Is Your Medical Group Hitting the Mark?
How to Drive Value, Engagement and Success

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Medical groups are the linchpin of hospital and health system operations, the core of the clinical enterprise and the indispensable driver of success. With increasing size, scale and scope, today’s medical groups wield greater impact on healthcare delivery and performance than ever before. Leading health systems recognize that medical group capabilities and leadership are critical to transforming care delivery and cost structure in an environment of shrinking revenue and increased risk. Across the country, effective physician-health system partnerships are achieving remarkable results in clinical outcomes, cost management, access and capacity, and patient and provider experience — and are positioning themselves for success in an increasingly cost-sensitive and value-based market. Only by optimizing medical group clinical, financial and operational performance, and fostering aligned, committed and accountable physician leadership, can health systems and physicians together address the complexities and challenges facing today’s healthcare providers.

Medical Group definition: Any group of physicians requiring active management for a defined purpose, whether single specialty or multi-specialty, faculty or community, networked or employed, in either ambulatory or hospital-based settings.

While the healthcare payment environment continues to evolve, and is now more uncertain than ever, the imperatives facing providers — to demonstrate meaningful differences in quality, reduce costs, enable access and deliver a superior patient experience — have not changed. Provider accountability is here to stay.
The Changing Nature of Medical Practice and What It Means for Physicians and Health Systems

**Increasing Size and Complexity**

Over the last 30 years, U.S. medical group size and structure have changed dramatically. More than a quarter of medical practices today are comprised of 50 or more physicians, and an increasing number of physicians are part of very large groups — 35 percent of physicians work in groups of at least 100 members, and 15 percent of physicians work in groups of at least 500 members. This is a meaningful change from 30 years ago, when most doctors worked in solo or small practices. Ownership and governance structures have changed too; more than 30 percent of physicians work directly for a hospital or in practices with partial hospital ownership, increasing physician-system interdependence and integration of financial planning, controls and operational decisions. The largest medical groups in the country have vast scale and scope with associated organizational complexities, and national hospital-based organizations now find themselves with thousands of employed physicians in various markets, configurations and management models.

In many cases, the growth in practice size and complexity has been extremely rapid, and infrastructure development has not kept pace. Many groups do not have the clinical and administrative resources, capabilities, leadership or support necessary to address the demands of the current reimbursement and regulatory environment or perform at the level required of larger and more complex medical groups. In fact, many are struggling with performance across multiple dimensions: cost management, operational efficiency, patient access and capacity, clinical outcomes, contracting and reimbursement, patient and family experience, and physician productivity and satisfaction. All medical groups — whether ambulatory, hospital-based, emergent/urgent care, highly specialized (e.g. dialysis centers) or high-tech (e.g., virtual care; radiology/imaging) — are facing unprecedented environmental pressures and internal strategic and operational challenges.

**Impact on Health System Performance**

Medical group management and operations have a direct impact on all major components of health system performance, including patient access and engagement, clinical outcomes and service, referrals and capacity, and billing and collections. As medical groups have grown in size and scale, so has their impact on the health systems with which they are connected, either as employed physician groups or as affiliates participating in an integrated network or ACO. Health systems confronting a shrinking reimbursement environment and heightened market demands for better quality, service and value, can no longer absorb the negative financial impact experienced by many medical groups. According to the Medical Group Management Association (MGMA), median losses on hospital-owned multispecialty practices are $128,000 per physician and Moody’s called physician employment “a principal driver of hospitals’ margin pressure.”

Health systems must address the performance needs of all their physician constituents, in all settings. The requirements of MACRA, for example, will impact both clinic-based and hospital-based physicians. Both will need to meet quality and service expectations, develop new and efficient care models, effectively manage their revenue cycle, and meaningfully deploy and use information technology.
Example 1 - A comprehensive improvement initiative, resulting in a 20% improvement in medical group losses would result in $12.8M in additional operating income for the health system.\(^4\)

Example 2 - Furthermore, assuming Medical Group A has $200M in Medicare revenue, a 4% positive or negative payment adjustment under MACRA’s Merit-based Incentive Payment System (MIPS) would translate to plus or minus $8M in revenue to the health system.
What Does an Aligned, High-Performing Medical Group Look Like?

