

# Practice Management in Local Health Departments

March 13-14, 2014

Sanford, NC

*This PPT version contains new slides developed to Recap Day 1 based on participant questions, Key Messages & Issues Parking Lot developed in the training*

[ 1 ]

## Welcome & Meeting Logistics

- **Welcome**

- Please silence your phones
- Lunch & breaks
- Restrooms
- Questions will be taken at the end of each section; please jot down your questions
- Consultants will generate a “Parking Lot” for issues requiring follow-up



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## Training Agenda

### DAY 1

- Overview of PM context
- Review & application of finance data, benchmarks, & staffing model
- LUNCH 12 noon
- Adjourn 5:00PM

### Day 2

- Best practice improvement strategies
- Change management overview
- Next steps
- LUNCH 11:30am
- Adjourn 3:00PM

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## Training Objectives

- Provide an **overview** of the PM work to date
- Provide context for the assessment and improvement planning to improve efficiency and revenue to sustain clinical services → the training & your data review will generate questions for follow-up by your PM Teams
- Review resource & DPH consultation model to support PM work including the role of consultants and LHDs
- Provide an opportunity for questions and feedback and networking

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## Practice Management Kaizen

- Requested by health directors based on current public health context for clinical services:
  - ↓ Number of clients all programs = ↓ revenue
  - ↓ Medicaid Cost Study funding
  - ↓ Block Grant funding
  - Continued staffing and facility costs
- Local health directors and nurse managers joined DPH consultants to address current costs of delivery of clinical services in LHDs

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## Practice Management (PM) Workgroup

Local Health Department Participants	DPH Participants
<b>Ann Abshur</b> <i>Wilkes County Health Department</i>	<b>Kathy Brooks</b> <i>Administrative Consultant</i>
<b>Kristy Brantley</b> <i>Franklin County Health Department</i>	<b>Pamela Cochran</b> <i>PHNPD Nurse Consultant</i>
<b>Teresa Ellen</b> <i>Wilson County Health Department</i>	<b>Betty Cox</b> <i>Women's Health Nurse Consultant</i>
<b>Cindy Evans</b> <i>Wake Health &amp; Human Services</i>	<b>Tara Lucas</b> <i>Child Health Nurse Consultant</i>
<b>Vicky Howell</b> <i>Nash County Health Department</i>	<b>Elizabeth Mizelle</b> <i>Data Manager, Children &amp; Youth Branch</i>
<b>Anita Knight</b> <i>Rockingham County Health Department</i>	<b>Joy Reed</b> <i>Local Technical Assistance &amp; Training Branch</i>
<b>Pam McCall</b> <i>Orange County Health Department</i>	<b>Phyllis Rocco</b> <i>Communicable Disease Nurse Consultant</i>
<b>Laura Price</b> <i>Union County Health Department</i>	<b>Jean Vukoson</b> <i>Child Health Nurse Consultant</i>
<b>Leah Thorndyke</b> <i>Johnson County Health Department</i>	
<b>Chris Szwagiel</b> <i>Franklin County Health Department</i>	

[ 6 ]

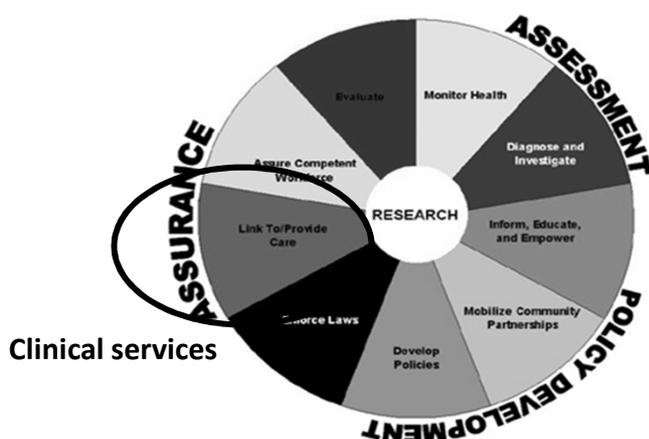
## PM Workgroup Objectives

- Improve health outcomes by improving clinic efficiency and cost effective services
- Develop and test productivity benchmarks & staffing models
  - Provider/RN productivity: average 20/visits/day
  - Consensus staffing model for public health
- Develop tools and skills training to support
  - Balance-Supply and Demand for services
  - Improve revenue
  - Decrease cost of care

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## Why is PM work important?

The role of public health is to improve health outcomes of our communities



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## Why is PM work important?

**Improved practice management skill supports your ability to sustain personal health services to assure access to care**

- Loss of Medicaid revenue impacts all programs & services
  - WCH services have traditionally helped cover the cost of mandated services
  - Limited clinical revenue → reduces funds to cover the services
- PM cost reduction helps sustain needed clinical services & creates opportunity for redeployment of resources to community health

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## Practice Management

- Creates the structure, skills and processes to understand your clinical services & take data driven actions to:
  - Improve the clinical outcomes & patient experience of care
  - Optimize staff resources to highest level of skill & licensure
  - Reduce costs through system waste reduction
  - Free resources for needed public health strategies

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## DPH Practice Management Team Charge

- Develop benchmarks & staffing models for public health
- Develop data dashboard for practice management
- Develop training to support practice management
  - Practice management overview & tools
  - Billing & coding
  - Data reports and analysis



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## PM Team Recommendations

- Establish Clinical Services Manager position or a Practice Management Team to cohesively manage clinical services
  - Joint objectives & decision making
  - Joint communication with staff
- Team members:
  - Finance
  - Nursing/clinical manager
  - ADM Support manager



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## PM Team Recommendations

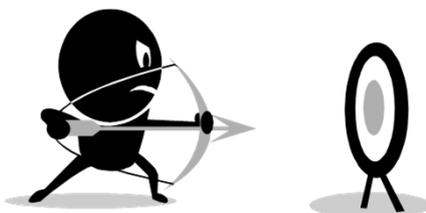
- Health director develop specific clear SMART objectives for change
  - Joint objectives for the PM Team supports team work and team success
- Develop a local data dashboard to monitor progress & guide decision making
- Train PM Team in data analysis & joint decision making
- Designate a QI lead for change initiatives



