understand and agree to the new working dynamic and all established expectations. Some solo dermatologists have found the shift difficult, particularly when navigating personality differences, streamlining and standardizing workflows, and building consensus-based business priorities (12). More physicians and larger staff may also result in loss

of control and autonomy, which has been found to correlate to less satisfaction with a particular practice model (8).

Multispecialty

Multispecialty groups can be non-profit, an accountable care system, an integrated medical group, or for-profit businesses (13). These groups utilize centralized billing, support enhanced compliance with regulatory requirements, increased negotiating power, and can provide other management and clinical resources. On average, dermatologists who are part of multispecialty groups report seeing about 107 patients in a 4-day work week (11).

Being an employed physician in a larger system typically comes with a secure base salary and coverage for time away from the office (14). Other benefits may include better access to equipment and coordinated multispecialty care.

Physicians working within a multispecialty group may be affiliated with, or be subjected to acquisition by, a larger group. Affiliation implies financial autonomy, but reliance on the larger group for referrals and management of regulatory requirements (10). It should be noted that the type of contract dictates how one is reimbursed, and it is essential to review carefully. Clinicians considering transition to a multispecialty practice should be aware that a contractual salary could be less beneficial as it may be based on “work RVUs” which represent roughly 35% of the total RVU practice expense reimbursement (15).

Being employed includes some of the same benefits mentioned previously, but can result in loss of autonomy with respect to many business and patient care variables, such as the electronic health record system, scheduling, number of support staff, and access to supplies (16) (17) (18). Avoiding issues directly related to reimbursements can be appealing to physicians.

Dermatology-Only Groups

Distinct from multispecialty groups are dermatology-only groups. Regardless of size, these groups allow subspecialty expertise within dermatology, which can enhance profitability, and provide better care for patients with more complex problems (1). Smaller groups may be less susceptible to physician burnout as they are more likely to maintain control over their workloads and decision-making capabilities (19). On average, dermatologists who belong to dermatology-only groups report seeing about 125 patients in a 4-day work week (11). Group practices also typically have more negotiating leverage which could lend itself to increased patient access (1). The biggest single variance among dermatology groups is the ownership structure.

Academic Medical Centers

Academic Medical Centers (AMCs) provide some unique opportunities, but an evolving business model reflects some aspects of large multispecialty practices. Acquisitions by AMCs are becoming more frequent as they try to expand coverage into neighboring communities. This may attract some patients to AMC-affiliated community hospital clinics (24). A major area of concern regarding many AMCs is their decentralized administration and governance as they grow. Since AMCs often have the tripartite mission, dermatologists may be expected to contribute to research

projects, mentoring, publications, and education in addition to clinical care (25). Dermatologists at AMC's should review their employment contracts thoroughly before signing; like dermatologists considering multispecialty employment, they should keep in mind that compared to other specialties, work RVUs represent significantly less reimbursement in dermatology than the practice expense RVU (15).

In order to stay viable, this practice model may also undergo multiple changes. Due to the vast array of expertise and resources at an AMC, best practices and care models can be developed, standardized, and disseminated to their various affiliates (26). As a result, AMC's may be best positioned to tackle CMS' value-based payment in ways that other practice models cannot. The experience and training physicians receive are also unique. Physicians who are part of AMC's often see a broad patient mix, are trained in the newest technologies and treatment methods, and work amongst other researchers in their field (27). AMC's also can have more negotiating power than smaller practice models. On average, dermatologists who are currently part of an AMC report seeing about 82 patients in a 4-day work week as the remainder of their time may be committed to research and education endeavors (11).

