nthrive®

Physician Analytics

Leverage data to improve physician practice profitability

Produced in Partnership with MGMA®

Seeing red? Leverage data to transform your physician practices

As the healthcare industry continues to move toward an integrated healthcare delivery model, more and more organizations own physician practices, representing a fundamental shift from the traditional private practice model. While this employed physician trend is only expected to continue, it hasn't been an easy transition for doctors who work in hospital-owned groups or organizations that own and manage these facilities. Many healthcare organizations report substantial yearly losses per physician and expect a red number related to physician group profitability on their income statement.

The flip side is that physicians greatly contribute to hospital profitability in other ways, often bringing in millions in net revenue to their health system beyond what they generate through their practice. For instance, a cardiologist, on average, has been shown to bring in an additional of $2.5 million in net revenue to their health system through referrals and ancillary services. Understanding and accounting for total physician value is important to determining a physician's overall net worth to an organization.

How can you accurately value and manage your practice while also implementing operational improvements to improve profitability? Analyzing physician data is a great place to start. Knowing the rights metrics –and how to interpret them—can help you gain a clearer picture of total contribution while also allowing you to benchmark against key performance drivers to reveal root cause productivity and efficiency problems. Once you've uncovered the gaps, you'll be well on your way to building a data-driven playbook for sustainable improvement that leads to greater financial health.

PHYSICIAN ECONOMICS TODAY

- The number of **doctors in the U.S. totals approximately 1.1 million**, with 827,261 in active patient care practice[1]
- Between July 2016 and January 2018, hospitals **acquired 8,000** medical practices and **14,000 physicians left** private practice[2]
- The number of hospital-acquired physician practices **increased from 35,700** in 2012 **to more than 80,000** in 2018[3]
- **Forty-four percent of U.S. physicians were employed** by hospitals or health systems by January of 2018, compared to just one in four in 2012[4]
- **20% of physicians practice in groups of 101** doctors or more, up from 12% in 2012[5]
- Most hospital/IDS-owned **practices lose money**, with the median losses per full-time equivalent (FTE) physician ranging from about $150,000 to $400,000[6]

[1] Statista | [2,3,4] Physician Advocacy Institute | [5] The Physicians Foundation | [6] MGMA

COMPUTING TOTAL VALUE

There's a reason why the vast majority of today's hospital CFOs are seeing red at the bottom of their income statement for employed physician practices and it is as much an accounting issue as an operational one. Physician practice performance is often reported as a loss because most organizations strip out the ancillary revenues related to employed physician groups, accounting for those revenues somewhere else. This accounting error often shows an increase in cost, at least on paper, reducing the way that a physician practice performs relative to its own income statement.

When calculating for value, the picture is often quite different. Yes, a cardiologist may lose an average of approximately $200,000 per clinical FTE. However, they might also bring in an additional $2.5 million in net revenue outside of their practice in referrals, services, and supplies that are recognized as revenue for the healthcare system.

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Looking at a physician practice by itself and not within the context of the overall healthcare delivery model presents a very skewed perspective on how the practice is performing, ultimately resulting in the all too familiar big red loss number. Aggregating all the data together–a not so daunting task utilizing today's analytics technology–often reveals a profitable service line that could likely go from good to great with workflow and process improvements.

WHAT CAN BE IMPROVED?

The logical question any CFO typically asks is, "What can we fix?" Ruling out variables you can't fix, like payor mix, especially for safety net providers in large urban markets, any organization can maximize their potential by examining these top three key barriers related to improving physician performance:

1) Access to patient data

Many organizations still struggle to capture accurate information on the performance of their physician practices, often because they simply don't have the resources to extract the required data and turn it into actionable information. Unfortunately, The Health Information Technology for Economic and Clinical Health Act (HITECH Act) did not mandate physician practices to adopt Electronic Health Record (EHR) systems in the same way as hospitals, making it difficult to aggregate and analyze practice results.

2) Multiple EHR and billing platforms

With acquisitions often come multiple EHR and billing platforms. It is not uncommon when acquiring practices and employing doctors to inherit multiple information systems. In a typical scenario, the main hospital could be on one platform while physician practices may be on any number of others. Integrating the platforms can be challenging as organizations may not have access to all the data in a way that is consistent and accessible. Each system may capture and report data elements a little differently, making an apples-to-apples comparison tricky.

