UNLOCKING FINANCIAL PERFORMANCE IN RURAL HEALTHCARE: PRACTICE OPERATIONAL IMPROVEMENT PLANS

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WHAT IS A PRACTICE OPERATIONAL IMPROVEMENT PLAN (AKA PRACTICE ASSESSMENT)?

A Practice Operational Improvement Plan is a structured, data-driven evaluation of how a medical practice functions—**operationally, financially, and clinically—**paired with a clear roadmap to improve performance and sustainability, particularly in rural and community-based settings.

It goes beyond identifying problems—it delivers:

- **Actionable recommendations**
- **Financial impact estimates**
- **Implementation roadmap**

Core Purpose

The goal is to answer:

- Where are we losing money or underperforming?
- Why is it happening?
- What specific changes will improve performance?
- What is the financial impact of fixing it?

For rural organizations (CAHs/RHCs), it's often about:

- Maximizing limited resources
- Improving provider utilization
- Stabilizing financial performance

HOW A PRACTICE IMPROVEMENT PLAN IS CONDUCTED

1. Data Analysis	2. Benchmarking	3. On-Site or Virtual Observations	4. Provider & Staff Interviews	5. Patient Access Evaluation
• Review of financial, operational, and productivity metrics • List of metrics includes visits, wRVUs, cost per visit, payer mix, revenue trends, no show/cancellation rate, loss per provider by location (by year) • Establishes a baseline of performance and identifies variation	• Compare performance to national and rural-specific peers (CAH/RHC). Identify gaps in productivity, access, and revenue cycle performance • Highlights where the organization is underperforming vs. peers	• Direct observation of clinic operations and patient flow • Review of scheduling, intake, clinical workflows, and check-out processes • Identifies inefficiencies that data alone cannot reveal	• Conversations with providers, leadership, and frontline staff • Understand daily challenges, barriers, and workflow realities • Surfaces the root causes behind performance issues	• Assess appointment availability, lag times, and scheduling practices • Evaluate ease of entry into the system for new and returning patients • Identifies missed revenue opportunities and access barriers

INDICATORS FOR INITIATING AN OPERATIONAL IMPROVEMENT PLAN

Stagnant or Declining wRVUs:

If primary care productivity consistently falls below the national median of 4,500–5,000 wRVUs or trends toward the 25th percentile (~3,800), a diagnostic deep dive is required.

High Appointment Lag Times:

When poorly designed templates lead to long wait times, causing "Patient Leakage" to urban centers, the practice must optimize its scheduling.

Significant Revenue Leakage:

An improvement plan is necessary if the revenue cycle shows signs of 10–20% losses due to undercoding, missed charges, or high denial rates.

Provider Underutilization:

If providers are bogged down by administrative burdens or open slots while patients remain on waiting lists, a "top-of-license" workforce review is triggered.

Lack of Data Visibility:

If leadership and providers are not aligned on goals due to data silos, the organization should initiate a plan to establish baseline visibility and provider scorecards.

Facility Inefficiency:

When the clinic is failing to act as a high-performing "front door" for hospital labs, imaging, and referrals, the system integration needs immediate correction.

High No-Show Rates:

An early indicator of poor patient engagement or inefficient scheduling systems.

Loss per Provider by Location:

Tracking the net financial loss per provider on an annual basis to identify outliers.

