Enhancing Staffing Efficiency & Improving Physician Clinic Performance

Opal H. Greenway, Director and Principal

Stroudwater

Agenda

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The challenge: County-owned hospitals are primarily rural, and the losses in physician practices have reached unsustainable levels

- Current State of Rural Providers
- The Operational Toolbox
- Physician Practice Losses
- Plan of Action
- Questions

OPERATIONAL PERFORMANCE IMPROVEMENT TOOL BOX

Strategic Risk & Operational Improvement

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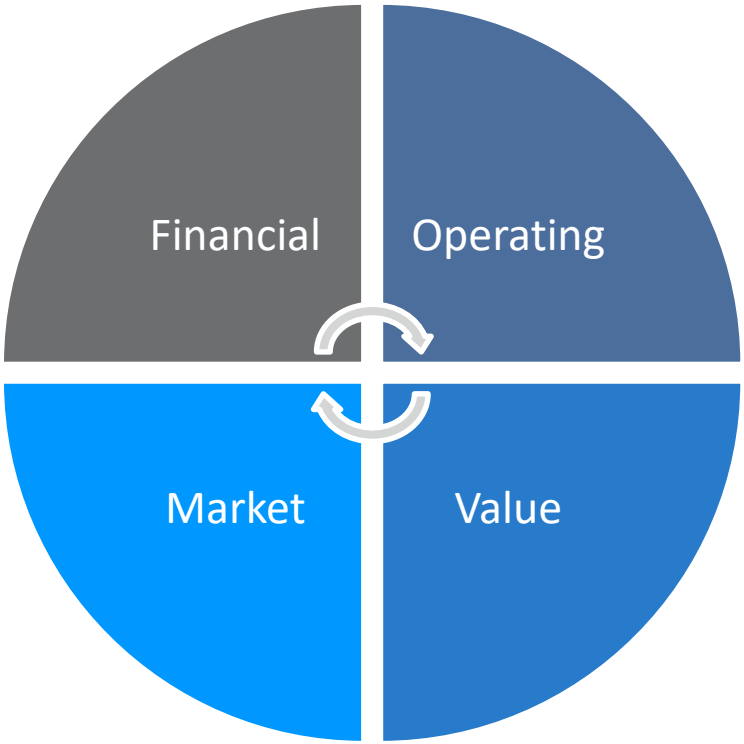
- Define “gaps” in performance
- Develop budget consistent with “sustain” threshold
- Quantify cash “run rate”
- Examine five-year trends at least annually



- Demand-Based Staffing tools
- **Provider practice operations improvement**
- Revenue cycle and coding
- Cost report reviews (CAHs)
- Practice / clinic designations
- Process redesign
- Supply chain & purchasing

- Identify growth opportunities
- Invest in aligned provider base
- Develop ambulatory network
- Address industry disruptors
- Implement retail pricing, access strategy
- Direct contracting
- De-escalate conflict between Boards

- Annual payor contract reviews
- Contracting strategy re: payor products and value-based models
- Value-based payment strategy
- Self-Insured population tools
- Medicare Advantage products
- Define need for payor and provider partners
- Manage total cost of care
- Address industry disruptors

Each of the four strategic and operating risk vectors have potential mitigating management responses. We are going to focus on two powerful performance improvement tools today.

CURRENT STATE OF RURAL PROVIDERS

Overall Physician Supply Shortages

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Nationwide shortages:

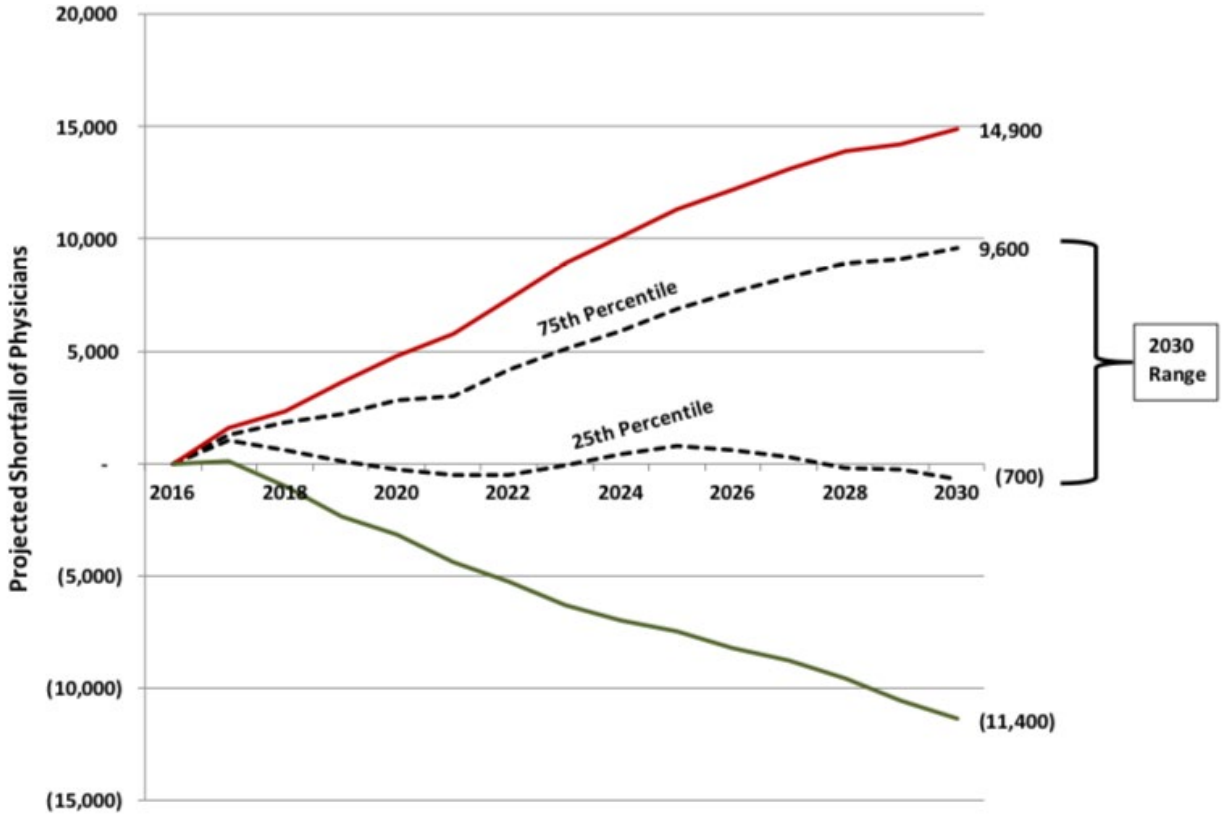
- 42,600 to 121,300 physicians by 2030
- 14,800 to 49,300 primary care physicians

Contributing factors:

- Population and demographic trends
- Reduced physician hours
- Physician retirements (30% of the current supply within in the next 10 years)
- Demand created by population health initiatives

Sources: 2018 Update: The Complexities of Physician Supply and Demand: Projections from 2016 to 2030 (Association of American Medical Colleges); Association of American Medical Colleges 2017 State Physician Workforce Data Book

Projected Specialty Physician Supply/ Demand by 2030



- Physician supply is **growing in medical specialties,** but not at a rate to keep pace with demand according to AAMC
- Medical specialist physician supply and demand ranges from a **surplus of 700 to a deficit of 9,600 by 2030**

Source: AAMC, 2018 Update: Complexities of Physician Supply and Demand: Projections from 2016 to 2030