3) Lack of definition on what performance looks like

Performance can be a moving target for healthcare organizations, especially those that are new to managing physician practices. For instance, if a health system only looks at the bottom line of a physician practice, it will miss a lot of key variables inside. Compounding this is a general expectation that physician practices in an employed model are expected to lose money. **Those that assume a loss actually set themselves up for failure because:**

- **Even if the physician practice is performing optimally, resources and stresses may be placed on the practice, incurring unnecessary additional cost, or**
- **Losses are ignored and no one does anything to create efficiency gains**

Setting such a low bar can also make it a struggle to understand what metrics are important, especially if there is no consistent definition on what to measure. For instance, an organization may want to count patient encounters, only to find multiple industry definitions, all valid, on what a patient encounter inside a physician practice should be. **If you've got multiple definitions within the same organization, here are just a few questions to explore before deciding where to focus:**

- **What metrics are most important to track?**
- **What will actually drive value?**
- **What benchmark or target should your organization use?**

WHAT CAN BE IMPROVED OPERATIONALLY?

The most valuable and important asset in any practice is the provider's time, with schedule barriers representing some of the most common impediments to increasing patient access and provider productivity. The schedule should reflect how a provider's time is budgeted, managed and accounted for. **Here are some key requirements to successful schedule management:**

- **Maximize the provider's productive time**
- **Eliminate waste**
- **Delegate time management to support staff**

To help identify many of the most common scheduling barriers in hospital-based practices and surface opportunities for quick wins, long-term solutions, and high-impact changes, seek answers to these top three questions:

1) Does the provider's schedule align with the number of encounters necessary to bring them to the 50th percentile or budget?
2) What are the slot lengths in their schedule?
   Are the slot lengths appropriate for the type of patient visit?
3) What is the no-show, same-day cancellation rate?

Provider behavior and contractual barriers can also present challenging, complex, and impactful impediments to provider productivity. Behavioral choices and contractual limitations deeply impact three other barrier types, including:

- Schedule
- Practice
- Market

Assessing and addressing these barriers requires collaboration between network operations, finance, and legal teams, working closely together to identify where these barriers may exist and how they can best be removed. **Here are the top three questions to ask to help isolate the most widespread provider behavior and contractual barriers:**

1) Does clinical FTE and compensation align with contractual expectations?
2) Is the provider audited regularly for coding compliance and optimization?
3) Is every provider being used to the maximum level of their licensure?

Other operational practice barriers can also hinder provider productivity and adversely affect the patient experience. From the time the patient schedules their appointment to the time they leave the practice there are multiple potential barriers that can range from office staffing to having enough rooms for providers to see patients. **Not every practice situation is the same, but the following questions will help you to identify many of the most widespread practice barriers:**

1) Are there sufficient patient rooms for all the providers in the practice?
2) Does the office layout inhibit patient flow or cause the provider to move unnecessarily?
3) Are all clinical staff being used to the highest level of their licensure?

MARKET BARRIERS

Market barriers also should be considered, as they can result in how a provider acquires new patients, grows their practice, and gains referrals from other network providers. Some market barriers will require input from an internal marketing function to create and implement action plans. **The following questions can help identify many of the most common market barriers healthcare organizations face today:**

1) Is there enough patient volume in the geographic area to support the number of providers? (excess supply of physicians)
2) Is there an adequate number of providers to support the patient volume in the geographic area? (excess uncaptured patient demand)
3) What is the ramping expectation for a new provider and is that ramping expectation clearly communicated to the provider?

ANALYTICS: THE JOB TO BE DONE

Once an organization has done its due diligence to understand barriers related to physician performance, the next step is to effectively deploy analytics to help measure, improve, and communicate that performance. While this may sound straightforward, organizations often miss one or two of these steps, most often leveraging analytics as a tool to communicate the numbers based on monthly close cycles and other traditional requirements. While analytics can improve the accuracy and efficiency related to getting reports out on time, this is just a small piece of its overall value.

Beyond communicating, organizations should be asking, "How are we doing? Are we okay?" To arrive at the answer requires measuring specific metrics, benchmarks, and budgets, ultimately arriving at what you are measuring against. For instance, if you have 10,000 work RVUs, is that good or bad? If it puts you in the 20th percentile, there's a lot of room for improvement.

Unfortunately, a lot of organizations don't use this analysis to improve performance, often because they don't have the internal capability to extract the data and make the necessary comparisons. Technology is a key enabler to pull and aggregate data, as is expertise to interpret it.

For those with data analysis capability, the next and hardest step is change, addressing workflows and turning them into work plans, actions and activities that lead to positive, sustainable gains.