INDICATORS FOR INITIATING AN OPERATIONAL IMPROVEMENT PLAN – PRIMARY CARE PERFORMANCE & ASSESSMENT THRESHOLDS

Metric	National/Best Practice Benchmark	"Alarming" Threshold (Assessment Indicated)
Annual wRVUs	**4,500 – 6,000** wRVUs per year	**~3,800 wRVUs** (25th percentile) or lower
Annual Encounters	**2,500 – 3,500** visits per year	Significant variation from peers or inability to meet local demand
Daily Visits	**20+** visits per day (Target)	**16 visits** per day or fewer
No-Show Rate	**Below 5%**	High rates indicating lost revenue or poor engagement
Coding Accuracy	Accurate E&M level distribution	**10% – 20%** revenue loss due to undercoding/missed charges
Patient Access	Short lag times for "Third Next Available"	Long lag times causing "patient leakage" to urban centers
Workflow	Providers practicing at "Top-of-License"	High "Administrative Burden" (e.g., 2+ hours on non-clinical tasks)

THE RURAL REALITY

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	Lower Patient Volumes	A smaller population base naturally limits organic growth, making every single patient encounter more valuable to the bottom line.
	Seasonal Fluctuations	Revenue and staffing needs are often volatile due to local economic drivers like agriculture or tourism cycles.
	Higher Fixed Cost Burden	Compliance, staffing, and facility maintenance costs do not scale down when patient volume drops, creating a financial challenge.
	Workforce Shortages	Chronic difficulty in recruiting and retaining both providers and support staff leads to a high reliance on expensive temporary labor.
	Government Payer Dominance	Medicare and Medicaid dominate the payer mix, meaning the organization must operate efficiently within lower reimbursement rates.

CAH & RHC REGULATORY CONTEXT

Critical Access Hospitals (CAHs):

- These facilities rely on cost-based reimbursement (roughly 101% of allowable costs) but are limited by a 25-bed cap, making outpatient and clinic performance the real drivers of viability.

Rural Health Clinics (RHCs):

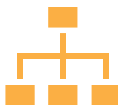
- These operate on encounter-based reimbursement via an All-Inclusive Rate (AIR); because revenue is tied to visit volume rather than complexity, provider productivity is the engine of the clinic.

THE POWER OF TRANSPARENCY

THE MISSING LINK: VISIBILITY AND DATA SILOS

Limited Performance Visibility

Many rural organizations have difficulty retrieving accurate data, but those that have data often fail to share it consistently with the people who influence it most—the providers.



Financial and Operational Silos

Leadership often reviews financial losses in a vacuum, while providers operate based on assumptions rather than hard data.

Unknown Metrics

Providers are frequently unaware of their own specific productivity (wRVUs), no-show rates, or current panel sizes.

WHY TRANSPARENCY DRIVES PERFORMANCE

Goal Alignment	Sharing data ensures that providers and administrators are working toward the same organizational and financial health goals.
Accountability and Ownership	Visibility encourages providers to take ownership of their schedules and clinical output.
Reduced Performance Variation	Transparency highlights outliers, allowing the organization to standardize care and productivity across the team.
Engagement and Morale	Presenting data fairly reduces the feeling of "top-down" management and turns providers into partners.

QUESTIONS TO ASK

Do we have a "single source of truth"?	Are we still struggling with visibility and data silos that prevent us from seeing the full financial picture?
Are our goals aligned?	Is the data being shared in a way that ensures both providers and administrators are working toward the same financial goals?
Do we provide regular scorecards?	Have we implemented baseline visibility through provider scorecards to establish exactly where the organization stands today?
Is our data perceived as “fair"?	Are we using transparency to turn providers into partners rather than victims of "top-down" management?

BENCHMARK REALITY CHECK

- **Primary Care Median:** National productivity typically sits between 5,000 to 6,000 wRVUs per year and 2,500 to 3,500 encounters per year.
- **The Performance Gap:** The difference between the 25th percentile and the top quartile is often a result of system constraints, not provider effort.