Major Professional Activity of Physicians, 2017

Specialty	Total Active Physicians	Patient Care	Teaching	Research	Other1
Internal Medicine	115,557	101,953	1,414	1,475	10,715
Family Medicine/General Practice	113,514	104,937	1,622	253	6,702
Pediatrics	58,435	52,824	841	662	4,108
Emergency Medicine	42,348	38,964	469	96	2,819
Anesthesiology	41,762	38,960	553	187	2,062
Obstetrics and Gynecology	41,656	38,850	503	192	2,111
Psychiatry	38,205	33,364	573	752	3,516
Radiology and Diagnostic Radiology	27,719	24,682	418	153	2,466
General Surgery	25,042	21,644	262	139	2,997
Cardiovascular Disease	22,211	20,303	299	584	1,025
Orthopedic Surgery	19,001	18,069	118	57	757
Ophthalmology	18,817	17,488	155	127	1,047
Otolaryngology	9,526	8,932	93	23	478
Gastroenterology	14,747	13,488	186	292	781
Urology	9,921	9,374	78	39	430
Neurology	13,717	11,674	244	638	1,161
Other	280,678	227,079	4,719	7,169	41,711
All Specialties	892,856	782,585	12,547	12,838	84,886

- Primary Care (IM, FM, Peds and OB/GYN) comprises 36.9% of all physicians currently active, 38.2% of physicians focused primarily on patient care
- 12.4% of physicians are engaged primarily in non-patient-care activities

Source: Association of American Medical Colleges; "Active Physicians in the Largest Specialties, 2017"

Rural Areas Hit Hardest

- Financial hit is undeniable (lost revenue of over $400K per physician during the time between losing a physician and replacing them), but the primary impact is on quality of care
  - Delays in getting care (average wait time for appointment is 54.3 days for family practice)
  - Poor continuity
  - Lack of specialty services
  - Lack of patient education
- As of July 2018, HRSA projects that it would take over 17,000 additional primary care physicians to achieve target ratio of 1 primary care physician per 3,000 patients in the current 6,739 HPSAs
- Difficulty recruiting to rural areas
  - Spouse employment difficulties
  - Lifestyle impact (call schedule, access to colleagues, etc.)
  - Low preference among newly trained physicians

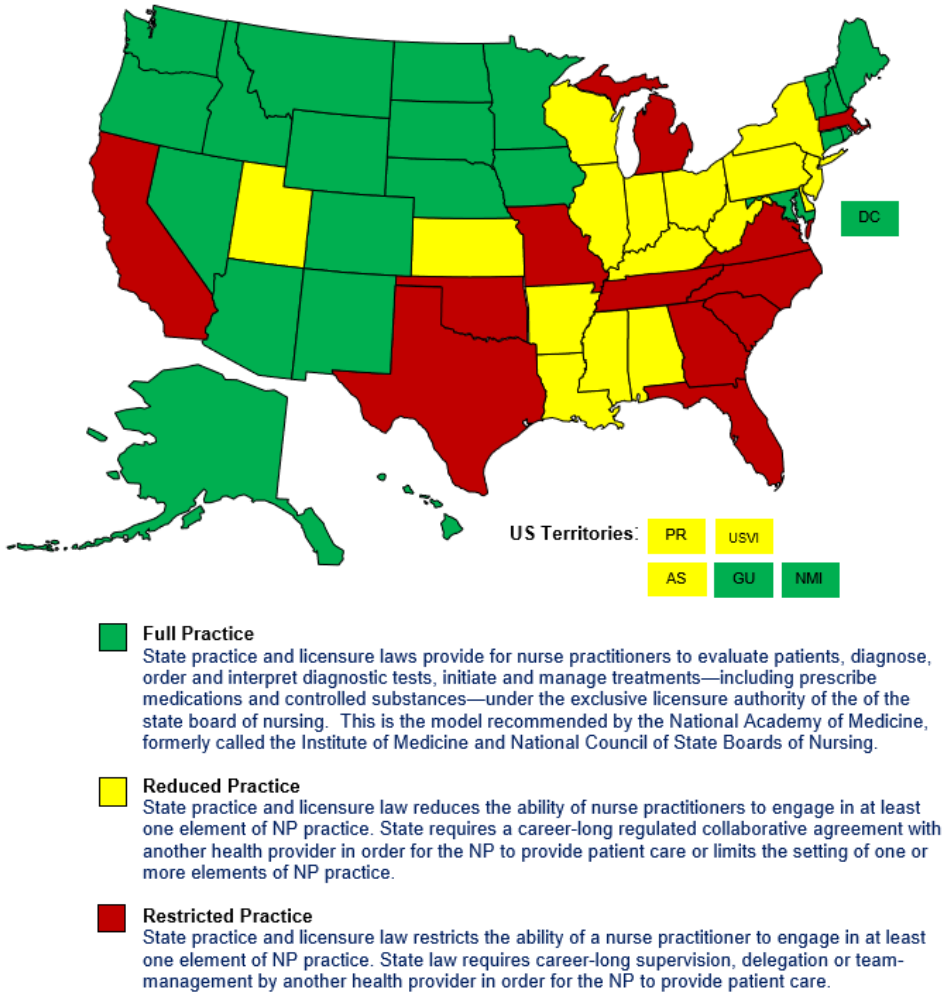
Final-Year Medical Resident Practice Location Preferences by Community Size

