STROUDWATER

TOP FOUR KEY ISSUES IN PROVIDER SCHEDULES

Is your practice losing revenue because of vague language regarding "reasonable clinical hours"?

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Many physician contracts stipulate that physicians must provide "reasonable clinical hours." For the hospitals that employ these physicians, this vague language has led to millions of dollars in lost revenue. While vague contract language is problematic for myriad reasons, its impact on physician scheduling is a commonly missed component of practice management in over 70 percent of the practices we have worked with on performance improvement. Hours that are not on a schedule are patients that are not seen. Patients that are not seen are services not provided, and hit the bottom line. The following are four key issues that arise frequently and corresponding solutions to keep in mind:

1. **No set clinical hours are required**. "Reasonable clinical hours" is completely open to interpretation. "Reasonable" could indicate 20 hours of clinical time for a physician who spends two full days in an OR at the hospital, but it could also indicate 40 hours for a primary care physician who does not round at the hospital. A clear understanding of the expected hours is best memorialized in the contract in specific terms.

2. **Not monitoring the schedule to ensure schedules match the contract**. Stroudwater worked with one hospital administrator who was pleased to have completed a yearlong effort to incorporate a base requirement of 36 clinical hours in all of the physician contracts. Six months later the administration was surprised to find that several schedules had significantly fewer than 36 hours scheduled—some had as few as 25 hours for a full-time physician. After all the time spent negotiating contracts with physicians, the new contracts had never made it into the system. Contracts are useless unless monitored, measured and enforced on all sides.

							Opportunity based on 47 weeks per year at 32 hours per week					
										Avg. Collections		
	Patient Scheduled Hours							Additional	Additional	Per Visit		
Provider	Mon	Tues	Wed	Thu	Fri	Total Hours	New Hours	Hrs/Wk	Patients/Wk	X New Pts/Wk	X 47 wks	Opportunity
Dr. A	9:30-12:15	1:30-4:45	9:30-12:15	9:00-12:15	9:00-12:15							
	1:30-3:30		1:30-3:15	1:30-4:45	1:30-4:45	27.25	32	4.75	14.25	$ 1,069	$ 50,231	
Dr. B	Off	8:30-12:15	7:00-12:00									
	(8 hr PCMH Di	1:30-4:45	12:45-3:00	6:000-8:45	1:30-4:45	25.25	32	6.75	20.25	$ 1,777	$ 83,516	
Dr. C	8:00-12:15	OFF	12:30-4:45	8:00-12:15	8:00-12:15							
	1:30-4:45			1:30-4:45	1:30-4:45	29.50	32	2.50	7.5	$ 768	$ 36,096	
Dr. D	12:30-4:45	7:30-12:15	7:30-12:15	OFF	8:00-12:15							
	6:000-8:45	1:30-4:45	1:30-4:45		1:30-4:45	27.50	32	4.50	13.5	$ 1,017	$ 47,797	
NP				8:00-12:00	8:00-12:00							
				1:00-4:00	1:00-4:00	16.00	16	0.00	0	$ -	$ -	
Total Practice Patient Care Hours Per Week:						125.5	**144**				**New Revenue:**	**$ 217,640**

Opportunity based on 47 weeks per year at 40 hours per week					
			Avg. Collections		
	Additional	Additional	Per Visit		
New Hours	Hrs/Wk	Patients/Wk	X New Pts/Wk	X 47 wks	Opportunity
40	12.75	38.25	$ 2,869	$ 134,831	
40	14.75	44.25	$ 3,883	$ 182,498	
40	10.50	31.5	$ 3,226	$ 151,603	
40	12.50	37.5	$ 2,825	$ 132,769	
16	0.00	0	$ -	$ -	
176				New Revenue:	$ 601,702

This was not laziness by the physicians. There was no maliciousness. It was a simple lack of follow through, but it is unfortunately far more common than anyone suspects. The income and patient access potential were significant, as shown in the table below (this practice had struggled with patient access with significant wait times for patients). Increasing patient access hours for every physician to 40 hours, would result in over $600,000 in new revenue.

3. **Resource allocation does not match the schedule.** Patient scheduling is a dynamic process relying on several factors. Many practices have gone to modified wave scheduling to provide increased access for patients. Modified block scheduling can be an efficient way to increase access for patients, particularly for physicians who have surgical or administrative blocks. However, practices may overlook the resources requirement to keep those blocks working efficiently. If a provider is working a double block schedule, the provider should have adequate support staff to keep workflow moving efficiently. This can be particularly difficult in a rural area where access to clinical support staff may be limited. Make sure the double block is appropriate for your practice and there are resources necessary to support such; otherwise, patients may face even longer wait times.

4. **Not monitoring what contributes to break-downs in the schedule**. Most EHR systems allow for monitoring of where the patient is at any given time: *patient checked in, patient in waiting, patient in room, patient with initial consult, patient with provider, patient at check out*. Inconsistent use of this information by staff is common in many practices, but worse is having the powerful tool to be able to make appropriate adjustments to patient flow in a schedule and not using it. Only a handful of practices we encounter both know they have this capability in their system and regularly monitor it, and even fewer adjust based on the data. This is unfortunate when considering how the information can be used. By monitoring where there are roadblocks, practices can reallocate resources, develop workflow policies for efficiencies, or examine staffing ratios. These tools also allow practices staff to monitor how much time physicians require for each type of patient encounter, enabling better scheduling of all visits.

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