Growth Spurt

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Featuring Melinda Cannon, M.S., Wendi Fish, M.B.A., CPA, and Rose Wagner, RN, M.H.S., FACMPE

Medical group transformation through practice optimization

Even the country's finest, high-performing health systems—organizations that seem unassailable in their operational and clinical capabilities—strive to improve themselves. Recently, Virginia-based Valley Health Medical Group (VHMG) experienced a period of rapid and significant growth. Looking to determine whether there were opportunities to enhance and develop its performance further, the group embarked on a comprehensive operational and financial gap analysis assessment, undergoing a robust evaluation in the areas of revenue cycle, provider compensation and productivity alignment, clinic staffing, and operational expense structure.

Once the gaps were identified, VHMG created a Transformation Workgroup focused on three main areas: operations and structure, finance and revenue cycle, and provider compensation and productivity. During the AMGA 2020 Virtual IQL Conference, VHMG's Corporate Director of Practice Operations Melinda Cannon, M.S., and Director of Finance Wendi Fish, M.B.A., CPA, joined AMGA Consulting Chief Operating Officer Rose Wagner, RN, M.H.S., FACMPE, discussed the group's transformation and optimization journey.

Assessments for Adjustments

Fish began the presentation with an overview of VHMG's exponential expansion. In just a four-year period, from 2016 to 2020, the "cute little medical group," as Fish described it, grew from approximately 27 practices to 60, with more than 20 specialty offerings and 280 providers. In addition, it experienced a 50% increase in patient encounters and a 226% increase in net patient revenue. Looking to optimize performance under this new, wider organizational umbrella, VHMG sought out AMGA Consulting to conduct an unbiased, comprehensive gap analysis of its medical group's finance and operations.

The first stage of the assessment was the measurement of VHMG's performance through benchmarking the medical group against national metrics. Going from clinic to clinic and breaking data down by specialty, they examined staffing ratios, compared expenses line item by line item to the industry benchmark, and measured variation—not just the organization compared to the national standard, but also the variation from clinic to clinic. Volume adjustments were applied through appropriate metrics (i.e., work RVUs, panel size, patient visits).

"I think the most important part, once we had the findings, was to develop an action plan and assign authority, accountability, and responsibility," said Wagner. "Authority means that I have the ability to make decisions. Accountability says I'm accountable for the actions and the outcomes. And responsibility is that it's been assigned to me and is clear. A lot of organizations get these mixed up. They may assign responsibility to someone who doesn't have accountability over an area, or they may assign accountability to someone who doesn't have the authority to make the change. So, it's really important as you put your action plan together to assign these categories. I really believe this is probably the single most important piece of the whole process."

The next phase was to conduct a detailed financial analysis of VHMG's net revenues and expenses. In addition to an internal billing office run by the hospital revenue cycle staff—as opposed to a medical group revenue cycle staff—VHMG had three different outside billing vendors, as well as seven different electronic health records.

"You can imagine how difficult that must be to manage in that situation," said Wagner. "As we dug deeper into the revenue cycle, we found that there was some lost revenue due to denials and there were variable upfront collections from clinic to clinic. Another important issue was that there was limited communication between the business office and the clinics, and there weren't a lot of standardized processes."

Looking at the net revenue, VHMG's performance compared to the national benchmark was under the median by a considerable

Figure 1

Workgroup Focus Areas

Operations and Structure

- Clinic:staff ratio
- Sites and size; scheduling
- Practice optimization
- Practice management structure and consolidation
- Volume-based staffing
- Expenses

Finance and Revenue Cycle

- Reporting
- Internal vs. external billing office
- Epic integration
- Contract management

Provider Compensation and Productivity

- Clinic:staff ratio
- APPs, M.D.s
- APC:M.D. ratios
- Clinic contact hours
- Patient panel

amount. The net revenue data was further broken down to per work RVU by specialty and then further between the rural health clinics and non-rural health clinics. This allowed the medical group to zero in on specific areas.

Turning to provider productivity, the analysis found that there was variable alignment of productivity and compensation across the medical group. Data showed that a large number of providers were below the median for productivity. Most organizations strive to reach the 60th percentile for work RVUs just to make the medical group financially viable, and VHMG had an opportunity to better align compensation with productivity and close the gap that was identified. There were also a significant number of advanced practice providers (APPs) who were not producing at median, which spoke to the need to implement production targets and establish hiring guidelines and criteria for physicians and providers.

In regard to VHMG's care model, the assessment found that there was wide variation in staffing models, even within like specialties, and approximately 20 practices had two or fewer providers.

"We know it's very costly to run those small practices," said Wagner. "It also just makes it hard to operate when you have so few providers at a location."

