FIELD REPORT

DRIVE ENGAGEMENT, VALUE AND SUCCESS

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ABSTRACT: Medical groups are key to health system operations, the core of care delivery and the indispensable driver of success. With increasing size, scale and scope, today's medical groups wield greater impact on health care delivery than ever. Groups and leaders are critical to transforming care delivery to improve outcomes and affordability, yet many struggle to meet the increasing marketplace demands. This offers a comprehensive approach to assessing performance — to uncover improvement opportunities.

TODAY'S PHYSICIAN GROUPS ARE LARGER

and more complex than ever, and they face an increasingly challenging health care environment. Reimbursement rates are declining, operating costs are rising, and demands for improved performance — better clinical outcomes, more efficient operations, better access and capacity — continue to intensify.

Nearly a third of physicians work in groups of at least 30 physicians, while nearly 20 percent work in groups of at least 100 members.[1] Ownership and governance structures have changed, too. According to the American Medical Association, 2016 marked the first year in which fewer than half (47 percent) of practicing physicians owned their own practices. 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.[2]

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. Health systems confronting a shrinking reimbursement environment and heightened market demands for better quality, service and value no longer can absorb the negative financial effects of poorly performing medical groups. According to the Medical Group Management Association, median losses on hospital-owned multispecialty practices are $128,000 per physician,[3] and Moody's Investors Service has called physician employment "a principal driver of hospitals' margin pressure."[4]

It is no surprise that, for many health systems, improving medical group performance has become a financial and strategic priority. New approaches to medical group management that engage physicians broadly, and as leaders, in assessing group performance, developing and executing on actionable improvements, and sustaining improved performance, are urgently needed.

This article defines the key characteristics of an aligned, high-performing medical group and its potential impact on overall health system financial performance. It also describes an innovative framework for the comprehensive assessment of medical group performance that emphasizes physician and administrative engagement and leadership as key to improving clinical, financial and operational performance. It includes examples of improvement solutions and a case study of a Midwestern health system that has realized significant gains by employing a similar approach.

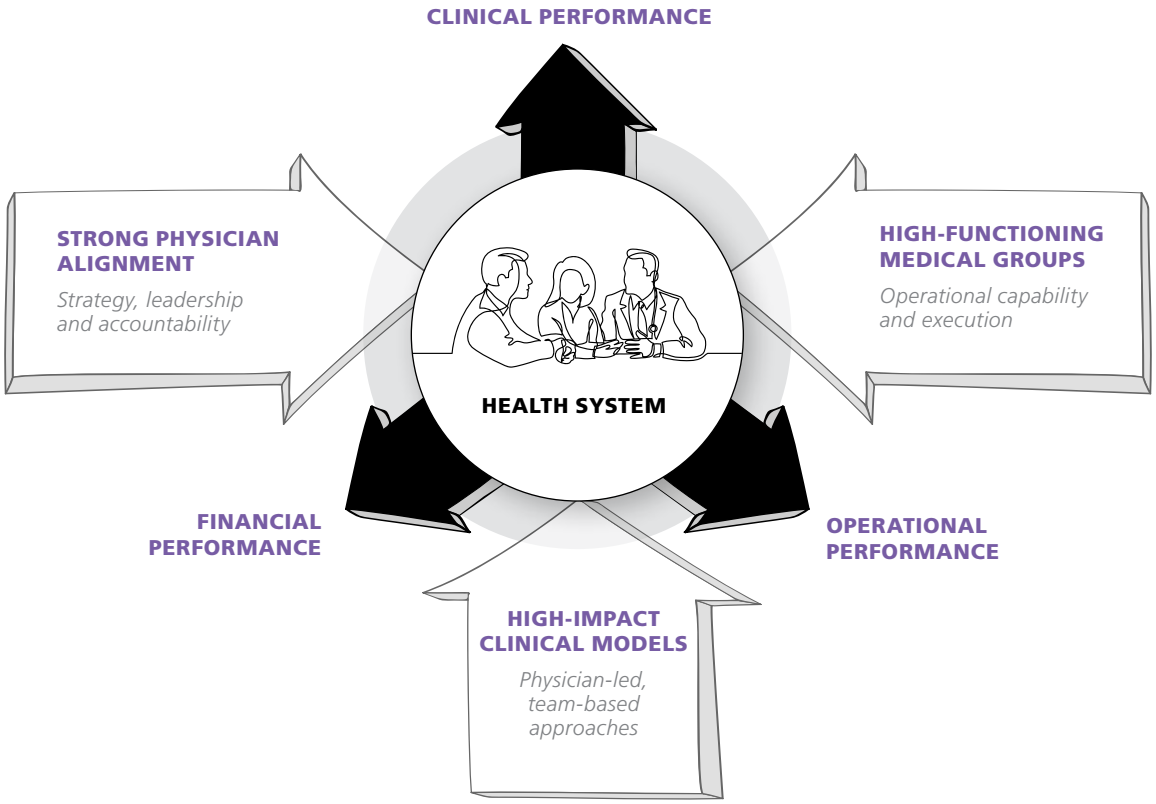
For the purposes of this article, we define "medical group" as a group of physicians requiring active management for a defined purpose, whether single specialty or multispecialty, faculty or community, networked or employed, in either ambulatory or hospital-based settings.