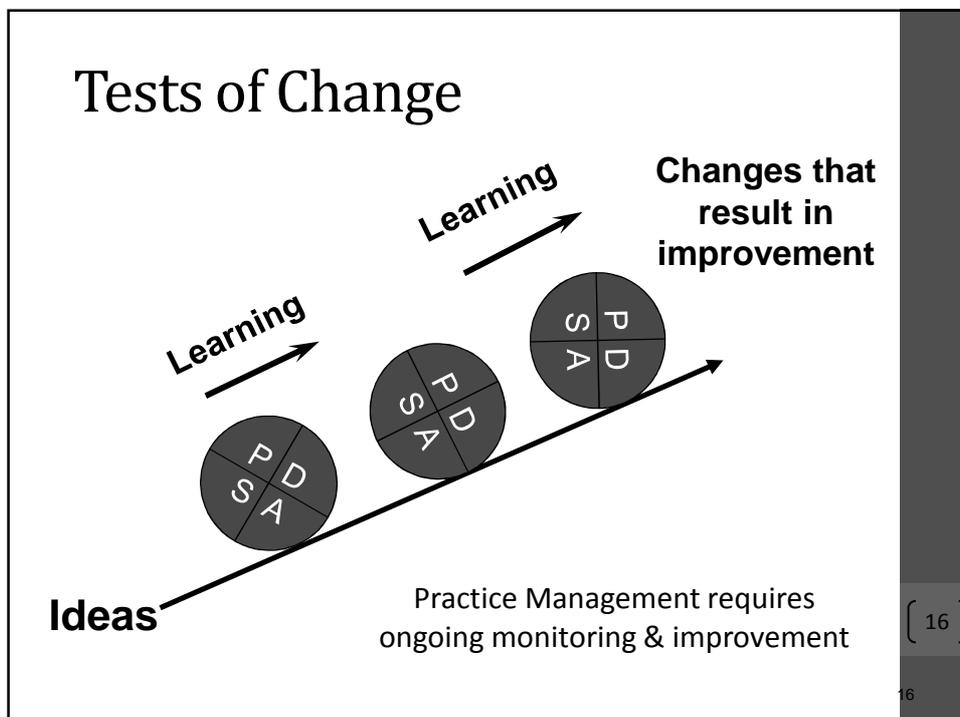
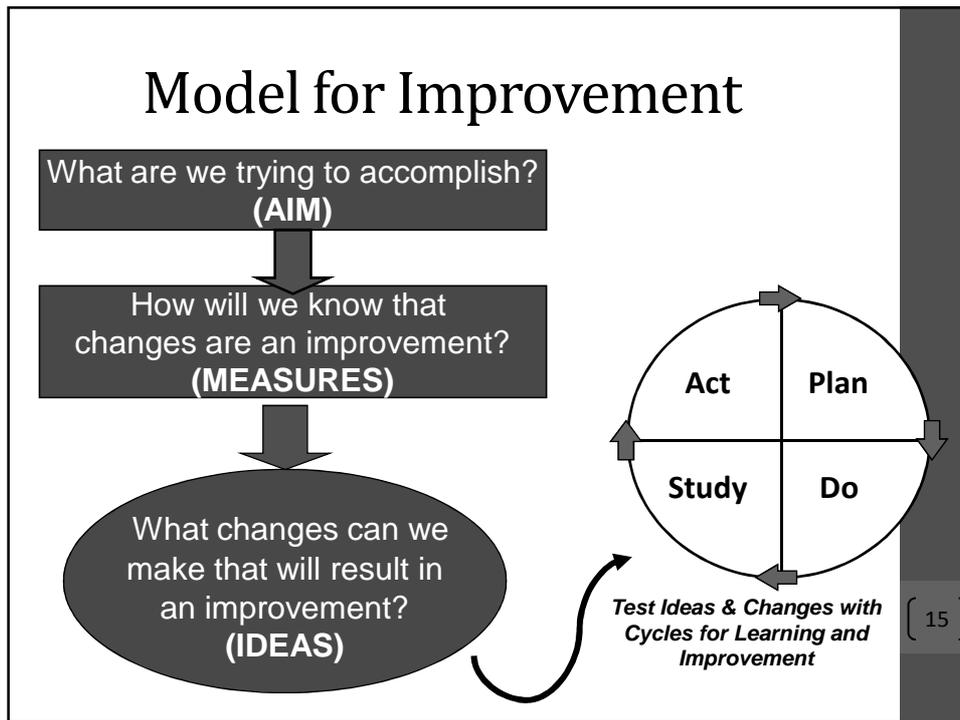
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What are we trying to accomplish?

AIM



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## Public Health Productivity Benchmarks

- Provider: Average 20 visits/day  
4,800 visits/year
- Nurse Clinic: Average 20 visits/day/RN  
4,800 visits/year
- CH ERNs: Average 6\* WCC exams/day  
with clinical support  
1,440 visits/year
- STD ERNs: 45 min full assessments; *visit expectations based on demand*

*Annual productivity & capacity calculations based on 5 days/week X 48 Weeks*

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## Benchmark Calculations

- **Average of 20 patients seen per day X 48 weeks per year**
- More appointment slots must be available in schedule to average (assume no show rate of 10-15%)
- MD/NP/PA schedule assumes 40% preventative & 60% problem visits
- Child Health ERN benchmark assumes support for work up and immunizations



*The benchmark represents the number of patients seen not appointment availability*

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## Public Health Staffing Model

STAFFING	PRIVATE PRACTICE MODEL		CONSENSUS PUBLIC HEALTH MODEL	
	FTE	RATE/HOUR	FTE	RATE/HOUR
Provider	1.0 NP	\$ 50	1.0 NP	\$ 50
RN	0.5	\$ 20	1.0 *	\$40
Clinic Assistant	1.0	\$ 18	0.5	\$ 9
Lab	0.15	\$ 2.70	0.5**	\$ 9
Interpreter ( <i>compare to PH</i> )	0.75	\$ 21	0.75***	\$ 21
Clerical (Reception, Eligibility, Med Records)	1.0	\$18	1.0	\$ 18
Billing	0.25	\$4.50	0.25	\$ 4.5
<b>Total all staff per hour</b>		<b>\$ 132.20</b>		<b>\$ 151.5</b>
<b>Total all staff X 8H/day</b>		<b>\$ 1,073</b>		<b>\$ 1,212</b>
<b>Total all staff X 2080H/year</b>		<b>\$ 279,136</b>		<b>\$ 315,120</b>
<b>Projected revenue****</b>		<b>\$ 374,400</b>		<b>\$ 374,400</b>
<b>Revenue minus costs</b>		<b>\$ 95,264</b>		<b>\$ 59,280</b>

\* Assumes a minimum of 40% preventative visits; process driven need  
 \*\* Assumes primary care plus WCH  
 \*\*\* Assumes no providers or staff are bilingual; assumes ~40% LEP clients  
 \*\*\*\* NP/PA average 20 patients/visit x 48 weeks = \$374,400 revenue; Revenue calculation based on 99213 Medicaid rate  
 Revenue projected based on 99213 Medicaid rate  
 SALARY/FRINGE  
 NP/PA: \$50  
 MD: \$75

Total all staff per hour x 2080HRs (1.0FTE) = \$315,120

1.0 FTE = 4,800 visits/year (Avg 20 visits/day (100/week) X 48 weeks) 4,800 visits X \$78 (99213) = \$374,400

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Projected revenue minus cost

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Note: projected revenue based on 100% reimbursement for services

\$315,120 divided by 4,800 visits = \$65.65 per visit cost

Revenue minus staffing cost "in the black" or positive number

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## Interim Model based on Stakeholder Feedback

STAFFING	CONSENSUS PUBLIC HEALTH MODEL		PROPOSED INTERIM PUBLIC HEALTH MODEL DEC 2013	
	FTE	RATE/HOUR	FTE	RATE/HOUR
Provider	1.0 NP	\$ 50	1.0 NP	\$50
RN	1.0 *	\$40	2.0	\$80
Clinic Assistant	0.5	\$ 9		
Lab	0.5**	\$ 9	0.5	\$9
Interpreter ( <i>compare to PH</i> )	0.75***	\$ 21	0.75	\$21
Clerical (Reception, Eligibility, Med Records)	1.0	\$ 18	2.0	\$36
Billing	0.25	\$ 4.5	0.5	\$9
<b>Total all staff per hour</b>		<b>\$ 151.5</b>		<b>\$205</b>
<b>Total all staff X 8H/day</b>		<b>\$ 1,212</b>		<b>\$1,640</b>
<b>Total all staff X 2080H/year</b>		<b>\$ 315,120</b>		<b>\$426,400</b>
<b>Projected revenue****</b>		<b>\$ 374,400</b>		<b>\$374,400</b>
<b>Revenue minus costs</b>		<b>\$ 59,280</b>		<b>minus -\$52,000</b>