In high-performing medical groups, physicians and administrators are aligned around the strategic needs and goals of the organization. They work in partnership to develop and implement solutions to the challenges that healthcare faces, including: enabling timely patient access, achieving desired clinical outcomes, maximizing capacity, reducing leakage, engaging patients and families, maintaining efficient cost structure, and deploying information systems and resources in a manner that supports how care is delivered. Leading health systems recognize that a high-functioning medical group is the execution arm of the enterprise strategic agenda and critical to driving clinical, financial and operational performance.

The financial equation for medical groups includes not only the profit or loss per physician, but also the group's contribution to value-based contract performance. In virtually every type of payment model, whether value-based or fee-for-service, the medical group's performance and capabilities are the primary drivers of results. As health systems face intense downward pressure on volume, revenue and margins, and a dramatically more competitive consumer marketplace, they need medical groups to become high-performing partners able to drive solutions to their most pressing clinical and financial challenges. It is no surprise that for many health systems, improving medical group performance has become a financial and strategic priority.

In our experience, high-performing medical groups have the following key characteristics in common, which collectively enable physicians to be highly effective and thrive personally:

Clear Vision, Goals and Expectations:
- Strong alignment exists among and within health system and medical group leadership on shared enterprise vision, goals and strategies. The purpose and performance expectations of the medical group are well articulated and understood by all.
- Physician leaders are successfully positioned as “owner operators” of the clinical enterprise with the leadership skills, management capabilities and decisional authority to drive performance. They are empowered and accountable for managing the group and creating results — and have the required administrative partnerships to ensure successful planning and execution.

High-Impact Clinical Models:
- The medical group has top-quartile clinical quality outcomes and captures associated performance-based revenue incentives.
- The medical group can implement and manage to consensus-driven practice standards in association with a comprehensive quality and variation management program.
- Clinical care models support improved outcomes, reduced cost of care and success in value-based and fee-for-service payment models and population health management.
Strong Practice Management:
- Patients access the right provider, at the right time, in the right setting to get the care they need.
- Operations are effectively managed, including productivity, revenue generation and collection, resource management, patient experience and financial performance.
- Information technologies, information management and analytic resources are optimized to support an innovative and transformative clinical environment.
- Medical group performance is effectively measured and managed using strong data management, analytics, reporting and measurement of quality, cost and service metrics.
- Patient-medical group interactions support strong relationships and loyalty.

Assessing Your Medical Group's Alignment and Performance

Every medical group will benefit from a comprehensive review of its performance — how well it is meeting peer, patient and health system needs — and how that performance aligns with strategic imperatives for itself and the broader health system. The framework below can help you think through the essential components of medical group performance, regardless of setting, and begin to identify gaps and areas of opportunity:

Figure 2.

ENTERPRISE PHYSICIAN/ADMINISTRATIVE ALIGNMENT
Alignment around vision, purpose and goals
Strong leadership structures, governance and culture
Physicians are effective and thriving

<table>
<thead>
<tr>
<th>Clinical Mgmt. and Quality</th>
<th>Access and Capacity</th>
<th>Productivity and Efficiency</th>
<th>Patient Experience</th>
<th>Cost Management</th>
<th>Revenue Cycle Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliable, highest quality clinical results</td>
<td>Multimodal access for patients</td>
<td>Optimal physician productivity</td>
<td>Patient centered care</td>
<td>Optimal clinical support and non-clinical staffing</td>
<td>Optimized revenue cycle across all dimensions:</td>
</tr>
<tr>
<td>Well-defined practice standards</td>
<td>Optimized capacity and appointment scheduling management</td>
<td>Effective use of APP’s and care team</td>
<td>Customer service orientation</td>
<td>Revenue Access</td>
<td>Patient Access</td>
</tr>
<tr>
<td>Effective clinical variation management</td>
<td>Network design to support easy navigation</td>
<td>Purposeful, aligned incentives, compensation</td>
<td>Environment of care to support long term relationships and loyalty</td>
<td>Revenue Integrity</td>
<td>Revenue Integrity</td>
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<tr>
<td>Patient centered care model</td>
<td>Effective resource utilization</td>
<td>Performance measurement and monitoring system supports ongoing improvement</td>
<td>Community outreach to connect patients to care</td>
<td>Health Information Management</td>
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<td>Robust care management</td>
<td>Effective referral management</td>
<td>Clear and effective brand promise</td>
<td>Clear and effective brand promise</td>
<td>Coding</td>
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<td>Optimal care team design</td>
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<td>Business Office</td>
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<td>Effective panel management</td>
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Timely and Effective Communication