10,000 or less	1%
10,001 – 25,000	2%
25,001 – 50,000	5%
50,001 – 100,000	9%
100,001 – 250,000	16%
250,001 – 500,000	20%
500,001 – 1 million	24%
Over 1 million	24%

Sources: Merritt Hawkins 2017 Survey of Final-Year Medical Residents and 2017 Survey of Physician Appointment Wait Times

APPs Can Reduce the Strain

- Using APPs (nurse practitioners and physician assistants) can reduce the strain of the provider shortages
- Common practice utilization in rural areas (required usage in rural health clinics – 2,100 visits/year/APP)
  - Physician can supervise multiple APPs to expand their panel size
- In states with highest restrictions on use, APPs can only augment physician work, not replace
- Payor contracts tend to be more restrictive on how they can be used and what is the best way to bill for their services – know your contracts!



Sources: https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment

Advanced Practice Provider Supply/Demand

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- The number of NPs and PAs will **grow by 6.8% and 4.3% annually**, respectively, relative to physician average annual growth of 1.1% by 2030

Historical and Projected Numbers of Physicians, Nurse Practitioners, and Physician Assistants.*

Provider Group	No. of Full-Time Equivalents				Average Annual Growth (%)		
	2001	2010	2016	2030 (projected)	2001–2010	2010–2016	2016–2030 (projected)
Physicians	711,357	862,698	920,397	1,076,360	2.2	1.1	1.1
Nurse practitioners	64,800	91,697	157,025	396,546	3.9	9.4	6.8
Physician assistants	44,282	88,047	102,084	183,991	7.9	2.5	4.3

* Based on data from the American Community Survey (ACS) and the National Sample Survey of Registered Nurses. Estimates for NPs in 2001 are interpolated on the basis of data from the 2000 and 2004 surveys. Full-time equivalents are defined on the basis of reported usual weekly hours worked and a 40-hour workweek for NPs and PAs and a 50-hour workweek for physicians. NPs include a small number of certified nurse midwives who were not separately identified in the ACS because of their small numbers. PAs in the ACS reporting an associate's degree or less education were excluded. All estimates are based on sample weights provided in each survey.

Every Decision Is Expensive

- Rural hospitals must **always be recruiting** physicians
  - Vacancies result in lost revenue and increase turnover
  - Each new physician spot can create $200K-$300K in expense
- But losses in physician practices cause hospitals to be hesitant regarding employing physician practices
- We need physicians, but how do we afford them?
  - Medical staff development plan that is on strategy
  - True practice management
  - Effective physician leadership/engagement

PHYSICIAN PRACTICE LOSSES

Losses in Hospital-Owned Practices

- Hospitals are increasingly concerned with large subsidies paid to cover practice losses – particularly in primary care
- Current average loss across all specialties is $196K per FTE physician
- Most hospitals "host" practices rather than manage them