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## Staffing Calculations

- FTE directly supporting clinical services:  
“If you did not provide clinical services what staff would be needed?”
- Includes:
  - Supervision of clinical services
  - Triage, follow-up of care, and program coordination (Administrative Time for staff)
- Excludes:
  - Overhead costs
  - CD management (non-clinical services)
  - Community services (PPNBV, CC4C, OBCM)
  - Preparedness, Accreditation

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## Staffing Cost Calculations

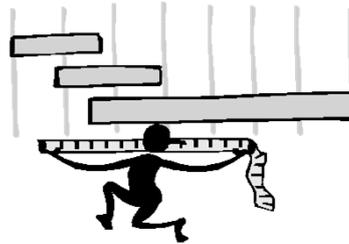
- Cost reflect *average* salary plus 28 % fringe; LHDs may want to calculate an average per discipline which reflects your actual costs
- Hourly rates were calculated based on FTE & added for total staffing cost/hour; multiplied by 8 hours for staffing cost per day; and the total hourly rate multiplied by 2080 hours for annual costs

### SALARY/FRINGE/HR Calculations:

NP/PA:	\$50
MD:	\$75
RN:	\$40
CA:/LAB/Clerical:	\$18
INTERPRETER:	\$28

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## How will we know that changes are an improvement? MEASURES



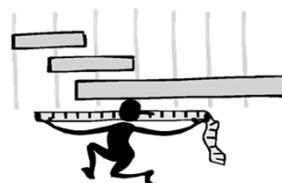
### Why Measure?

- Make data driven, informed decisions
- Monitor progress toward goal(s)
- Monitor sustainability

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## What do we measure?

- Budgeted vs. actual revenue
- Revenue compared to costs
- Payer source by program
- Productivity benchmarks: capacity vs. actual
- Demand for services by program
- No show rate by program



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## Data Resources

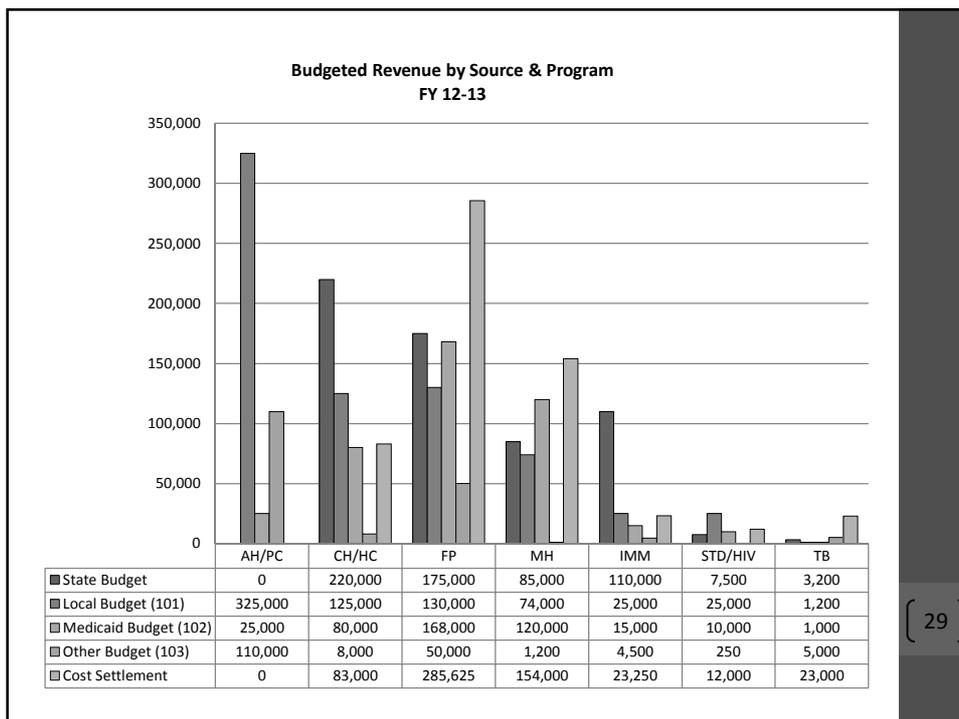
- See Practice Management Resources webpage under RESOURCES for a guide to HIS/CDSW reports:  
<http://sgiz.mobi/s3/Public-Health-Practice-Management-Resources>
- LHDs migrating to vendor EHRs are reminded that each agency is required to submit service data to HIS monthly
  - Option to use vendor reports or HIS reports
  - EHR vendors are not using LU codes

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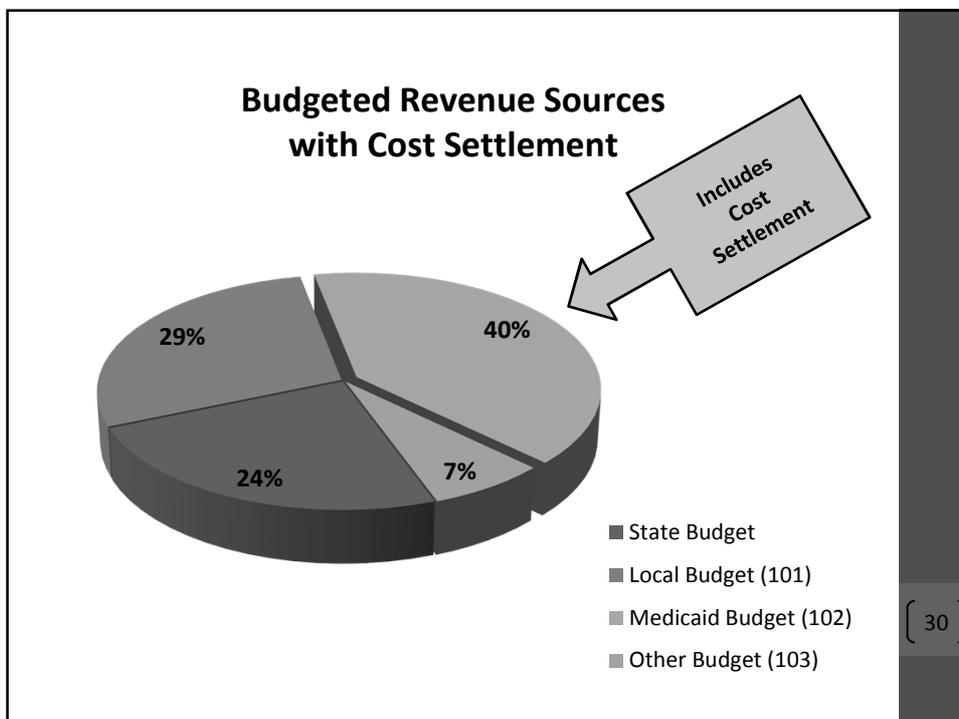
## Sample Health Department Data Dashboard July 2012-Jan 2013