Optimized Technology and Decision Support Tools

Performance Measurement and Monitoring
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Enterprise Physician/Administrative Alignment: At the practice, medical group and network levels, are your physicians aligned with and capable of owning and executing on broader enterprise strategic goals? Are your physician leaders successfully positioned as “owner-operators” of the clinical enterprise, with the management skills, training and experience that drive performance accountability? Are your physicians and administrators highly engaged and optimistic about their ability to navigate the challenges ahead? Is there a culture of trust, collaboration and engagement?

Clinical Management and Quality: Is your medical group producing the clinical outcomes necessary for top quartile performance in all patient segments and managing variation to defined practice standards to create highly reliable clinical results? Can the medical group achieve the clinical outcomes necessary for success under value-based and advanced alternative payment models?

Access and Capacity: Are your patients able to readily access providers and services when, where and how they want and need to? Are both primary and specialty care providers able to achieve the total patient capacity required to support strategic and financial goals for themselves and the organization? Are referrals effectively managed? Are patients seen by the most appropriate provider and in the most appropriate setting? Is there effective communication between and among providers?

Productivity and Efficiency: Is physicians’ time optimized so that care is delivered in the most effective way, patient access is maximized and administrative burden on clinicians is reduced? Is the medical group getting targeted return from its investments, including facilities and technology? Are performance expectations clearly established and communicated?

Patient and Family Experience: Is care delivered in a way that builds ongoing patient satisfaction and engagement with the medical group and health system? Is there a consistent brand experience across the medical group regardless of physical location? Is a customer service culture embraced and evident in all interactions with patients and their families? Are patients (and their families) informed and empowered to take a lead role in their own care?
**Cost Management:** How is the medical group performing financially? How well is the group managing operating expenses, including staffing, and maximizing the return on its investments, such as facilities and technology? Are staff and other resources deployed in a manner consistent with both current and evolving payment models? Are staff and non-physician providers efficiently and effectively employed to support clinical operations and outcomes, with effective processes and technology to reduce unnecessary burdens?

**Revenue Cycle Performance:** Is reimbursement optimized for all payors and patient segments? Is complete patient data collected and reviewed as patients are scheduled to ensure financial clearance? Are contracts effectively managed? Does the medical group revenue model reflect anticipated changes in payment models, for both primary and specialty care? How is the medical group adjusting to changes in health plans, high deductibles, new product designs, and managed Medicaid or Medicare? Are key metrics consistently monitored, with feedback loops to clinical service areas and individual providers?

**Timely and Effective Communication:** Do physicians, administrators and staff at all levels receive information in ways that are meaningful to them? Are patients appropriately informed and engaged in two-way communication? Are strategic requirements and priorities well understood throughout the organization?

**Optimized Technology and Decision Support Tools:** Does the medical group effectively employ decision support tools and information-sharing technology to support clinicians and staff to deliver superior care to their patients? Is the information technology environment optimized to support enhanced performance for physicians and staff? Do the systems and tools in place support patient empowerment?

**Performance Measurement and Monitoring:** Are expectations and goals for the medical group clearly defined, measured, monitored and communicated in a consistent and meaningful way? Do leaders, physicians, and staff understand the data provided, and do they know how to affect change? Are appropriate systems, processes, resources and skills in place to ensure ongoing and continuous performance improvement?
Getting Started: A Sequential, Focused Approach

For many organizations, taking a step-by-step approach to improving medical group performance and “tackling the basics” first is the most effective way to begin. For example, small practice changes that increase provider productivity (e.g., maintaining reliable clinical hours, leveraging nurse practitioners, effective template management, altering clinic workflows and monitoring critical performance metrics) can create meaningful improvements across key performance requirements. Each of these, done properly, contributes to a more engaged, successful and professionally satisfied physician community.