Infrastructure Change
- Higher benefits
- Staff & management expense
- IT Investment
- **Physician gives up ancillary revenue**
- GPO

Poor Pre-Purchase Due Diligence
- **Understanding culture & operations**
- Payor mix
- Not comparing productivity to salary
- Inaccurate proforma
- Reimbursement

Lack of Consolidation
- Buy and stay
- No network planning for locations

No Standards & Measures
- **Multiple one-off employment contracts**
- **Compensation model**
- Vague work out language
- Inadequate performance standards
- **Poor operations and management**

Revenue Cycle Mismanagement
- **Poor overall RCM performance**
- Poor on-boarding and credentialing
- **No RCM integration with operations**
- **Bad pro fee contracts**
- Change in payor mix

Sources: MGMA 2018 Cost and Revenue Report

Practice Management

Polling Question

- What is the average level of losses in your clinics per provider?
  - Less than $150K per provider
  - $150 - $220K per provider
  - $220K - $300K per provider
  - Greater than $300K per provider
  - We don't track this metric/No idea

Proforma Comparisons

	Current State	Proj. Employed State
Revenue		**Revenue**
Patient Revenue FFS	400,000	570,000
Revenue Capitation	100,000	-
Revenue Other	5,000	-
Subtotal	$ 505,000	$ 570,000
Expense		**Expense**
Staff salaries	102,400	141,720
Benefits & Tax	20,480	38,264
401K	-	2,004
Medical Supplies	1,200	1,764
Office Supplies	1,500	11,880
Professional Services	2,000	-
Housekeeping	1,800	2,500
Rent	48,000	87,000
Billing	20,200	51,300
Malpractice	12,000	11,000
Travel/CME/Dues	2,500	5,000
Other	1,000	2,000
IT (EMR/Tele)	7,200	5,832
Allocated Cost	N/A	21,144
Management Fee	N/A	57,000
Expense Subtotal	220,280	438,408
Net P/L before Phy Sal	284,720	131,592
Physician Salary	284,720	300,000
Benefits/tax/401K	59,791	81,000
Net Physician Salary	224,929	
Net Profit (loss)	0	**(249,408)**

Proforma changes:

- Additional staff and salary and wage adjustments
- Additional rent
- Additional IT cost/data migration
- Additional billing cost
- Higher benefit and/or additional benefit costs
- Physician salary at FMV still more than previously earned
- Hospital allocated costs
- Management fee allocation

On top of this, most planning does not fully understand the revenue of the practice

- Technical fees for procedures are usually removed from the practice proforma
- Ancillary services are moved to the hospital

Standards and Measures – Contracts

Know your physician contract

- Most rural hospitals have negotiated each physician contract at the individual level; there is no standard contract
- **County-owned hospitals have the added complexity of community members involved in physician compensation at an increased level**
- Several hospitals are missing contracts or are operating on expired contracts
- Changes are not reflected in contracts
- Reality does not mirror the contracts
- Contracts do not match fair market valuation reports

Consequences

- Poor contracts with physicians hinder practice management
- Can be costly, at the expense of the community
  - **Example:** FMV report put an overall cap on compensation for physician producing at the 90th percentile; report referenced a per WRVU rate that was used in the contract
    - Result: overpaid the physician by $600K; had to self-report; damaged relationship with physician by asking for the money back

Standards and Measures – Compensation

- Key to physician recruitment and retention is to have a model that is uniform across all physicians within a specialty

- Best practice historically is to tie to productivity, but movement to value-based care requires more compensation to be tied to outcomes and cost of care
  - Currently only 2.5% of total physician compensation is tied to quality or outcomes
  - Use of withholds and clawbacks in a stoplight compensation model
- Productivity is not the same for specialists and primary care
  - Specialists: Common set up is a base salary + WRVU bonus
  - Key consideration – what should the base be? Where do we set the productivity threshold?
- What about primary care?
  - Panel size becomes a key measurement for primary care physicians
  - These can be combined with WRVU productivity and quality components, but will differ in size from specialists
- Paying APPs? Hourly? Salary? Productivity? All are currently being used so you must consider how are you using your APPs.