ALIGNED, HIGH-PERFORMING MEDICAL GROUPS

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 actionable solutions, 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 operational and execution arm of the

FIGURE 1: BEHAVIOR OF A HIGH-PERFORMING MEDICAL GROUP



enterprise strategic agenda — and critical to driving clinical, financial and operational performance *(see Figure 1)*.

High-performing medical groups have the following key characteristics in common:

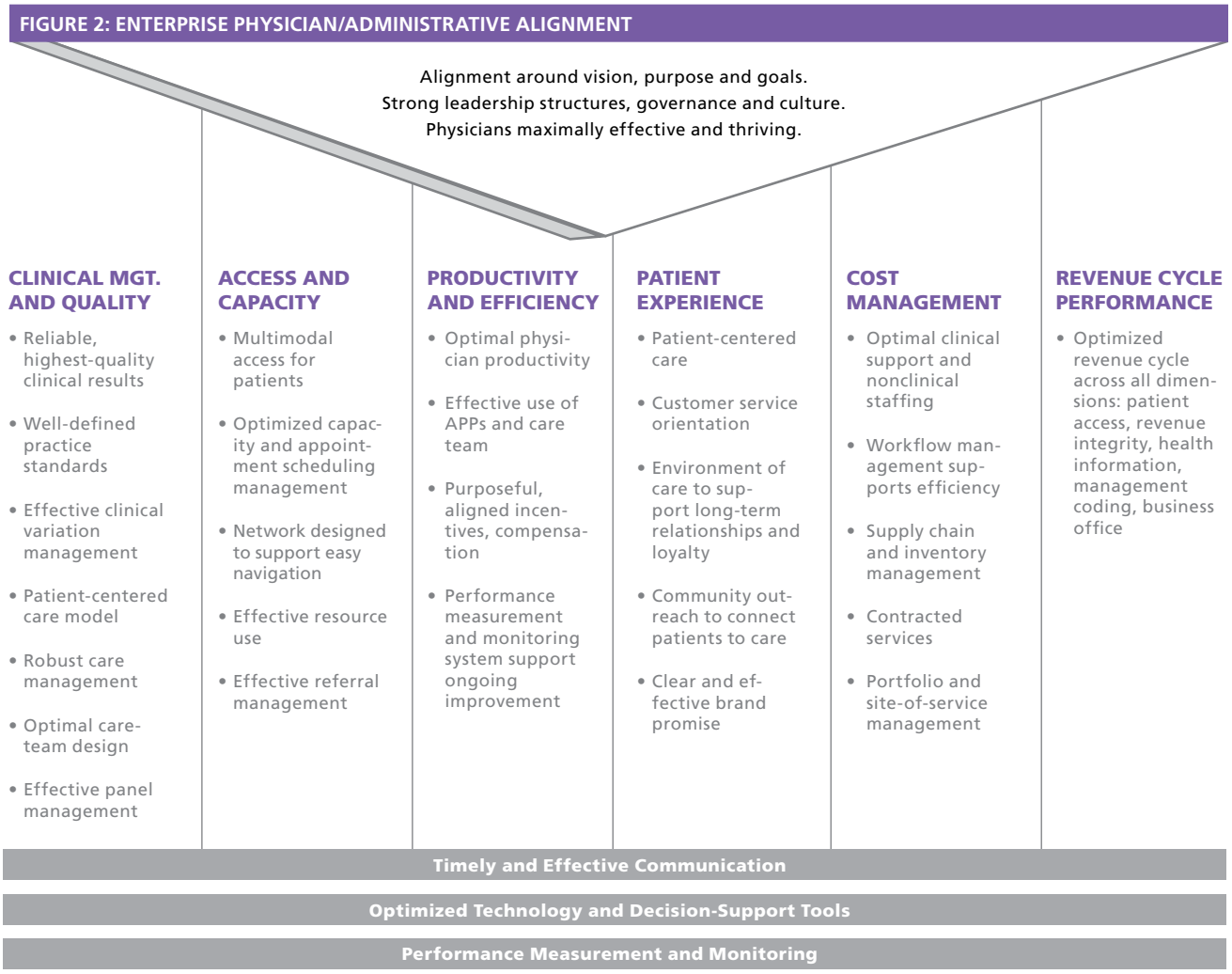
VISION, GOALS AND EXPECTATIONS

- Health system and medical group leadership share a common vision, goals and strategies. The purpose and performance expectations of the medical group are well articulated, understood by all, and linked to strategic goals for both the medical group and associated health system. Strategic plans are translated into actionable understanding such that all physicians understand what success is, what is expected of them and the group, and how their daily practice aligns with strategic requirements.
- 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. Practice dashboards are tightly focused on critical operational, financial, and clinical performance metrics of the medical group.

HIGH-IMPACT CLINICAL MODELS

- The medical group has top-quartile clinical quality outcomes and captures performance-based revenue incentives.
- The medical group has an effective quality and variation management program and manages to consensus-driven practice standards.
- Clinical care models support improved outcomes, reduced cost of care, success in value-based and fee-for-service payment models, and effective population health management.
- Care teams are purposefully deployed to assure all providers and staff work to the optimal use of their training and expertise. Team member roles and responsibilities are well-defined and integrate into a highly effective patient and provider experience.