MGMA Data (Encounters)							
Benchmark	Specialty	10th%	25th%	50th%	75th%	90th%
Total Encounters	Family Medicine (with OB)	1,735	2,228	2,646	3,273	4,801
Total Encounters	Family Medicine (without OB)	1,881	2,793	3,638	5,053	8,103
Total Encounters	Internal Medicine: Ambulatory Only (No Inpatient Work)	2,289	2,732	3,222	4,290	7,715
Total Encounters	Internal Medicine: General	1,408	2,416	3,207	4,462	7,504

MGMA Data (wRVUs)						
Benchmark	Specialty	10th%	25th%	50th%	75th%	90th%
Work RVUs	Family Medicine (with OB)	3,269	4,230	5,199	6,385	8,102
Work RVUs	Family Medicine (without OB)	3,446	4,759	6,028	7,572	9,824
Work RVUs	Internal Medicine: Ambulatory Only (No Inpatient Work)	4,055	5,058	6,147	7,458	9,236
Work RVUs	Internal Medicine: General	2,894	4,364	5,736	7,295	9,468

MGMA Provider Compensation Survey: 2025 Survey based on 2024 Data

Note:
- In remote rural areas, national medians may be unattainable due to low population density. The goal is to reach the maximum volume the local market can support while maintaining essential coverage.
- Utilization Focus: Maximizing existing facilities and providers before pursuing expensive new growth.

QUESTIONS TO ASK

Where do we sit against the National Median?

Is our primary care productivity hitting the typical benchmark of 4,500 to 5,000 wRVUs per year?

Are system constraints hindering our top performers?

If we are closer to the 25th percentile (~3,800 wRVUs), is the cause a lack of provider effort or underlying system inefficiencies?

Are our facilities being maximized?

Instead of looking for expensive new growth, are we fully utilizing the providers and facilities we already have?

How high is our "Administrative Burden"?

Are open slots and paperwork preventing providers from seeing the patients who are currently waiting for care?

IDENTIFYING & FIXING INEFFICIENCIES

WHERE RURAL PRACTICES LOSE MONEY

Access and Scheduling:

- Poorly designed templates and long appointment wait times drive patients away.

Provider Underutilization:

- Open slots and high administrative burdens prevent providers from seeing the patients who are waiting for care.

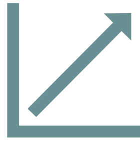
Revenue Cycle Gaps:

- Significant revenue is lost to undercoding (estimated at 10–20%), missed charges, and high denial rates.

Patient Leakage:

- When local access is poor, patients travel to urban centers, taking vital healthcare dollars out of the community.

RHC- & CAH-SPECIFIC OPPORTUNITIES



RHC Volume Focus

Since revenue equals encounters multiplied by the AIR, increasing daily visits directly impacts the bottom line.

CAH System Integration

High-performing clinics act as the "front door" for the hospital, driving necessary volume for labs, imaging, and referrals.

QUESTIONS TO ASK

What is our estimated loss to undercoding?

Are our scheduling templates optimized?

What is our "Patient Leakage" rate?

Are we capturing "Front Door" opportunities?

WORKFORCE AND CODING OPTIMIZATION

Maximizing Clinical Impact	
	Top-of-License Practice: Freeing physicians and APPs from administrative duties to focus on patient care.
	Compensation Alignment: Evaluating if current provider contracts and incentive structures drive the desired productivity and quality outcomes.
	Staff Flexibility: Cross-training support staff to handle the volume fluctuations inherent in rural healthcare.
	Coding Transparency as Empowerment: Sharing coding distribution data so providers can correct unintentional undercoding.
	Quick Wins: Implementing low-cost changes, such as no-show reduction programs, for immediate bottom-line impact.

QUESTIONS TO ASK

Are providers practicing at "Top-of-License"?

Are physicians, NPs, and PAs focused strictly on clinical tasks, or are they bogged down by support staff duties?

Is our support staff cross-trained?

Do we have the flexibility needed to handle rural volume fluctuations?

Does coding transparency exist?

When providers see their own coding distribution data, are they empowered to correct unintentional undercoding?

What are our "Quick Win" targets?

Have we identified low-cost changes—like no-show reduction—that can immediately impact the bottom line?