Source: American Medical Association 2016 Physician Benchmark Survey

Standards and Measures – Compensation (continued)

- What else are physicians looking for?
  - Consider non-salary compensation
    - Spousal employment assistance
    - Housing allowance
    - Educational loan forgiveness
    - Flex scheduling

Most importantly, the compensation model must be clear, understandable, and logical.

Standards and Measures – Practice Management

- Lack of due diligence prior to acquiring a practice or hiring a physician usually cannot be undone
- Focus on going forward, by knowing your practice

What is done in the practice?	• Services – clinic visits, procedures, labs, diagnostics • Scheduling • Billing and coding
Who is doing what?	• Accurate job descriptions and training • Team-based care model • Quality measurements
Who is really in charge?	• Physicians? • Practice manager? • Hospital administration? • Best practice will use a collaborative model

Standards and Measures – Practice Management

- Underperforming practice with budgeted losses of ($731,510), or ($182,877) per physician

	Patient Scheduled Hours						Opportunity based on 47 weeks per year at 32 hours per week					
Provider	Mon	Tues	Wed	Thu	Fri	Total Hours	New Hours	Additional Hrs/Wk	Additional Patients/Wk	Avg. Collections Per Visit 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**

Employment contracts state "reasonable full time hours"

Opportunity based on 47 weeks per year at 40 hours per week					
New Hours	Additional Hrs/Wk	Additional Patients/Wk	Avg. Collections Per Visit 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**

Standards and Measures – Practice Management

Opportunities	Scenario 1: @32 hours per week	Scenario 2: @ 40 hours per week
Collection Improvement	$ 84,627	$ 84,627
Expense Reduction/reallocation	74,113	74,113
Increased Provider Productivity	217,640	601,702
Less: Expense of additional staff	(33,282)	(66,564)
Total Improvement Opportunity	343,098	693,878
Project Less	(731,510)	(731,510)
Net Loss w/Improvements	(388,412)	(37,632)
Per Physician	$ (97,103)	$ (9,408)

Financial scenario at **32 hours** of patient time per week per provider

Increasing patient hours by 4.62 hours per physician per week reduces losses by $184,358; with other practice improvements losses went from ($731,510) to ($388,412) or ($97,103) per physician

Financial scenario at **40 hours** of patient time per week per provider

Increasing patient hours by 12.62 hours per physician per week reduces losses by $535,138

Key Takeaways:

- Be prepared to make investments to off-load work by physicians
- Be aware of barriers to increased patient panels
- Reduce variability in patient flow

Polling Question

- What tools are you using to check patient flow?
  - We track seen, rescheduled, cancelled, and no show appointments by provider.
  - We utilize scheduling templates for each provider.
  - We have done a time motion study to optimize workflow and remove inefficiencies
  - I'm not sure/We don't.

Patient Throughput

- Are you tracking how the required patient care time is making it into your schedule?
- What are your own internal benchmarks and standards?
- Do the physicians understand the differences between how many patients are **scheduled** per hour versus how many are **seen**?

FTE status	Hours of Face to Face Time/ Week	Scheduled Clinic Hours	Scheduled Patients per Hour	Patients Seen per Hour
1.0	39.0	31.5	2.8	1.8
1.0	42.0	32.0	2.0	1.6
1.0	39.0	31.5	1.8	1.5
1.0	28.0	28.0	2.5	1.6
1.0	29.3	29.3	1.9	1.3
1.0	26.5	21.5	2.4	1.7
1.0	36.0	26.0	2.0	1.4
1.0	33.0	21.0	2.5	1.4
1.0	29.0	29.0	1.5	0.9
1.0	40.0	40.0	0.8	0.7
1.0	34.5	34.5	0.8	0.7
1.0	29.5	29.5	1.2	0.8
0.5	16.5	16.5	1.7	1.3
0.6	16.5	16.5	1.8	1.2
0.5	16.0	16.0	1.4	1.2
1.0	37.5	37.5	0.5	0.3
1.0	38.0	22.0	0.8	0.5
1.0	38.0	22.0	0.9	0.5