	AH/PC	CH/HC	FP	MH	IMM	STD/HIV	TB	Total
State Budget	0	220,000	175,000	85,000	110,000	7,500	3,200	600,700
Local Budget (101)	325,000	125,000	130,000	74,000	25,000	25,000	1,200	705,200
Medicaid Budget (102)	25,000	80,000	168,000	120,000	15,000	10,000	1,000	419,000
Other Budget (103)	110,000	8,000	50,000	1,200	4,500	250	5,000	178,950
Cost Settlement	0	83,000	285,625	154,000	23,250	12,000	23,000	580,875
<b>Budget (all w/o cost settlement)</b>	<b>460,000</b>	<b>433,000</b>	<b>523,000</b>	<b>280,200</b>	<b>154,500</b>	<b>42,750</b>	<b>10,400</b>	<b>1,903,850</b>
Budget (Current Month)	38,333	36,083	43,583	23,350	12,875	3,563	867	158,654
<b>YTD Expenditures</b>	<b>275,020</b>	<b>380,977</b>	<b>236,819</b>	<b>135,926</b>	<b>185,000</b>	<b>27,359</b>	<b>4,729</b>	<b>1,245,830</b>
% of annual budget expended YTD	60%	88%	45%	49%	120%	64%	45%	65%
<b>YTD Billing (BL110)</b>								
Medicaid	18,365	96,000	84,359	72,350	9,743	6,700	650	288,167
Insurance	2,700	1,632	25,468	756	2,670	95	0	33,321
Patient Pay	43,850	31,733	36,000	8,350	2,200	0	2,800	124,933
<b>Total All Billing</b>	<b>64,915</b>	<b>129,365</b>	<b>145,827</b>	<b>81,456</b>	<b>14,613</b>	<b>6,795</b>	<b>3,450</b>	<b>446,421</b>
<b>YTD Revenue (BL110 or AR404)</b>								
Medicaid (102)	16,345	85,440	75,080	64,392	8,671	5,963	579	256,469
Insurance (103)	3,245	734	11,461	340	1,202	43	0	17,024
Patient Pay (103)	9,647	6,981	7,920	1,837	484	0	2,650	29,519
<b>Total all Revenue</b>	<b>29,237</b>	<b>93,156</b>	<b>94,460</b>	<b>66,569</b>	<b>10,357</b>	<b>6,006</b>	<b>3,229</b>	<b>303,012</b>
<b>% of annual budgeted revenue received YTD</b>	<b>22%</b>	<b>106%</b>	<b>43%</b>	<b>55%</b>	<b>53%</b>	<b>59%</b>	<b>54%</b>	<b>51%</b>
<b>Current Month Visits (GC020P-T)</b>	<b>80</b>	<b>15</b>	<b>155</b>	<b>180</b>	<b>100</b>	<b>82</b>	<b>10</b>	<b>622</b>
<b>YTD Visits (GC020P-T)</b>	<b>434</b>	<b>157</b>	<b>1266</b>	<b>1218</b>	<b>724</b>	<b>547</b>	<b>85</b>	<b>4,431</b>

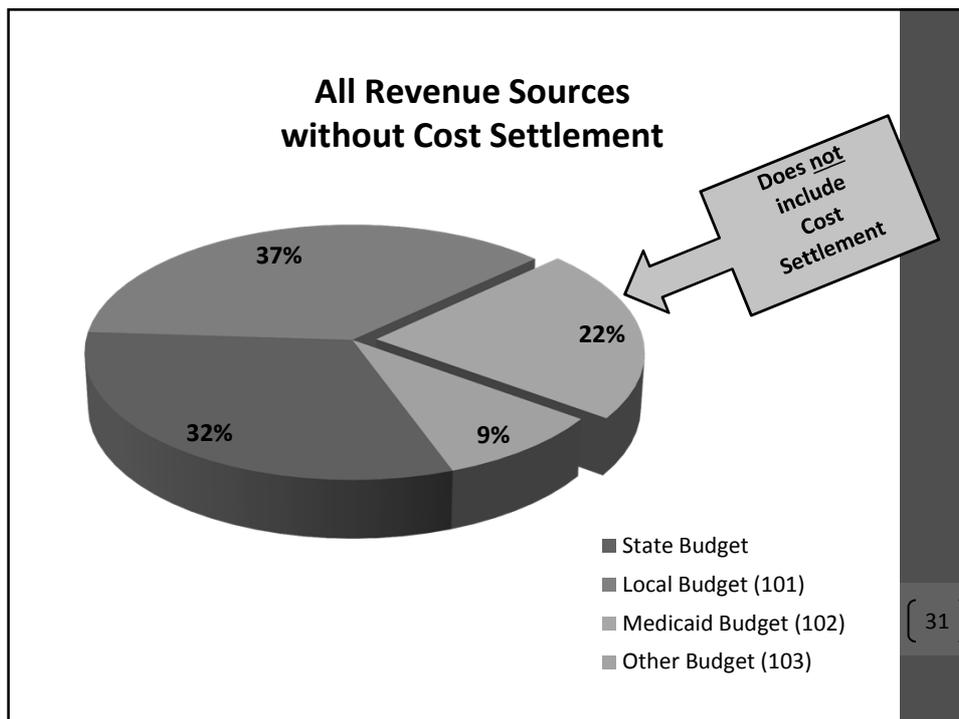
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## The Budgeting Process

- What is the budgeting process within your agency?
  - Who is involved?
  - What factors are used to determine increases or decreases?
  - What percent of your overall budget comes from Local County contributions?
- What revenue reports are used in determining budget amounts for Medicaid, Insurance and Patient Pay?
- Are budget updates shared with staff throughout the year?

AR404 Period Income Report Summary by Program Date of Receipt: 7/1/2012 Through 1/31/2013				
Program	QTY (svcs)	Guarantor Liability (amount billed)	Payments	
AH	28	\$18,365.00	\$16,344.85	
CH	396	\$96,000.00	\$85,440.00	
FP	227	\$84,359.00	\$75,079.51	
IM	473	\$9,743.00	\$8,671.27	
MH	157	\$72,350.00	\$64,391.50	
ST	33	\$6,700.00	\$5,963.00	
TB	18	\$650.00	\$578.50	
<b>RSC Totals:</b>		<b>\$288,167.00</b>	<b>\$256,468.63</b>	( 33 )

AR404 Period Income Report Summary by Financial Class Date of Receipt: 7/1/012 Through 1/31/2013				
Financial Class	QTY	Service Fee (amount billed)	Payments	
Commercial	1,571	\$33,321.00	\$17,024.00	
Medicaid	2,249	\$288,167.00	\$256,469.00	
Self Pay	611	\$124,933.00	\$29,519.00	
<b>County Totals</b>	<b>4,431</b>	<b>\$446,421.00</b>	<b>\$303,012.00</b>	
<b>RSC Totals</b>	<b>4,431</b>	<b>\$446,421.00</b>	<b>\$303,012.00</b>	( 34 )

## Total Billed by Program

	AH/PC	CH/HC	FP	MH	IMM	STD/ HIV	TB	Total
<b>Medicaid</b>								
<b>Insurance</b>								
<b>Patient Pay</b>								

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## Billing & Revenue Review

- Are you receiving your anticipated reimbursement from all pay sources?
- Does your agency bill insurance (other than Medicaid)?
  - To remain competitive in today's market it is recommended that you seek "in network" status from additional third party payers
- Do you currently have a designated staff person who reviews denials and rebills as needed?
  - This activity is an important piece in the reimbursement process and can make a significant impact on whether or not you meet the amount budgeted for each pay source.