For VHMG's overall clinic staffing, data showed that 30% of employed clinics were staffed above the median in the back office, and about 80% of clinics were above the median in the front office. At leased clinics, on the other hand, 80% were staffed in the back office below the median, and 70% were above the median in the front office. Taking into account positive and negative variances, bottom line metrics showed that VHMG's back offices were understaffed by about 43 FTEs, and its front offices were overstaffed by about 70 FTEs based on volume and specialty. The low back office staffing may have contributed to the lower provider production. A portion of the front office overstaffing was related to the small practices, with two or fewer providers, which require a minimum number of front-office staff.

Finally, AMGA Consulting addressed the numbers around VHMG's overall finances. Gathering the dollar amounts of physician salaries, medical receptionist salaries, medical and surgical supplies, drug supplies, building and occupancy expenses, as well as other expenses and revenue opportunities, a total opportunity of approximately $12 million was identified. VHMG further analyzed and evaluated what they felt was achievable and identified a target of $3.7 million (or approximately 30% of the total opportunity) in the first two years. "While the numbers are large, what we typically see is that during a build-up/acquisition phase, there are financial implications that, when analyzed more closely, typically produce an opportunity consistent with these findings," said Wagner.

Consequential Changes

In the wake of AMGA Consulting's findings, VHMG initiated the development of a Provider Advisory Group to provide input and make decisions toward a formal action plan. The Provider Advisory Group then moved forward by assigning targets of improvement across three categories: finance and revenue cycle, operations and structure, and provider compensation and productivity. Within operations and structure, they assessed clinic staffing ratio, practice optimization, practice management consolidation, expenses, site size and scheduling, and other factors. On the finance and revenue cycle side, they looked at reporting, the dichotomy of internal and external billing offices, the integration of Epic practice management system, and contract management. Finally, delving into provider compensation and productivity, VHMG reviewed clinic

staffing ratios, the number of APPs and M.D.s, clinic contact hours, and patient panels (see Figure 1).

Within each of these areas, changes and new strategies were applied through communication, education, and training, as well as refined data management and reporting, all resulting in significant outcomes.

In regard to the organization's revenue cycle, VHMG established an official Revenue Cycle Operation Committee, as well as an entirely new position, Director of Revenue Cycle and Practice Operations. Monthly key performance indicator (KPI) reports were developed in order to best track and align operations and revenue cycle numbers with benchmarks. VHMG has also begun the process of populating payer contracts into Epic, which will allow the organization to evaluate if they are getting exactly what is stated in a given insurance contract. Finally, they have also begun the consolidation of medical group billing to a single source.

Turning to operations, VHMG adopted a medical group, volume-adjusted staffing model, utilizing AMGA's productivity model, which is work RVU-based. They also restructured operations management to align with the medical staff. Utilizing a dyad model by region, VHMG advanced a number of operations managers to director positions and then created positions for medical directors for collaboration and support in the day-to-day operations of the medical groups. They also created a number of new roles, including an associate medical information officer, a clinical informatics director, and an APP director.

Looking to improve access, VHMG made the move to centralize scheduling. Beginning with primary care, the system began optimizing slot utilization, standardizing appointment types, and building schedules to increase patient access and assist providers in meeting productivity targets. Practice proficiency was also addressed, primarily by combining practices within one mile of each other. The group is also evaluating bringing together practices located on the same campus.

Coinciding with all of these changes were staffing model considerations. "The reason that we wanted to go throughout the year was we didn't want to start jumping in and making staffing adjustments as productivity decreased or increased quarterly," said Cannon. "We wanted to evaluate a year in and then plan to adjust based on where we ended up. We are hoping to put processes in place that will help us improve our performance and productivity measures." VHMG has already started looking at utilization within the practices, examining slot utilization, market share (primary and secondary), capacity by provider, and capacity by practice.

Lastly, VHMG directed its efforts towards compensation. To effectively recruit individuals across geography, service lines, and provider types, the larger health system established an official compensation committee, drafting a charter, philosophy, and guiding principles. From there, VHMG sought to optimize the alignment of provider compensation with productivity, setting target expectations with a shift to the median. They also began to accommodate for onboarding and ramp-up phases. They additionally created an APP compensation model that rewards productivity and allows for an earned incentive. Finally, they have begun work on a visual dashboard for monitoring and tracking performance.

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— Melinda Cannon, M.S.

"We've always given our providers monthly production reports showing where they stand, but we never really put it into a visual where we say, 'Here's your threshold, here's the benchmark data, the median, and here's where you're performing each month,'" said Cannon. "But it's just a matter of having them be a part of that conversation and seeing it monthly and knowing that if something doesn't happen, they're going to experience a decrease in their compensation."

In light of the various changes and adjustments VHMG has made in the wake of its consultation, Cannon says the organization has recognized a number of important lessons in the process. In addition to establishing a vision for its leadership, the organization came to understand that "what gets measured gets managed" and that cohesion is created through collaboration.

"With such rapid growth, you have to have some way to look back and make sure those practices got up and running, and that we're meeting the measures that we projected," Cannon concluded. "It's about collaborating more between departments to be able to evaluate how we're doing and how it looks moving forward." GPJ

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