If you are measuring and communicating performance, but your people aren't focused on improvement, you are wasting time in terms of data extraction, report building and other activities. A good analytics report should not only tell you how you did and measure performance against something, it should lead you to the next step, ultimately getting to the root cause of a problem.

Root cause analysis happens when you discover and change what is causing the problem. Your analytics tool should be set up in a way that guides the operator through this process, drilling down to the root cause to change something that will lead to performance improvement.

Getting beyond communicating and measuring performance improvement is where industry often misses the boat relative to data utilization. Understanding that it is an iterative process is important to achieve continuous improvement.

10 MEASURES FOR SUCCESS

Utilizing the "measure, improve, communicate" approach is further enabled by focusing on 10 key revenue and cost gaps to identify opportunities and interventions. These can be grouped as volume, revenue, and cost drivers to help focus analysis and improvement efforts.

VOLUME DRIVERS:

- **Physician productivity** – visit and procedure volume relative to benchmark
- **Visit coding** – coding patterns of patient E&M visits relative to benchmark
- **Procedure utilization** – procedure acuity relative to benchmark

REVENUE DRIVERS:

- **Revenue cycle** – efficiency and effectiveness of billing and collections
- **Rates** – commercial rates relative to benchmark
- **Payor mix** – Composition of payor sources relative to benchmark
- **Charge Master** – Charge Master optimized to contracts

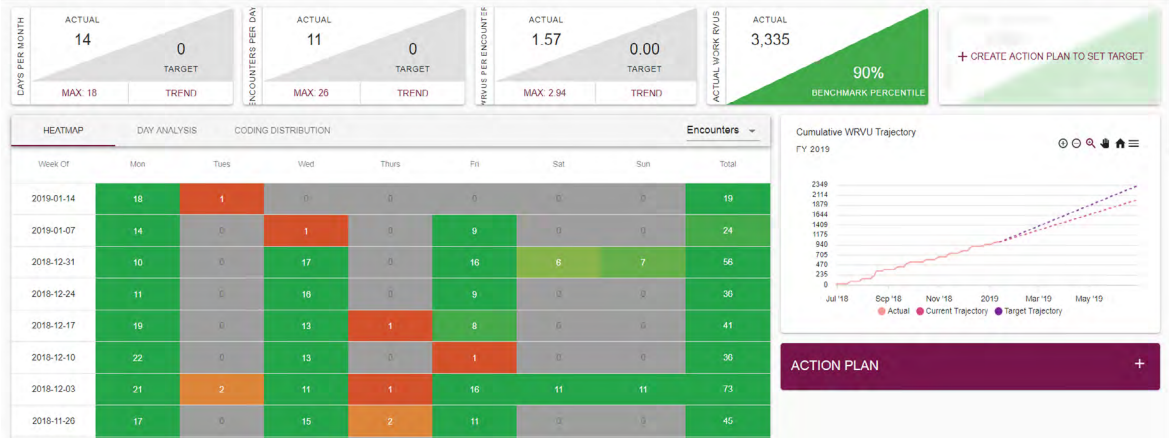
COST DRIVERS:

- **Overhead/labor cost** – Labor costs relative to benchmark
- **Overhead/other cost** – Other costs relative to benchmark
- **Compensation** – Provider compensation relative to benchmark

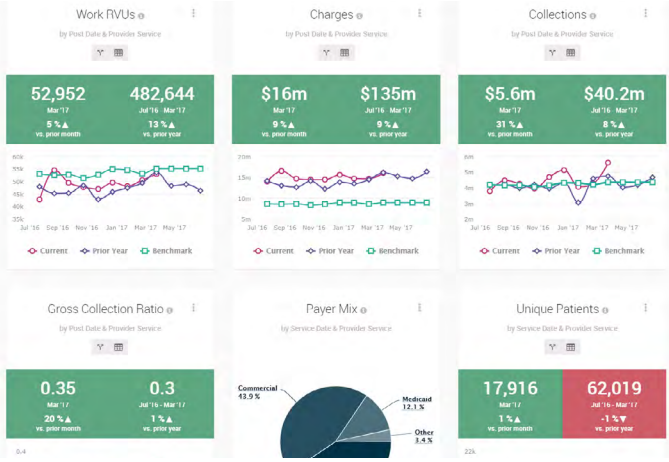
Analytics can help aggregate physician practice billing, payroll and financial data across the economic drivers for all physician and physician groups across a healthcare system. Organizations can detect root cause issues related to productivity, visit coding, utilization, Charge Master, Payor mix, rates, revenue cycle, staff and other costs, as well as physician compensation. Quantifying individual performance gaps informs development of an improvement action plan to enhance physician revenue through increased operational efficiency.