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GC020P-T Patient Count by Program 7/1/2012 Through 1/31/2013					GC020P-T Patient Count by Program 1/1/2013 Through 1/31/2013				
Program	Total Unduplicate d Patients	Total Visits	Medicaid	Non-Medicaid	Program	Total Unduplicate d Patients	Total Visits	Medicaid	Non-Medicaid
AH	338	434	399	35	AH	62	80	74	6
CH	111	136	125	11	CH	22	27	25	2
FP	879	1266	215	1051	FP	108	155	26	129
HC	21	21	19	2	HC	8	8	8	0
IM	682	724	326	398	IM	94	100	45	55
MH	367	1218	1060	158	MH	48	155	136	19
ST	462	547	20	527	ST	69	82	3	79
TB	45	85	85	0	TB	5	10	0	10

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## Unduplicated vs Visits

- Unduplicated numbers reflect the individual clients seen
- Visits reflect the number of visits made by each unduplicated client
- Review the number of unduplicated clients and visits in each program you provide
  - Are the results what you expected? If not consider why.
  - Do you need to make changes to affect them up or down?
  - What changes would you make?

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GC020P-T Patient Count by Program 1/1/13 Through 6/30/2013							
MODIFIED TO INCLUDE PERCENTAGES							
Program	Total Unduplicated Patients	Total Visits	% of Total	Medicaid (Unduplicated Pts)	Medicaid % of Program Unduplicated	Non-Medicaid (Unduplicated Pts)	Non-Medicaid % of Program Unduplicated
AH	338	434	10%	313	93%	25	7%
CH	111	136	3%	103	93%	8	7%
FP	879	1266	29%	187	21%	692	79%
HC	21	21	0%	21	100%	0	0%
IMM	682	724	16%	307	45%	375	55%
MH	367	1218	27%	322	88%	45	12%
ST	462	547	12%	20	4%	442	96%
TB	45	85	2%	0	0%	45	100%
<b>Total</b>	<b>2905</b>	<b>4431</b>					

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## Pay Source by Program

- Does your agency track how many visits are made by Medicaid and Non-Medicaid clients?
  - Identify the percent of Medicaid and Non-Medicaid clients in each program. Chances are you will find a greater number in some programs versus others (e.g.. Family Planning typically has fewer Medicaid clients than Maternal Health)
  - Consider ways to increase the number of clients with Medicaid coverage. Examples could be ensuring that clients receive the application and having someone assist clients with the application process. *Remember you can encourage but not require them to apply.*

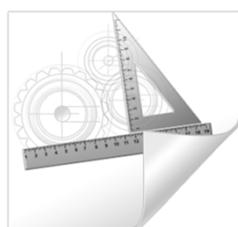
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# Review Financial Data Dashboards

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# Practice Management Assessment Tools Public Health Staffing Model



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**\$315,120 staffing costs divided by 4,800 visits/year = \$65.65/visit**

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RN	0.5	\$ 20	1.0 *	\$40
Clinic Assistant	1.0	\$ 18	0.5	\$ 9
Lab	0.15	\$ 2.70	0.5**	\$ 9
Interpreter ( <i>compare to PH</i> )	0.75	\$ 21	0.75***	\$ 21
Clerical (Reception, Eligibility, Med Records)	1.0	\$18	1.0	\$ 18
Billing	0.25	\$4.50	0.25	\$ 4.5
<b>Total all staff per hour</b>		<b>\$ 132.20</b>		<b>\$ 151.5</b>
<b>Total all staff X 8H/day</b>		<b>\$ 1,073</b>		<b>\$ 1,212</b>
<b>Total all staff X 2080H/year</b>		<b>\$ 279,136</b>		<b>\$ 315,120</b>
<b>Projected revenue****</b>		<b>\$ 374,400</b>		<b>\$ 374,400</b>
<b>Revenue minus costs</b>		<b>\$ 95,264</b>		<b>\$ 59,280</b>

Note: projected revenue based on 100% reimbursement for services

Compare agency's actual Medicaid revenue to projection  
EX: 37% Medicaid = actual revenue of \$138,528

## Public Health Staffing Model

STAFFING	PRIVATE PRACTICE MODEL		CONSENSUS PUBLIC HEALTH MODEL	
	FTE	RATE/HOUR	FTE	RATE/HOUR
Provider	1.0 NP	\$ 50	1.0 NP	\$ 50
RN	0.5	\$ 20	1.0 *	\$40
Clinic Assistant	1.0	\$ 18	0.5	\$ 9
Lab	0.15	\$ 2.70	0.5**	\$ 9
Interpreter ( <i>compare to PH</i> )	0.75	\$ 21	0.75***	\$ 21
Clerical (Reception, Eligibility, Med Records)	1.0	\$18	1.0	\$ 18
Billing	0.25	\$4.50	0.25	\$ 4.5
<b>Total all staff per hour</b>		<b>\$ 132.20</b>		<b>\$ 151.5</b>
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<b>Projected revenue****</b>		<b>\$ 374,400</b>		<b>\$ 374,400</b>
<b>Revenue minus costs</b>		<b>\$ 95,264</b>		<b>\$ 59,280</b>

At 50% productivity it costs \$131.30 to deliver each visit

If 37% Medicaid: \$48.58 (37%) of the \$131.30 cost is covered

↓ Medicaid revenue + ↓ productivity + ↑ cost = practice management change imperative

{ 45 }

## Sample County Health Department

Public Health Staffing Model applied to a sample LHD

STAFFING	PUBLIC HEALTH CONSENSUS MODEL		SAMPLE COUNTY HEALTH DEPARTMENT		Benchmark comparison
	FTE	RATE/HOUR	FTE	RATE/HOUR	
Provider	1.0 NP	\$ 50	1.5 NP	\$ 75	➔ 2.25 FTE
RN	1.0 *	\$40	5.5	\$220	
Clinic Assistant	0.5	\$ 9	1.0	\$18	➔ 1.87 FTE
Lab	0.5**	\$ 9	1.0	\$ 18	
Interpreter ( <i>compare to PH</i> )	0.75***	\$ 21	2.0	\$ 36	➔ \$472,680
Clerical (Reception, Eligibility, Med Records)	1.0	\$ 18	8.0	\$144	
Billing	0.25	\$ 4.5	2.0	\$ 36	➔ \$88,920 <sub>46</sub>
<b>Total all staff per hour</b>		<b>\$ 151.5</b>		<b>\$547</b>	
<b>Total all staff X 8H/day</b>		<b>\$ 1,212</b>		<b>\$4,376</b>	
<b>Total all staff X 2080H/year</b>		<b>\$ 315,120</b>		<b>\$1,137,760</b>	
<b>Projected revenue****</b>		<b>\$ 374,400</b>		<b>\$561,600</b>	
<b>Revenue minus costs</b>		<b>\$ 59,280</b>	<i>minus</i>	<b>(\$576,160)</b>	