Ownership

Groups that are not physician owned may be owned by a private equity firm, academic medical center, insurer, hospital, or large health system (20). The operation and structure of these groups are based on both state and federal laws. Private-equity owned practices have recently proliferated in dermatology with close to 14% of dermatologists working for a private-equity backed practice (35). This model has brought concerns related to the relationship between patient care and investor profits. According to the AMA resolution on Private Equity, "Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships" (21). To reiterate, the physician's responsibility is to the patient's welfare and physicians should always be aware of potential conflicts of interest and contracting (21). Additionally, private equity firms often have a high owner turnover rate, often selling a practice in 3-7 years (23). That alone can be stressful to the practice and physicians, depending on how involved the existing owner is and what financial expectations they may have (22). The subsequent sale could be to another private equity firm or other large interest (37). Another option to be aware of, which could still be profitable to the private equity firm, is to file for bankruptcy (37). This occurred recently to a hospital system, which resulted in the closing of its residency and fellowship programs affecting numerous specialties (38).

Additionally, more than half of all dermatologists have an ownership stake in their practice either as a shareholder, owner, or partner (8). Health systems own approximately 24% of dermatology practices, while private equity accounts for around 14% (8). 35% of dermatologists who work in PE-owned practices are shareholders — 14% are partners, and 72% are employees (36). As a note, dermatologists could classify themselves into more than one category, as they could be both (36).

Other options

While we've focused largely on the dominant models in dermatology, there are other options dermatologists may wish to consider.

For example, some may elect to pursue a **concierge model** (7). This model allows for more personalized care, to fewer patients, who pay a premium for access to their physician and enhanced services (28). This model does limit access as the physician is handling fewer patients. Physicians focusing on cosmetic services or those working in urban and suburban areas would be most likely to adopt this model.

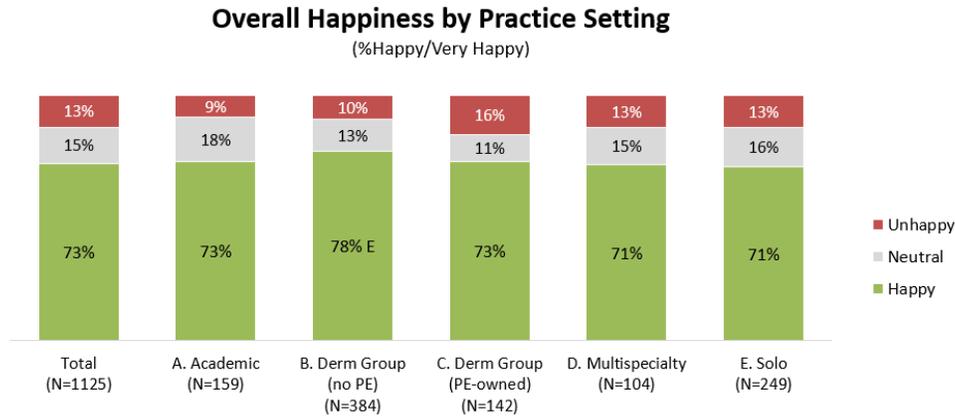
Accountable Care Organizations (ACOs) and Alternative Payment Models (APMs) allow physicians to focus on keeping patients healthy instead of being paid for each visit (7). This practice model allows groups of providers to work together to coordinate care for a payer specific population (29). ACOs and APMs allow for new competitive landscape within the patient population a physician is interested in (30). Currently there are limited options for dermatology participation in APMs or ACOs.

An **Independent Practice Association (IPA)** is a practice model that allows a network of independent physicians to retain their independence while becoming part of a separate payer contracting organization (31). This model is on the rise to combat the difficulties that come with navigating compliance regulations, administrative requirements, and payer contracts (32). Because the IPA is dealing with third party negotiations, it is important to ensure the priorities of all practices align as to avoid internal conflict (32).

Joint venture is a practice model that involves two or more practices that have a formal agreement for a specific business project (33). The balance of risk and control can be tricky, but with due diligence, a beneficial working arrangement can be created. A major benefit to this model can be the shared financial responsibility and ability to create buying power for supplies and services (34). The disadvantages to look out for are the opportunities for either party to make a poor business decision that may affect the joint venture relationship or project outcome (32).