Productivity Opportunities

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Example:

- Patient throughput per hour averages 1.1 patients per hour.
- If each provider achieves the average patients per hour, without adjusting their scheduled clinic hours, potential increase in revenue is over $500K, based on average of $139.01 per patient.
- Note: This would also require providers who are scheduled with less than 1.1 patients per hour to adjust scheduling templates to accommodate an increase in throughput.

FTE status	Scheduled Clinic Hours	Scheduled Patients per Hour	Patients Seen per Hour	Variance to Avg. Patients Seen per Hour	Total Add'l Revenue
1.0	32.0	2.0	1.6	0.0	-
1.0	31.5	1.8	1.5	0.0	-
1.0	28.0	2.5	1.6	0.0	-
1.0	29.3	1.9	1.3	0.0	-
1.0	26.0	2.0	1.4	0.0	-
1.0	21.0	2.5	1.4	0.0	-
1.0	29.0	1.5	0.9	0.1	22,106
1.0	40.0	0.8	0.7	0.4	102,658
1.0	34.5	0.8	0.7	0.3	75,943
1.0	29.5	1.2	0.8	0.2	40,698
0.5	16.5	1.7	1.3	0.0	-
0.6	16.5	1.8	1.2	0.0	-
0.5	16.0	1.4	1.2	0.0	-
1.0	37.5	0.5	0.3	0.7	178,218
1.0	22.0	0.8	0.5	0.5	74,797
1.0	22.0	0.9	0.5	0.5	78,234
Total				$	572,653

Cancellations and No Shows

- What impacts throughput?
  - How the physician sees patients
  - How patients flow through the practice
  - What are your scheduling policies?
- **Industry median no show rate in a multispecialty practice is 6%.**

Total	% of Attended Patients	No Show Rate	No Show + Cancellation Rate
86.94	67%	3%	14%
62.55	80%	4%	11%
57.40	80%	6%	10%
70.00	64%	5%	11%
54.19	69%	2%	9%
50.58	71%	5%	18%
51.94	68%	2%	8%
52.16	55%	4%	13%
42.90	64%	6%	13%
32.29	83%	3%	7%
26.19	96%	1%	4%
34.10	74%	4%	10%
28.23	75%	4%	12%
29.31	69%	1%	10%
22.58	82%	1%	8%
17.28	75%	5%	13%
18.16	66%	2%	8%
18.74	61%	2%	11%

Standards and Measures – Scheduling and Workflow

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- Basic workflow needs policies for effective practice management
- Standardize the patient flow from sign-in to rooming to scheduling the next visit
- Basic checklists will move mountains for hitting quality metrics and moving toward population health
- Policies will make no impact if they are not enforced – perform regular audits to make sure policies are sticking (particularly if turnover is a problem)
  - People do what is **INSPECTED**, not what is **expected**.
- Policy must address the following:
  - Creating an appointment
  - Deleting an appointment – cancellation and no show policies
  - Waiting list
  - Appointment reminders
  - Appointment prep (required signatures, payments, waivers, insurance verification)
  - Delinquent balances
  - Patient wait time monitoring
  - Walk-ins
  - Follow-up appointments
  - Same-day appointments

Staffing Ratios – Why Productivity Matters

- Clinics have more than just the providers to account for – the staff that supports the provider is critical to its success
- Having workflows that optimize the providers productivity is crucial
- Sometimes staffing shortages can impeded productivity – sometimes clinics are overstaff
- Sometimes you have the wrong people for the job