PROVIDER COMPENSATION PLANS - RURAL

Why a Tailored Rural Comp Plan Is Essential

Incentivizing Throughput: Moving beyond a flat salary to a model that rewards productivity (e.g., wRVU or visit-based incentives) encourages providers to maximize their clinical "engine."	**Recruitment & Retention:** A competitive, transparent plan makes the organization a "destination of choice" by offering clear financial upside that offsets the challenges of rural practice.	**Goal Alignment:** Ensures that both providers and administrators are working toward the same financial health and sustainability goals.	**Addressing the "Market Bear" Reality:** Provides a framework to reward providers who maximize volume in low-density areas, even when national medians are mathematically out of reach.

PROVIDER COMPENSATION PLANS - RURAL

Core Components of an Aligned Plan

- **Productivity Incentives:** Use benchmarks (e.g., MGMA, AMGA, etc.) to create productivity metrics that drive patient volume.
- **Clinical Quality & Outcomes:** Transition from purely volume-based pay to incorporating MIPS, HEDIS, or specific rural health quality measures that reflect the impact on the community's health.
- **Value-Based & Risk Alignment (ACO/At-Risk Contracts):** Strategic Contract Integration: Align provider compensation with ACO shared savings and at-risk contract performance by rewarding the reduction of the total cost of care, completion of Annual Wellness Visits (AWV), and accurate HCC coding to ensure proper risk adjustment and network integrity.
- **Citizenship & Leadership:** Reward "top-of-license" practice and participation in monthly performance dashboard reviews to foster a culture of continuous improvement.

The Financial Impact of Alignment

- **Revenue Generation**: Small shifts in productivity, such as increasing from 16 to 20 visits per day, can generate an additional $100K–$150K in annual revenue per provider.
- **Sustainability**: A well-structured plan turns providers into partners who understand that their productivity is the primary driver of the RHC/CAH All-Inclusive Rate (AIR) and overall organizational survival.

PROVIDER COMPENSATION PLANS - RURAL

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Provider Compensation Summary

- A modern rural compensation plan must shift from a "salary-only" mindset to a Hybrid Productivity & Value Model that balances clinical output with long-term organizational health. By rewarding both Operational Throughput (visits and wRVUs) and System Sustainability (coding accuracy, community access points, and ACO performance), the organization transforms providers into active financial partners who are directly invested in the practice's viability. This alignment ensures that providers are incentivized to maximize the availability of local primary care while simultaneously managing the total cost of care and clinical quality required by modern at-risk contracts.

THE IMPLEMENTATION ROADMAP

Diagnostic Phase

Conduct a deep dive into current data, coding accuracy, and workflow bottlenecks.

Baseline Visibility

Immediately implement provider scorecards to establish where the organization stands today.

Quick Wins

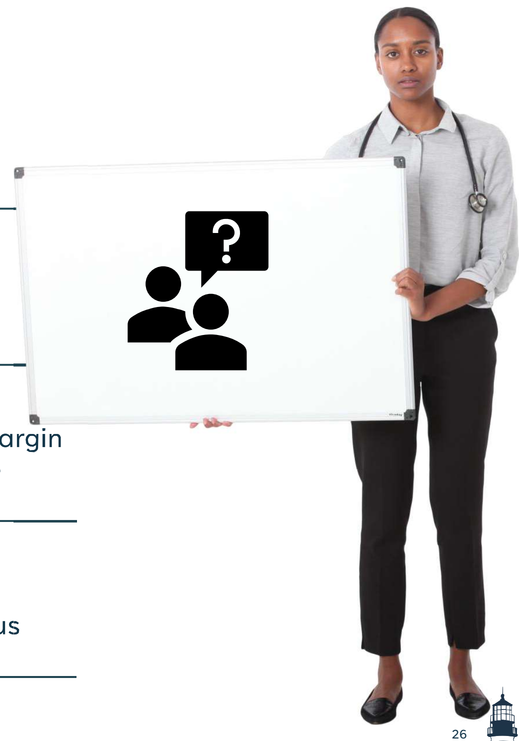
Start with high-impact, low-cost changes like template optimization and no-show reduction.