\$374,400 X 1.5 FTE

## The bottom line for SCHD

SAMPLE COUNTY HEALTH DEPARTMENT		
STAFFING	FTE	RATE/HOUR
Provider	1.5 NP	\$ 75
RN	5.5	\$220
Clinic Assistant	1.0	\$18
Lab	1.0	\$ 18
Interpreter (compare to PH)	2.0	\$ 36
Clerical (Reception, Eligibility, Med Records)	8.0	\$144
Billing	2.0	\$ 36
<b>Total all staff per hour</b>		<b>\$547</b>
<b>Total all staff X 8H/day</b>		<b>\$4,376</b>
<b>Total all staff X 2080H/year</b>		<b>\$1,137,760</b>
<b>Projected revenue****</b>		<b>\$561,600</b>
<b>Revenue minus costs</b>	<i>minus</i>	<b>(\$576,160)</b>

Cost per visit at benchmark productivity: **\$158**

*\$1,137,760 divided by 7,200 visits (1.5 FTE)*

Cost per visit at 50% productivity: **\$316**

*\$1,137,760 divided by 3,600 visits (1.5 FTE)*

Projected revenue minus cost at benchmark: **(-\$576,160)**

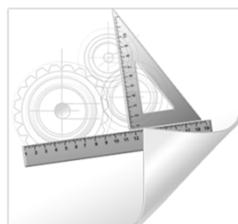
*\$1,137,760 minus benchmark projected revenue \$561,600 = (-\$576,160)*

37% Medicaid revenue minus cost = **(-\$929,968)**

*37% of projected revenue \$561,600 = \$207,792 subtracted from staffing costs \$1,137,760 = (-\$929,968)*

( 47 )

## Practice Management Assessment Tools Clinical Staffing



( 48 )

## Clinical Staffing Worksheet

- We recommend that you do it by program or clinic, i.e. MH Clinic or an integrated clinic (CH/FP/STD)
- Clinical hours are direct care tasks
  - All activities in care delivery including triage, assessment, referral & documentation
- Administrative Time for clinical services:
  - Policy and procedure development
  - Follow-up on abnormal labs or referrals
  - Team meetings & training

[ 49 ]

## Staffing Calculations

- FTE directly supporting clinical services:  
“If you did not provide clinical services what staff would be needed?”
- Includes:
  - Supervision of clinical services
  - Triage, follow-up of care, and program coordination (Administrative Time for staff)
- Excludes:
  - Overhead costs
  - CD management (non-clinical services)
  - Community services (PPNBV, CC4C, OBCM)
  - Preparedness, Accreditation

[ 50 ]

Staffing Model Worksheet

PH Consensus  
Hourly rate based  
on FTE of 1.0

Staffing	Private Practice		PH Consensus			
	FTE	Rate/Hour	FTE	Rate/Hour	FTE	Rate/Hour
Provider	1.0 NP	50.00	1.0 NP	50.00	\$50	
RN	0.5	20.00	1	40.00	\$40	
Clinic Assistant	1	18.00	0.5	9.00	\$18	
Lab	0.15	2.70	0.5	9.00	\$18	
Interpreter (compare to PH)	0.75	21.00	0.75	21.00	\$28	
Clerical (Reception, Eligibility, Med Rec)	1	18.00	1	18.00	\$18	
Billing	0.25	4.50	0.25	4.50	\$18	
Total all staff per hour		134.20		151.50		
Total all staff x 8h/day		1,073.60		1,212.00		\$0.00
Total all staff x 2080h/yr		279,136.00		315,120.00		\$0
Projected revenue (4800 visits x \$78)		374,400.00		374,400.00		
Revenue minus costs		95,264.00		59,280.00		\$0.00

( 51 )



## Compare Your Staffing Model

( 52 )



## Group Activity

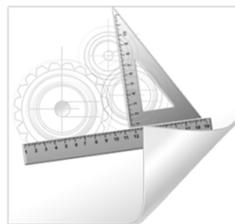


**With your agency team, use the Staffing Model Handout to compare your current staffing for a specific program or integrated model to the Public Health Staffing Model**

- Calculate your cost per hour
- Discuss & document your concerns re staffing levels and cost

53

## Practice Management Assessment Tools Productivity Calculations



[ 54 ]

## Calculating Capacity & Utilization of Capacity

- Benchmark Capacity = average 20 visits/day  
 $20 \text{ visits/day} \times 5 \text{ days/week} \times 48 \text{ weeks/year} = 4,800 \text{ visits/year}$
- Number of patient visits actually seen per year/capacity  $\times 100 = \% \text{ Utilization}$   
 For example: 2000 patients visits actually seen in 2013:  $2000/4,800 \text{ potential visits in 2013} = 0.416 \times 100\% = 41.67\%$  (Agency used less than 50% of their capacity.)

[ 55 ]

## Provider Productivity

- Provider productivity is impacted by provider efficiency, practice style & preference **AND how clinical services are organized:**
  - Demand for services
  - Best practice flow models
  - How services are scheduled
  - Staffing skill and licensure
  - Clinical space organization



[ 56 ]

## Notes on Clinical Data Worksheets

- The worksheets provide data on productivity & financing of services by program → this data will be used in more detailed review of your practice
- Review of the worksheets in this training is meant to stimulate questions for further evaluation by your PM Team



[ 57 ]

## Notes on Clinical Data Worksheets

- The clinical data worksheets will also be used to organize the data dashboards that the PM Team will use to assess & monitor your practice
- Organize the data to make sense for your teams
  - By county if district
  - By program if stand alone clinics or by clinic if integrated services



[ 58 ]



# Review Clinical Data Dashboards

CLINICAL DATA DASHBOARD

TABLE 1

Sample County Health Department

Data Summary July 1, 2013 – December 31, 2013

Program	Total Patients	Total Visits	Medicaid	Non-Medicaid	Percent Medicaid	Percent Non-Medicaid	Average Visit/Day	% of Total Visits By Program	Medicare	Insurance	Self-Pay
AH/PC	210	261	10	200	5%	95%	2/day	3	0	20	180
CH	132	136	132	0	100%	0%	1/day	2	0	0	0
FP	888	1998	631	257	71%	29%	17/day	26	0	37	220
HC	184	189	184	0	100%	0%	2/day	3	0	0	0
IM	1069	1310	926	143	87%	13%	11/day	17	0	139	4
ST	906	1100	423	488	47%	53%	9/day	14	0	3	420
TB	502	965	400	102	80%	20%	8/day	13	0	0	102
MH	518	1659	22	496	77%	23%	14/day	22	0	0	496
<b>Total</b>	<b>4409</b>	<b>7618</b>	<b>2728</b>	<b>1686</b>	<b>62%</b>	<b>38%</b>	<b>64/day</b>	<b>100</b>	<b>0</b>	<b>199</b>	<b>1422</b>

Note: 5 days/week X 24 weeks or 6 Months = 120 days



## Group Activity

### Review your data for Clinical Data Worksheets Table 1

#### Compare your programs:

- What is the largest and smallest programs based on # visits/day ? Discuss & document which programs you may have concerns about the productivity

#### What is the percent Medicaid for these program?

- Discuss & document your concerns re: your largest & smallest programs: is there revenue to cover the services? Identify concerns re: sustainability of the programs if revenue is not covering the cost

{ 61 }



## Group Activity

### Review your data for Clinical Data Worksheets Table 3

#### Choose a provider from your largest & smallest program & review their productivity and filled capacity (benchmark)

- If your provider is not at benchmark (20 visits/day), discuss & document possible causes?
- If your No Show Rate for this provider is >15%, discuss & document possible causes?