FIGURE 2: ENTERPRISE PHYSICIAN/ADMINISTRATIVE ALIGNMENT



HIGH-FUNCTIONING OPERATIONS AND MANAGEMENT

- Patients access the right provider, at the right time, in the right setting to get the care they need. Access is multimodal and seeks to enable patient preference for how they wish to receive care. New patients are consistently seen within two weeks, and follow-up visits are accommodated within two days. Primary care panel capacity is actively managed and, together with new patient visit targets, aligns with both community need and strategic imperatives.
- 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. Electronic health records are configured and have proper workflows to enable physician efficiency and clinical effectiveness. Decision support tools are embedded into clinical workflows and easily support high-quality outcomes and clinical variation management.
- Medical group performance is effectively measured and managed using strong data management, analytics, and reporting and measurement of quality, cost and service metrics. Performance dashboards are used at the medical group, practice site, specialty and physician levels.
- Patient-medical group interactions support strong relationships and loyalty. Patients can access care when and how they desire. They find using the medical group to be a seamless, frictionless and well-integrated experience.

ASSESSING YOUR MEDICAL GROUP

Every medical group will benefit from a comprehensive review of its performance — how well it is meeting patient and health

system needs, and achieving medical group and health system strategic goals. The framework below *(and in Figure 2)* guides leaders through an assessment of the essential components of medical group performance to identify gaps and areas of opportunity.