Sustainment

Move to regular performance discussions and monthly dashboard reviews to ensure improvements stick.

QUESTIONS TO ASK

Have we completed a "Diagnostic Phase"?	Have we conducted a deep dive into our specific workflow bottlenecks and coding accuracy?
Is there a mechanism for "Sustainment"?	Do we have a schedule for regular performance discussions and monthly dashboard reviews?
Are we managing waste?	Recognizing that rural settings lack the excess margin to absorb waste, have we made efficiency a core "survival" metric?
Is transparency a "Force Multiplier" in our culture?	Is our shared data creating a culture of continuous improvement across the whole team?



FINAL TAKEAWAYS

Efficiency as Survival: In rural settings, you don't have excess margin to absorb waste.

Utilization is Key: Maximize the providers and facilities you already have rather than looking for expensive new growth.

Transparency Is a Force Multiplier: Shared data aligns leadership and providers, creating a culture of continuous improvement.

SAMPLE PROVIDER PERFORMANCE SCORECARD

WHAT TO INCLUDE IN A PROVIDER SCORECARD

1. Clinical Productivity (The "Engine" of the RHC/CAH)

- **Total Completed Encounters:** [Number] (Actual) vs. [Number] (Target).
  - *Why it matters:* In RHCs, revenue is a direct function of visit volume multiplied by the All-Inclusive Rate (AIR).
- **Work Relative Value Units (wRVUs):** [Number].
  - *Benchmark Comparison:* You are currently at the [Percentile, e.g., 50th] percentile compared to the national median of ~4,500–5,000 wRVUs/year.
- **Average Visits Per Day:** [Number].
  - *Financial Impact:* Increasing from 16 to 20 visits per day can generate an additional $100K–$150K in annual revenue per provider.

WHAT TO INCLUDE IN A PROVIDER SCORECARD

2. Access & Capacity (The "Front Door" Efficiency)

- **No-Show Rate:** [Percentage].
  - *Target:* Below 5%.
  - *Note:* High no-show rates represent lost revenue and indicate a need for better patient engagement or reminder systems.
- **Third Next Available Appointment (Lag Time):** [Number of Days].
  - *Impact:* Long lag times drive patient "leakage" to urban centers and reduce overall community access.
- **Unused Scheduling Slots:** [Number/Percentage].
  - *Goal:* Maximize utilization of the existing schedule to protect organizational survival.

WHAT TO INCLUDE IN A PROVIDER SCORECARD

3. Revenue Cycle & Quality (The "Sustainability" Metrics)

- **Coding Distribution (E&M Levels):** [e.g., % Level 3 vs Level 4].
    - *Observation:* Current data suggests a 10–20% rate of undercoding, which leads to significant lost reimbursement.
- **Denial Rate (Provider-Related):** [Percentage].
    - *Action:* Focus on reducing front-end documentation errors to accelerate cash flow.
- **Patient Panel Size:** [Total Number of Unique Patients].
    - *Context:* This measures your footprint in the community and your impact on hospital "downstream" services like labs and imaging.

HOW TO USE A PROVIDER SCORECARD

Data should be discussed, not just distributed.

- **System Barriers:** [e.g., "I spent 2 hours on non-clinical administrative tasks today due to staffing gaps"].
- **Next Month Focus:** [e.g., "Adjusting template to allow for two same-day 'urgent' slots to reduce lag time"].

How to Use This Effectively

- **Consistency:** Deliver this scorecard monthly so providers can track trends over time.
- **Anonymized Peer Benchmarking:** Show where the provider stands relative to their peers to foster a healthy culture of improvement.
- **Visual Dashboards:** Use simple charts (e.g., bar graphs for visits) to make the data actionable at a glance.

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THANK YOU

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