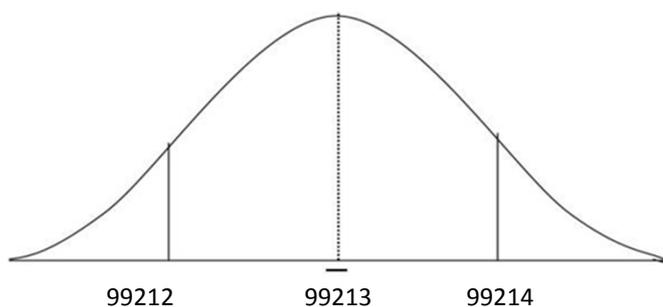
62

TABLE 4  
 Sample County Health Department  
 CPT Code by Program July 1, 2013 – December 31, 2013

CODE	AH/PC	CH	HC	IM	FP	MH	ST	TB	TOTAL	%TOTAL
99211	0	12	0		134	139	0		385	5%
99212	141	0	0		613	312	210		1276	17%
99213	90	0	0		150	368	632		1140	15%
99214	10	0	0		279	497	518		1304	17%
99215	10	0	0		66	321	114		511	7%
Prevention	10	124	189		756	0	0		1979	26%
59425 4-6	0	0	0		0	4	0		4	0.1%
59426 7+	0	0	0		0	18	0		18	0.2%
Total	261	136	189	1310	1998	1659	1100	965	7618	

63

### Coding Bell Curve Established Visits



( 64 )



## Group Activity



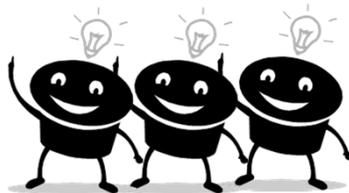
### Review your data for Clinical Data Worksheets Table 4

- Review the CPT codes by program. Are the codes distributed over a bell curve?
- Look for the codes with the most/least services. Do they reflect what is actually happening in the program?
- Do services seem to be coded too low/high? What are the patterns of coding among providers?

65

What changes can we  
make that will result in  
improvement?

DETAILED ASSESSMENT OF  
AGENCY CURRENT STATE



[ 66 ]

## Improvement Model

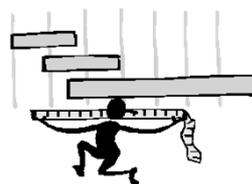
### AIM

- Improve visit outcomes through improved health literacy
- Improve efficiency/reduce wastes to optimize resources and improve revenue



### MEASUREMENT

- Productivity by provider and staff
- Lead time by visit type
- Patient satisfaction surveys
- Demand for services
- No show rate
- Cost and revenue



[ 67 ]

## Improvement Model

### CHANGE STRATEGIES

- Recommended strategies have been tested in public and private practices
- Will be implemented and evaluated through Plan Do Study Act cycles to “tweak” for your team
- Are staged to build experience in improvement process and allow for adjustment to your team



[ 68 ]

Reduce wastes → improve  
efficiency in care processes



[ 69 ]

## Identification of System “Wastes”

- Defects
- Overproduction
- Waiting
- Non Value-Added Processing
- Transportation
- Inventory
- Motion
- Employee (Underutilizing)

Typically 40-60% of all lead time is non-value added.

[ 70 ]

70

## Common Wastes seen in Management Support Staffing

### Non-value added Processing:

- Excessive lead times due to too many steps in process (duplicative or unnecessary): all clients going through eligibility/billing
- Completion of unnecessary tasks: i.e., unnecessary documentation, movement of staff or records

### Underutilized employees

- Assignment of care processes which do not require licensure and can be defined through policy & procedure (referrals, medical record requests, clinical data entry) to clinical staff

[ 71 ]

## Considerations for Assignment of Management Support Staff

### Cross training vs task-specific considerations

- Physical outlay of the facility
- Number and type of services provided
- Cycle times for registration/intake/eligibility/billing
- Status of billing and revenue
- Total Management Support staff
- Work schedules (e.g. Do you have all FT or some PT staff?)

[ 72 ]

## Common Wastes seen in Clinical Staffing

Underutilization of access capacity

- Provider or RN productivity less than benchmark
- Staffing capacity greater than demand for services
  - Calculate demand (Tool available); compare to your capacity
  - *Are you providing the services your clients want & need at times convenient to them?*
- No show rate >15%

[ 73 ]

## Common Wastes seen in Clinical Staffing

- Excessive lead times due to duplicative or unnecessary steps in process → increase cost, impact health communication & client satisfaction
- Two staff when one will do, i.e. duplication of follow-up or processing, interpreter + RN for check-in or RN reviewing history when FNP must also review → higher staffing costs; ↑ lead times
- Staff not utilized to highest education & licensure → increase staffing costs
- Referral & Follow-up in excess of programmatic requirements and evidence based practice → increase staffing cost without improvement in outcomes

[ 74 ]

## Clinical Productivity

- Clinical productivity is impacted by provider efficiency, practice style & preference **AND what services are offered & how clinical services are organized:**
  - **Demand for services**
    - *Is there demand for the services provided? Are there needs that you are not addressing? Should you provide vs assure services?*
  - **How services are scheduled**
    - *Are services provided on an Open Access Scheduling (OAS) system? Are services provided during days & times convenient to your clients?*

[ 75 ]

## Clinical Productivity

- Staffing scope, skill, and licensure
  - *Do you have the right mix of providers & support staff to deliver the defined services?*
  - *Are all staff functioning at their highest level of education & licensure? Are providers completing their required care processes? Are RNs assigned management support functions?*
  - *Is there a team approach to care: everyone supporting the process?*
- Clinical space organization & standardization
  - *Is clinical space organized for line of site direction & communication? Is room set up standardized to support multiple services with limited movement & transportation?*

[ 76 ]

## Clinical Productivity

- Best practice/evidenced based clinic flow models
  - *Long lead times for visits decrease the clients ability to hear & apply health recommendations*
  - *Duplicative and non-value added processes are eliminated*
- Move to EHR optimized clinic flow processes
  - *EHR should provide flexibility & tools to support the flow*
  - *Implementation should be planned to support consistent improvement in efficiency from initial rollout*

[ 77 ]

## Recap Day One



[ 78 ]



## Calculations Review

- **Calculating visits/day for part time staff:**

For 6 months: divide total # visits/provider  
by 24 weeks; divide by # days per/week they  
work

1000 visits divided by 24 weeks = 46/week  
46 divided by **3 days/week** = 15 visits/day

- **Use the same calculation to determine visits/day for programs offered less than 5 days/week**

MH: 1000 visits divided by 24 weeks = 46/week  
46 divided by **2 days/week** = 23 visits/day

[ 81 ]