- **Enterprise Physician/Administrative Alignment:** At the practice, medical group and network levels, are your physicians aligned with broader enterprise strategic goals? Are your physician leaders positioned as "owner-operators" of the clinical enterprise, with required management skills, training and experience?
- **Clinical Management and Quality:** Is your medical group producing the clinical outcomes necessary for top-quartile performance and success under value-based and advanced, alternative-payment models? Do your physicians actively establish practice standards and manage to them as a means to excel at clinical outcomes and cost of care management?
- **Access and Capacity:** Are your patients readily able to access providers and services when, where and how they want and need to? Are patients being referred to and seen by the most appropriate provider, in the most appropriate setting? Is provider capacity, both primary and specialty care, sufficient to meet community needs and health system strategic objectives? Is access to care managed and provided as a strategic market differentiator?
- **Productivity and Efficiency:** Is physician time optimized for care to be delivered effectively and efficiently? Are performance expectations clearly established and communicated? Are advanced practice providers used effectively with consistent roles, to enhance access, productivity and clinical effectiveness?
- **Patient and Family Experience:** Is care delivered in a way that builds ongoing patient satisfaction and engagement with the medical group and health system? 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?
- **Revenue Cycle Performance:** Is reimbursement optimized for all payers and patient segments? Does the medical group revenue model reflect anticipated changes in payment models, for both primary and specialty care?
- **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?
- **Optimized Technology and Decision-Support Tools:** Does the medical group effectively employ decision-support tools and information-sharing technology? Do the systems and tools in place empower both providers and patients? Is technology effectively embedded into workflows to enable efficient and rewarding physician experiences?
- **Performance Measurement and Monitoring:** Are expectations and goals for the medical group clearly and consistently defined, measured, monitored and communicated? Do leaders, physicians and staff understand the data provided, and do they know how to create change?

GETTING STARTED: A 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 — such as maintaining reliable clinical hours, leveraging nurse practitioners, effective template management, altering clinic workflows and monitoring critical performance metrics — quickly can create meaningful improvements. 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 (a 20- to 25-percent increase in patient visits is typical) and start an improvement journey across multiple areas and components.[5]

The access initiative might 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 might lead to reassessment of available resources and systems to support changes and to measure operational performance, which might, 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 focused, sequenced approach is often the best way to create sustainable change across the organization and elevate performance.

It also is critical for medical groups to define the operating standards that guide the behavior and expectations for their physicians. These standards should be established through a transparent and consistent process that enables them to serve as guardrails and management tools for physician performance. Standards should address all aspects of clinical care and operations including revenue cycle, patient access and capacity, productivity, efficiency and cost management, and clinical practice standards. For example, operating standards associated with access that are often helpful include the following:

FIGURE 3: STRATEGIC MEDICAL GROUP PERFORMANCE METRICS

CATEGORY	KEY PERF INDICATOR	FREQUENCY	DRILLDOWN LEVEL	EXAMPLE TARGETS
Patient Access	Actual panel size vs. target (PC only)	Quarterly	Physician/Care team	1,800 per MD, 1,400 per APP (18 months risk-adjusted)
	Pct. new patients seen within 2 weeks	Weekly	Provider/Care team	80%
	New patients seen	Weekly	Practice	115 points/week
	Schedule use	Weekly	Provider	90%
Provider Productivity	wRVU productivity	Monthly	Provider	MGMA median by specialty
Referral Management	Keepage/leakage volumes	Monthly	Provider/Specialty	85% keepage (controllable)
Financial Performance	Net revenue/expenses and net income, total, per RVU	Monthly	Practice	Budget
	Revenue-cycle metrics (specifics TBD)	TBD	TBD	TBD
Patient Experience	Patient satisfaction survey results	Monthly	Care team	Continuous improvement from baseline
Provider/Staff Experience	Provider in box volume	Monthly	Provider	

- Primary care panel size and associated risk adjustment methodology.
- New patient access requirements (for example, new patients being seen within two weeks of request at least 80 percent of the time) to be applied to primary and specialty care.
- Follow-up scheduling guidelines for patients with chronic conditions, including when it is proper to see a physician versus an advanced practice provider versus a care manager.
- Approaches to scheduling returning patients that enable scheduling within defined timeframes, while seeking to honor patient's preferences.
- Defined roles for medical assistants and registered nurses, implemented consistently and reliably across all appropriate settings.
- Performance dashboard, with consistent metrics to drive performance improvement, routine practice and physician management, and compensation incentives.

Medical groups should review their key performance indicators and dashboards to assure they are properly focused on outcomes linked to strategic and operational imperatives. Understanding those clinical, financial and operational results that must be achieved to reflect success as a medical group and health system is a critical, and often under-accomplished, step toward sustainability and market distinction. Reaching agreement on a limited set of metrics most critical to the medical group's success can, itself, enable market-differentiating performance.