An initial focus on one particular “pain point” or opportunity area, such as patient access or revenue cycle, can be an effective way to engage the organization and build momentum, without overwhelming clinicians or administrative staff. Organizations initiating a targeted access improvement program, for example, can quickly achieve significant benefit (20-25 percent increase in patient visits is typical), and kick off an improvement journey across multiple areas and components. The access initiative may uncover opportunities in care team roles and responsibilities, leading to development of a new care model and new thinking around staffing requirements. These care model and staffing changes may lead to a reassessment of available resources and systems to support changes and to measure operational performance; which may in turn drive a review of dashboards and performance metrics and development of a more comprehensive performance monitoring and practice management capability. This type of targeted, sequenced approach is often the most effective way to create sustainable change across the organization and elevate performance.

As providers contend with the uncertainty of a shifting political, regulatory and payment landscape, they will undoubtedly face increasing market demands for improved quality, superior experience and lower costs. Confronting these challenges will require a new level of partnership between health systems and their physicians — one that drives value, engagement and performance for the patient, the provider and the community.
**Case Study**

A large Midwestern healthcare provider partnered with The Chartis Group to improve patient access by transforming its approach to primary care. Objectives included ensuring timely and convenient access for patients, redesigning care team models to provide the best support and leverage to physicians, and developing care coordination/care management capabilities to support population health. Leadership’s initial focus on patient access resulted in rapid improvements as described below, and the identification of additional areas of opportunity, including compensation models, financial reporting and operational control metrics. Through a targeted, sequential approach, the medical group is realizing performance gains across multiple dimensions and is building the organizational capabilities required for ongoing performance improvement and sustainable change. Involving physicians early in the process and establishing physician leadership roles were critical to success, as was a comprehensive change management approach that focused on effective communication and powerful engagement of physicians and staff.

**Achievements Include:**

- Advancement of the clinic care team model, including use of physician extenders to expand capacity; standardization of pre-visit, visit and post-visit processes; and consistency of administrative and staff roles;
- New processes and mechanisms to promote streamlined communication and knowledge-sharing between centralized scheduling, referral sources and clinics;
- Development of a care management model for primary care, methodology for segmenting patients into populations for clinical and care management interventions, identification of functions needed for each population, and the roles required to support these functions - all critical to medical group success in existing MSSP and ACO arrangements;
- Informed approach to the physician compensation model that is aligned with enterprise strategies and medical group performance expectations; and
- Implementation of new physician leadership roles, along with a dyadic management model.

**Results to Date:**

- Immediate 8,800 additional patient appointments per year, based on existing providers and staff for an annual financial impact of $1.5M.
- Increased visit volumes by over 7%.
- Longer term improvements identified to grow access by 28,000 visits annually with $5.7M annual impact (includes additional investment in staff and providers).
- Same day appointment availability to match patient demand and preference.
- Increased primary care patient capacity by a minimum of 15%.
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4 Based on the research and experience of The Chartis Group consultants
About The Chartis Group

The Chartis Group (Chartis) is a national advisory services firm dedicated to the healthcare industry. Chartis provides strategic and economic planning, value-based care, advanced performance, and informatics and technology consulting services and decision support tools to the country's leading healthcare providers. Chartis has been privileged to work with over two-thirds of the academic medical centers on the U.S. News and World Report "Honor Roll of Best Hospitals," seven of the 10 largest integrated health systems, four of the five largest not-for-profit health systems, nine of the top 10 children's hospitals, emerging and leading accountable care organizations, hundreds of community-based health systems, and leading organizations in healthcare services. The firm is comprised of uniquely experienced senior healthcare professionals and consultants who apply a distinctive knowledge of healthcare economics, markets, clinical models and technology to help clients achieve unequaled results. Chartis has offices in Boston, Chicago, Minneapolis, New York, Portland and San Francisco. For more information, visit www.chartis.com.

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