Part 3: Impact

The Academy’s recent practice models survey shows that the majority of dermatologists are currently practicing in a form of group setting, with close to half in dermatology groups specifically. These single-specialty dermatology group practices run the gamut from 2-dermatologist, 1 location practices to over 100 dermatologists with multiple locations. However, the majority (54%) of those practicing in dermatology groups are in smaller groups with 5 or fewer dermatologists (8).



(8)

The practice setting has less impact on overall physician happiness than other factors. Overall, 73% of dermatologists are happy in their current practice. This increases to 78% — about 8 in 10 dermatologists — among those in dermatologist-owned group practices which is significantly higher than the happiness of solo practitioners (71%). Aside from this, there are no other statistically significant differences in happiness of dermatologists by practice setting.

The factors that physicians are happiest with across all practice models are:

1. Patient interaction
2. Autonomy in treatment
3. Variety of patient cases
4. Job security
5. Autonomy in referral decisions
6. Good colleagues
7. Work-life balance

However, the ability for each practice model to deliver on those factors varies significantly.

To investigate further, a relative weights multiple regression analysis was conducted to determine which of several pre-defined factors are the strongest drivers of physician happiness. In other words, which specific factors — if improved upon — would increase overall physician happiness. Or conversely, if physicians were unhappy with these factors, which would lead to a decline in overall physician happiness. The analysis found that the strongest drivers of happiness among all dermatologists were work-life balance and overall compensation. Second-tier drivers of physician happiness that are similar in strength to each other are: working in a collaborative environment, sufficient support staff to support the practice, and good management. Work-life

balance is a near-universal driver of happiness for dermatologists in all practice settings except multispecialty practices, where having good colleagues emerges as the strongest driver of happiness.

When reviewing overall compensation, dermatologists in multispecialty or private equity-owned practices were happiest with their compensation, while those in solo and academic practices were least happy (8). For solo practitioners, overall compensation was among the strongest drivers of happiness, ranking second behind work-life balance. Among academics, it held medium strength, ranking lower than “the opportunity to learn and grow,” “support with the administrative and regulatory burden,” and “a collaborative environment.” Therefore, while 1 in 2 academic dermatologists are happy with their compensation, improving it plays a lesser role in improving their overall happiness.

Survey data shows that common points of frustration for dermatologists (insurance delays and documentation requirements) are present throughout all practice models (36). The top four reasons for *unhappiness* among dermatologists are: insurance interference, time documenting visits in EHR, their EHR system itself, and too much administrative work (35). Dermatologists in academic and multispecialty practices are particularly unhappy with the amount of time that they spend documenting visits in their EHR.

Regarding job mobility, 25% of dermatologists have changed jobs in the last five years, with half transitioning to a dermatology group practice environment. Of that half, nearly 40% transitioned to a private equity-owned practice (35). Dermatologists transitioning to group practice most preferred smaller groups of 3-5 dermatologists (14), and these smaller groups are more likely to be physician-owned (11).

Regardless of practice setting, 72% of dermatologists are affiliated with a hospital and hold medical or consulting privileges (8).

Part 4: The Future

As long as health care costs continue to increase, all practice models will be under pressure to increase efficiencies. To keep pace, dermatology practices will have to increase efficiency wherever possible regardless of practice model. This may include optimization of office design and staffing, increased patient access through the adoption of telemedicine and other technologies, and integrating clinical decision support into the practice’s EHR (6).

The bottom line is that there are numerous practice models to choose from, and as of yet, there is no “best” practice model to be recommended. There are advantages and disadvantages to each model. One practice model may be ideal for one physician, and yet unacceptable to another physician. As of right now, there is no research to definitely answer if patient care is affected, for better or worse, by consolidation. However, given the exponential increases in consolidation in the last decade, now may be the appropriate time for such studies (21). The models studied in this survey as they pertain to non-physician clinicians were not addressed, but may be in a future survey. In the meantime, there is plenty of information available to help a physician weigh the pros and cons of each model to determine what will work best for them (www.aad.org/career/epm) (21).