The dashboard shown here *(see Figure 3)* provides an example of one focused on key strategic imperatives and the required performance expectations from an organization seeing significant improvement across its medical group performance.

A CASE STUDY

A large Midwestern health system had suffered a 15 percent reduction (approximately 18,000 patients) in unique patients served by its primary care physicians. Patient focus groups across a wide demographic spectrum revealed strong sentiments regarding challenges around access, convenience and attention to patient preferences. Primary care providers expressed a high degree of frustration with patient scheduling, staffing inadequacies and ineffective physician recruitment.

The health system used the described assessment framework and identified actionable opportunities to improve patient access by transforming its approach to primary care. Leadership sought to ensure timely and appropriate access to care; better support for physicians to focus on activities that require their training and expertise; and to develop population health capabilities, including better care coordination and management. Leadership's initial focus on patient access resulted in rapid improvements in appointment availability, capacity and visit volume, and identification of

additional areas of opportunity, such as compensation models, financial reporting and operational control metrics. Examples of the specific actions taken:

- Defined return-patient scheduling guidelines, and implemented a modified open-access methodology.
- Set specific targets for new patient visits on a weekly, monthly and annual basis.
- Revised schedule templates to reflect newly defined imperatives for patient scheduling.
- Redesigned and implemented new care team roles and responsibilities for medical assistants, nurses and care managers.
- Deployed a new primary care operations council and associated dyadic leadership structure based on a specific charter, defined accountabilities and performance expectations.
- Determined primary care panel management expectations and associated capacity.
- Began the journey of building a culture of transparency, trust, teamwork and shared accountability.

Through this targeted, pragmatic approach, the medical group is seeing significant performance gains and building organizational capabilities needed to sustain change.

Involving physicians early in the process and establishing physician leadership roles was critical to success, as was a comprehensive change management approach focused on effective communication and powerful engagement of physicians and staff. The health system came to understand that successfully engaging physicians required clarity of the "why" message: "Why now? What are the market pressures? How do we envision addressing these pressures? How do the proposed changes affect me?"

Physicians needed a description of the "what," including a description of the destination and the journey to get there. Often, leadership jumps too quickly to "how" a change will be made. Physicians are much more likely to engage, support and participate in change initiatives when they fully understand the "why" and the "what" first.

The health system made a genuine commitment to physician leadership, associated decisional authority, and ways in which physicians would meaningfully affect critical operational decisions. Physicians were positioned as owner-operators of their practices and the medical group through a new primary care operations council, new regional medical director roles, enhanced roles and professional development of site medical directors, and improved data reporting that included a new performance dashboard. Achievements included:

- Advancement of the clinic care team model, including physician extenders to expand capacity; standardization of previsit, visit and postvisit processes; and consistency of administrative and staff roles.
- New scheduling guidelines and templates that support new operating standards for patient access, patient growth, panel capacity management and referral management.
- 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 some existing arrangements.
- Physician compensation model aligned with health system and medical group performance expectations; new physician leadership roles and a dyadic management model.

Highlights of the results to date include:

- Immediate 8,800 additional patient appointments a year, based on existing providers and staff for an annual financial impact of $1.5 million.
- Increased visit volumes by more than 7 percent within the first three months; longer-term improvements identified to grow access by 28,000 visits annually with a $5.7 million annual impact (includes additional investments in staff and providers).
- Same-day appointment availability now matches patient demand and preference, with 90 percent accommodated.
- Third-next-available chronic care follow-up visits improved from four days to two.
- Increased primary care patient panel capacity by a minimum of 15 percent across all practices.
- Significantly improved success with physician recruitment, adding 26 new primary care physicians; provider feedback shifted from "We need more providers" to "We need more support staff."

As health systems and medical groups contend with an ever-changing political, regulatory and payment landscape, they will continue to face market demands for improved quality, superior experience and lower costs. In many respects, future success for medical groups and health systems is becoming all about access and affordability.

Confronting these challenges requires a new level of partnership between health systems and their physicians — one that drives value, engagement, physician leadership and accountability for performance. Only by optimizing medical group clinical, financial and operational performance, and aligning physician leadership around these imperatives, can health systems and physicians together position themselves for success.

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