Why Your Maternal Fetal Medicine Program Underperforms:
Four Lessons from the SMFM Practice Assessment Program

Part 1: An Introduction

If your practice, department, or division has experienced financial stress or come under scrutiny by your parent organization over the past two years, you are not alone. The COVID pandemic has impacted financial performance nationally due to challenges created by restricted patient access, elective surgery suspension, overrun capacity, and staff shortages. The resulting havoc created upon strategic, operational, and financial management has led to self-examination of all subspecialties, putting Maternal-Fetal Medicine (MFM) performance squarely in the crosshairs of ROI evaluation. The challenge in this examination centers around the many care delivery factors that contribute to the mission, clinical financial performance, and community need for the specialty. Assessing the ROI for quantitative and qualitative performance is difficult to perform. How does one establish markers of expected performance for a small, geographically dispersed specialty, operating under diverse business and clinical models? What consideration should be given to drivers such as organizational mission, market share, and health of your community in determining ROI? From a financial analysis perspective, what value should be placed on downstream revenues, global payments, carrier contracting considerations, and unprofitable services that benefit the community but not the practice's Profit and Loss Statement (P&L)?

For the past 7 years, Affina MFM Consulting LLC has been working with the Society for Maternal-Fetal Medicine (SMFM) and its member physicians to better understand the true value of their programs through its Practice Assessment Program. Consisting of on-site operational observation, statistical analysis, and discussion with physicians and administration stakeholders, the program’s goal is the creation of management alignment in strategy, performance benchmarks, and a blueprint for initiatives in attainment.

So, what lessons have been learned from "high and low performing" solo practices, health system owned, and faculty practices throughout the country? What differentiators were observed between high and low performers?
The first, and most critical - practices viewed as high performing by their owners operate in alignment with the goals of the mission and strategy set initially by all stakeholders. Using a rough analogy to shopping for a new automobile, if your desire is a high-performance sports car, a compromise is accepted in expectation of a smooth ride and fuel economy. This compromise, along with option choices such as entertainment system, seating, passenger, and trunk capacity, is considered versus budget to determine the value proposition that motivates purchase. This analogy can be compared to the decision process for the MFM practice in which determining investment commitment to support care strategy ranging from the scope of practice services to the size of the waiting room becomes a potential tradeoff to profitability.

The second lesson is that high-performing practices have the tools to proactively plan for, and quickly react to, three factors that affect performance: clinical efficiency, financial return, and community loyalty. In the second installment of this White Paper, the operational components of these factors will be focused upon in detail, as they create a matrix of decision options based on these three environmental factors.

The third lesson is that these practices create and nourish a collaborative, communicative culture in which practice performance becomes the priority. In examining statistics regarding client motivation for participation in a Practice Assessment, over 85% were for operational and strategic related issues for which the practice was challenged in resolution. Operational areas of scheduling templates, billing, market share, staffing models, recruitment, and leadership were some of the leading topics of investigation. Observation of these practice management components revealed that they have at their root cause of underperformance the inability of stakeholders to communicate, advocate and collaborate due to poor organizational culture. Distrust, self-interest, and lack of organizational loyalty blocked the teamwork needed to move the practice forward, and isolated departmental groupings (Ultrasound, Genetics, Nursing, etc.) from participation in achieving the divisional mission.

Two additional points were observed:

1. Efforts to drive efficiencies in an unhealthy culture through policies and procedures were often perceived as punitive to force collaboration. Once an unhealthy culture is created, repairing it requires an objective voice to advocate, "deliver the mail" between stakeholders, and objectively counsel all participants in rebuilding trust and collaboration.

2. Without a committed effort by all stakeholders to a collaborative approach in optimizing care to its served population, resolution of operational issues most often provided a short-term fix but not sustainable optimal practice performance.
The fourth lesson is that high-performing practices provide a clear and safe communication path for all levels of stakeholders to create objective advocacy. The challenge to creating this communicative culture differs depending upon the complexity of the practice's setting. The private practice will typically have a flatter management structure, creating a shorter communication chain as opposed to the healthcare system acquired, or faculty-employed practice, in which many layers of management exist.

Over the past decade, healthcare systems have struggled with the strategy of integrating acquired independent specialties into a large medical group employment model. Management of these ambulatory settings has been a departure from the historical mission of providing beds and surgical settings to the independent referring physician community. As market share became the overriding concern for these institutions, fierce competition developed to buy referral sources at inflated values. Management tools and support staff expertise were unable to be developed at the pace of acquisition, and practices were often left to operate as they had before the acquisition. Over time, the economics of overpayment for practices and the inability to evaluate operational needs (through specialty-specific and peer-specific benchmarks) led to misalignment and a lack of collaboration between administration and providers. Mid-level Operations Directors, often with insufficient experience in the management of the specialty, were left to “deliver the mail” between administration and physicians, negotiate need requests, and manage operations (along with other specialties with different needs), The optimism for contribution at the time of acquisition was often replaced by communication breakdowns and distrust on the part of stakeholders.

Faculty practices face different operational challenges regarding drivers of physician and administration dissatisfaction, communication breakdown, and lack of advocacy. Mission, educational responsibilities, and clinical models differ, but ultimately, they face the same issue as the system-acquired practice of needed advocacy in their administrative relationship to determine the fair valuation of performance. Additional P&L challenges face the faculty model related to the scope of practice that impacts the margin for the institution. Educational duties and low ROI of supporting services such as genetic counseling, fetal therapy, diabetic management, and the resulting demand for ultrasound services, impact the financial performance of the entire department. In addition, an institutional patient mix with lower reimbursement is often experienced due to community location.
In the second installment of this study, we will examine the strategic and operational components that promote measures of performance when adequately planned. To receive a copy of this second article, learn more regarding the Practice Assessment Program, or ask questions of the author, please contact Frank Ciafone, MBA, at fmciafone@gmail.com or by phone at (602) 885-8880.

About the Author

Frank Ciafone is a leading authority regarding health care management of the maternal-fetal medicine specialty. Since 1995, he has provided financial and operational expertise to private, system-owned, and academic physician settings nationally, assisting stakeholders in the optimization of organizational culture, profitability, and operations. He is a member of SMFM's Practice Management Advisory Board.