IMPROVING OPERATIONS WORKFLOW

A typical operations workflow (below) provides a visual representation of actual versus targeted performance, helping organizations monitor action plan progress.



These dashboards of performance metrics can be broken down further to show aggregate performance and overall financial impact.



Status dashboards can also help to open the lines of communications, especially with physicians, to gain buy-in and support.

CASE STUDY: REAL-WORLD PERFORMANCE

Applying the principles covered in this discussion may seem like a daunting process, especially for systems with multiple physician practices. However, consider the success achieved by one of the nation's largest multi-institutional healthcare delivery systems, which has 92 hospitals and 107 continuing care locations. Initially, its leaders set out to create a single data structure, aggregating and pulling data from 62 disparate billing systems. From there they recognized the need to have visibility into the performance of a subset of the organization's employed provider network, specifically monitoring productivity, visit coding, expense management and provider compensation across three practices. Determined to make reports a standard part of business operations, they established and maintained action plans by practice managers for all underperforming providers.

With leadership approval, they scheduled virtual group training sessions for directors and practice managers, providing materials to support users on their journey to proficiency using analytics tools and reports. By maintaining up-to-date data, the team was also able to utilize customizable reporting functions to report on residency performance and other key metrics supporting their medical group's operations.

Today, the leadership team frequently uses analytics technology as its standard business intelligence tool to drive performance improvement, conducting monthly guided conversations with practice leadership and physicians. Data reports drive everything from compensation discussions to coding compliance and contract reviews. A physician network governance committee also uses reports to review and analyze performance on the nearly 90 physicians included in their database.

Monitoring and corrective actions have resulted in:

- 15% reduction in loss per physician
- 30% improvement in productivity (RVUs)
- 20% improvement in schedule density
- Increased cost savings due to coding index visibility and retraining/education initiatives
- Improved provider efficiency and alignment with contracted hours
- Increased revenue capture due to coding and documentation compliance improvements and reduced charge lag

Despite 62 disparate data systems resulting from years of multiple acquisitions, the system has successfully consolidated physician practice data, giving administrators the ability to monitor performance and make improvements in quality, productivity and profitability. Regarding their implementation of nThrive analytics technology, a Vice-President of Operations at the hospital system said, "The responsiveness of the nThrive team was a key factor in pulling together disparate data sources across the hospitals. This and the timeliness of data have helped us make decisions faster."

HOW TO CHOOSE AN ANALYTICS SUPPLIER

To achieve this level of performance, it is important to pick a partner with the expertise and technological capability necessary to aggregate disparate data sources across the enterprise into a standard analytics package, enabling everything from reporting to root cause analysis, workflow optimization, and monitoring of key metrics via easy-to-use status dashboards.

Offering more than just software, an effective partner should work with leaders across the organization to understand and drive value out of the data, resulting in sustainable improvement and increased revenue.

During the vendor selection process, here are the top 10 questions to ask before engaging with any analytics supplier:

1. Does your company utilize the latest, cloud-based analytics technology?
2. Do you have experience working with hospitals and healthcare systems?
3. Do you have experts that can help leverage data to quantify the root causes of physician practice financial losses?
4. Can you aggregate data across disparate databases?
5. Do you have expertise in workflow optimization? Can you help turn workflows into work plans, actions and activities that lead to positive, sustainable gains?
6. What metrics do you recommend for identifying physician performance opportunities?
7. How do you quantify individual physician performance gaps based on revenue and cost drivers?
8. Can your platform create and distribute customizable, data-driven reports to all applicable stakeholders?
9. What is your implementation cycle time? Can you implement in 60 days?
10. What is your long-term growth strategy and technology roadmap?

With the right analytics vendor, healthcare organizations can better manage their physician practices, turning the numbers on their income statement from red to black. Combine this with more accurate accounting on physician value and the employed physician practice model can help improve margins and become a significant contributor to overall revenue growth.

AUTHOR

Kyle Kobe is the Vice President of Consulting and Analytic Services at nThrive. Kobe is an authority on the measurement, planning and improvement of the physician economic enterprise, including group practices and clinics, academic centers and faculty practice plans, and hospital-based & employed physicians.

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