	Based on Clinic provided FTE status					Based on Productivity Needs			
MGMA Specialty	FTE	FTEs / Provider	Median per FTE Provider	Variance per Provider	Total Variance	FTEs / Provider Based on Productivity	MGMA Median per FTE Provider	Prod. Adj. Variance	Total Variance
Total Front Office Support	2.00	0.19	0.68	-0.49	-5.21	0.37	0.68	-0.31	-1.70
Total Clinic Support Staff	2.60	0.25	1.29	-1.04	-11.07	0.48	1.29	-0.81	-4.42
Licensed Practical Nurse	4.03	0.38	0.24	0.14	1.49	0.74	0.24	0.50	2.72
Medical Assistant	2.00	0.19	0.62	-0.43	-4.57	0.37	0.62	-0.25	-1.37
Medical Receptionist Positions	1.00	0.09	0.67	-0.58	-6.10	0.18	0.67	-0.49	-2.65
Registered Nurses	10.43	0.98	0.44	0.54	5.77	1.92	0.44	1.48	8.04

Who's In Charge of the Staff?

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Increased competition for quality practice managers, as opposed to supervisors

Managers

- Responsible for the overall success of the practice
- Engage with physicians and are trusted to make decisions
- Address issues as they arise
- Think strategically about improvements

Supervisors

- Monitor scheduling and budgets
- Respond to staffing issues such as absences
- Produce reports

If you have a supervisor and not a manager, the importance of physician leadership is tenfold

PLAN OF ACTION

Working Harder Is NOT the Solution

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- The solution is not: "Work Harder – Increase Productivity…or Else!"
  - Physicians balk at demands of increased productivity – not because they are lazy, but because it is not a solution
  - Low productivity is a symptom of other issues
    - ✓ Change in physician incentives/alignment
    - ✓ Poor patient flow in the practice
    - ✓ Poor patient/provider scheduling
    - ✓ Increased time demands for EHR
    - ✓ Increased competition
    - ✓ Too many providers/improper utilization of APPs
    - ✓ Understaffing
- Must engage physicians around true solutions—identify the actual problems that have created the symptom (physicians love to triage and treat!)

Engaging Individual Physicians

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- Engage physicians around their productivity and the financials
- Reports should be reviewed with physicians monthly (in top performing practices real-time or weekly dashboards are available through a physician portal)
  - Productivity reports should include:
    - WRVUs, charges, collections – broken out into categories (ancillary, office visits, surgeries, etc.)
    - Comparison to survey data (MGMA percentile)
    - Comparison to other physicians in the hospital/practice
  - Financials
    - Revenue – YTD, budget, trendlines
      - Accounts Receivable issues
      - Payor Mix
    - Expenses – staffing issues
  - Regular and timely feedback on billing or coding issues

Practice Management To Do List

- Work with your practice managers and physicians as a team to understand what is happening with:
  - Physician contracts
  - Physician compensation
  - Scheduling
  - Staffing
  - Payor contracts
  - Revenue cycle process
- Set up management dashboard that monitors the following:
  - Gross collection rate
  - Net collection rate
  - Overhead ratio
  - Individual category expense ratio
  - Days in accounts receivable
  - WRVUs per provider
  - Accounts receivable per FTE physician
  - Staff ratio
  - Average cost and revenue per patient
  - Aging of accounts receivable by payor
  - Payor mix ratio

Key Takeaways

- **Always Be Recruiting** – the shortages are not going away, and rural hospitals in particular must always have a current medical staff development plan that is being executed
- Losses on physician practices, while the status quo, are not always necessary - Make sure you understand what is generating the losses
- **Monitor your metrics monthly!**
  - Setting up the tools to aid management can take as little as 4 weeks depending on your data system
  - Management tools should be monitored every month
- **Engage your physicians**
  - Unsustainable losses are EVERYONE's problem
  - Typical launching of a new physician action council takes 4-6 months before becoming effective when meeting monthly, but can be the vehicle for improvement to be implemented, to stick and to then focus on strategy