References

1. <http://hospital-medical-management.imedpub.com/physician-group-practice-trends-a-comprehensive-review.php?aid=9343>.
2. <https://www.investopedia.com/terms/p/privateequity.asp>.
3. <https://practicaldermatology.com/articles/2018-sept/the-dermatology-market-a-tidal-wave-of-private-equity-investment>.
4. <https://jamanetwork.com/journals/jamadermatology/article-abstract/2738309>.
5. https://www.bglco.com/wp-content/uploads/2018/12/bgl_healthcare_and_life_sciences_special_report_dermatology_practices.pdf.
6. <https://www.physicianspractice.com/healthcare-policy/trends-physician-practices-2018>.
7. https://www.bofaml.com/content/dam/boamlimages/documents/articles/ID19_0137/wp_12_18_0138_f.pdf.
8. 2018 Life in Practice: The Derm Happiness Survey, AAD.
9. <https://www.the-dermatologist.com/article/success-independent-practice>.
10. <https://www.healthleadersmedia.com/clinical-care/hospital-physician-consolidation-growth-trends-moderate>.
11. 2017 Dermatology Practice Profile, AAD.
12. <https://www.medicaleconomics.com/business/consolidation-transforming-medicine-heres-what-every-doctor-needs-know>.
13. <https://www.healthexec.com/topics/leadership/25-largest-integrated-health-systems>.
14. <https://www.medicaleconomics.com/medical-economics/content/questions-ask-joining-multispecialty-group>.
15. <https://www.aad.org/dw/monthly/2014/may/work-rvu-contracts-have-pitfalls-for-dermatologists>.
16. <https://www.hospitalrecruiting.com/blog/4751/benefits-of-joining-a-multi-specialty-group-practice/>.
17. <http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-117>.
18. <https://revcycleintelligence.com/news/major-healthcare-mergers-and-acquisitions-making-waves-in-2019>.
19. <https://www.continuumhealth.net/9-key-trends-for-independent-physician-practices-in-2019/>.
20. <https://www.ama-assn.org/system/files/2019-07/investment-model-checklist.pdf>.
21. AMA Resolution on PE (pdf).
22. <https://www.modernhealthcare.com/physicians/specialty-physician-groups-attracting-private-equity-investment>.
23. <https://www.dermatologytimes.com/dermatology/6-concerns-about-practice-consolidation/page/0/1>.
24. <https://uofuhealth.utah.edu/hcr/2012/resources/the-future-of-academic-medical-centers.pdf>.
25. [https://www.jaad.org/article/S0190-9622\(05\)03237-8/fulltext](https://www.jaad.org/article/S0190-9622(05)03237-8/fulltext).
26. https://www.huronconsultinggroup.com/-/media/Resource-Media-Content/Healthcare/HC_Leading-the-Change_Overarching_White-Paper_rebrand2016.pdf.
27. <https://www.modernhealthcare.com/operations/academic-medical-centers-face-identity-overhaul>.
28. <https://www.aad.org/member/career/epm/join/concierge>.
29. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/aco/>.
30. <https://www.healthcatalyst.com/insights/acos-cins-past-present-future>.

31. <https://www.aad.org/member/career/epm/models/ipa>.
32. <https://www.elationhealth.com/independent-practices-blog/independent-physician-association/>.
33. <https://thedoctorweighsin.com/what-medical-practices-should-know-about-joint-ventures/>.
34. <https://www.aad.org/member/career/epm/models/joint>.
35. AAD Life in Practice: The Derm Happiness Survey Executive Report.
36. 2017 Survey of Group Practices, AAD.
37. JAMA-Sharfstein_July 2019.
38. <https://blogs.scientificamerican.com/observations/the-closure-of-a-historic-hospital-is-an-ominous-warning-sign/>.
39. 2020 Member Profile, AAD.