## Calculations Review

### **Calculating FTE for staff who are not in clinic full time**

- Staff who work in a mix of clinical & non-clinical programs, calculate the portion of FTE assigned to each program
  - RN 0.5 FTE CC4C/0.5 Clinical  
Use 0.5 FTE for clinical staffing model calculation
  - Billing staff supporting Dental 0.4 & Clinical 0.6  
Use 0.6 FTE for clinical staffing model calculation

[ 82 ]

## Calculations Review

### Calculating FTE for supervision of clinical & community program or activities

- Supervisors: does the supervisor have accountabilities other than supervision of clinical services? If so calculate the portion of the total FTE designated for these duties & subtract from total FTE
  - Managing a community grants
  - Supervision of non-clinical program such as CC4C or Diabetes Education program
- DONs or ADM/Finance staff who are calculated in the overhead are not counted in the Clinical FTE

{ 83 }

## Sample County Health Department

Public Health Staffing Model applied to a sample LHD

STAFFING	PUBLIC HEALTH CONSENSUS MODEL		SAMPLE COUNTY HEALTH DEPARTMENT	
	FTE	RATE/HOUR	FTE	RATE/HOUR
Provider	1.0 NP	\$ 50	1.5 NP	\$ 75
RN	1.0 *	\$40	5.5	\$220
Clinic Assistant	0.5	\$ 9	1.0	\$18
Lab	0.5**	\$ 9	1.0	\$ 18
Interpreter ( <i>compare to PH</i> )	0.75***	\$ 21	2.0	\$ 36
Clerical (Reception, Eligibility, Med Records)	1.0	\$ 18	8.0	\$144
Billing	0.25	\$ 4.5	2.0	\$ 36
<b>Total all staff per hour</b>		<b>\$ 151.5</b>		<b>\$547</b>
<b>Total all staff X 8H/day</b>		<b>\$ 1,212</b>		<b>\$4,376</b>
<b>Total all staff X 2080H/year</b>		<b>\$ 315,120</b>		<b>\$1,137,760</b>
Projected revenue****		\$ 374,400		\$561,600
Revenue minus costs		\$ 59,280	minus	(\$576,160)

Calculation based on assessment of total FTE & excluding non-clinical FTE

- 5.5 RN includes:
- Provider support
  - Triage/Clinical FU
  - Program coordination
  - Supervision

## Sample County Health Department

*Public Health Staffing Model applied to a sample LHD*

STAFFING	PUBLIC HEALTH CONSENSUS MODEL		SAMPLE COUNTY HEALTH DEPARTMENT		
	FTE	RATE/HOUR	FTE	RATE/HOUR	
Provider	1.0 NP	\$ 50	1.5 NP	\$ 75	➔ 2.25 FTE
RN	1.0 *	\$40	5.5	\$220	
Clinic Assistant	0.5	\$ 9	1.0	\$18	
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Interpreter (compare to PH)	0.75****	\$ 21	2.0	\$ 36	
Clerical (Reception, Eligibility, Med Records)	1.0	\$ 18	8.0	\$144	➔ 1.87 FTE
Billing	0.25	\$ 4.5	2.0	\$ 36	
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<b>Total all staff X 2080H/year</b>		<b>\$ 315,120</b>		<b>\$1,137,760</b>	➔ \$472,680
Projected revenue****		\$ 374,400		\$561,600	
Revenue minus costs		\$ 59,280	minus	(\$576,160)	➔ \$88,920 <sub>85</sub>

\$374,400 X 1.5 FTE

**TABLE 3**  
**Sample County Health Department**  
 Data Summary July 1, 2013 – December 31, 2013  
**AVERAGE NUMBER OF PATIENTS SEEN PER DAY PER PROVIDER, CAPACITY AND NO SHOW RATE**

Provider (List Providers/RNS below)	Average # Patients Seen/Day	# Days in Clinic	Capacity of Provider/RNs (120 days worked in 6 months X 20 patients/day PH Consensus Model BM = 2400 potential patients/6 mos)	% No Show Rate By Provider
MD-A (AH/PC/STD/CH)	14/day 1686/120 (# visits/# clinic days)	5	70.25% of capacity used (1686 patients seen/2400 potential patients/day)	50%
MD-B (FP)	17/day 1998/120 (# visits/# clinic days)	5	83% of capacity used (1998 patients seen/2400 potential patients/day)	42%
MD-C (MH)	23/day 1659/72 (# visits/# clinic days)	3	115% of capacity used (1659 patients seen/1440 potential patients/day)	25%

1. 5 days/week X 24 weeks or 6 Months = 120 days
2. No-show rate is the % of scheduled patients who showed up for their appointment divided by the total number of scheduled appointments X 100%.

**TABLE 3**  
**Sample County Health Department**  
**Data Summary July 1, 2013 – December 31, 2013**  
**AVERAGE NUMBER OF PATIENTS SEEN PER DAY PER PROVIDER, CAPACITY AND NO SHOW RATE**

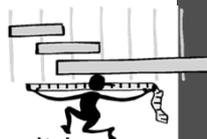
Nurse A (Gen RN)	2/day 178/120(# visits/# clinic days)	5	7% of capacity used (178 patients seen/2400 potential patients/day)	87%
Nurse B (Gen RN)	2/day 232/120(# visits/# clinic days)	5	10% of capacity used (232 patients seen/2400 potential patients/day)	87%
Nurse C (Gen RN)	5/day 555/120 (# visits/# clinic days)	5	23% of capacity used (555 patients seen/2400 potential patients/day)	67%
Nurse D (IM)	11/day 1310/120 (# visits/# clinic days)	5	55% of capacity used (1310 patients seen/2400 potential patients/day)	27%
OVER-ALL TOTALS	64/day 7618/120 (# visits/# clinic days)		48% of capacity used 7618 total patients seen/15840 total capacity	55% Over-all

1. 5 days/week X 24 weeks or 6 Months = 120 days  
2. No-show rate is the % of scheduled patients who showed up for their appointment divided by the total number of scheduled appointments X 100%.

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## What do we measure?

- Budgeted vs. actual revenue
  - What percent of your budgeted revenue did you actually receive?
- Revenue compared to costs
  - Compare your staffing costs to your actual revenue--do you have concerns?
- Payer source by program
  - Did you identify programs which are at risk due to low revenue?
- Think about what you will do--



( 88 )

## Sample Health Department Data Dashboard July 2012-Jan 2013

	AH/PC	CH/HC	FP	MH	IMM	STD/HIV	TB	Total
State Budget	0	220,000	175,000	85,000	110,000	7,500	3,200	600,700
Local Budget (101)	325,000	125,000	130,000	74,000	25,000	25,000	1,200	705,200
Medicaid Budget (102)	25,000	80,000	168,000	120,000	15,000	10,000	1,000	419,000
Other Budget (103)	110,000	8,000	50,000	1,200	4,500	250	5,000	178,950
Cost Settlement	0	83,000	285,625	154,000	23,250	12,000	23,000	580,875
Budget (all w/o cost settlement)	460,000	433,000	523,000	280,200	154,500	42,750	10,400	1,903,850
Budget (Current Month)	38,333	36,083	43,583	23,350	12,875	3,563	867	158,654
YTD Expenditures	275,020	380,977	236,819	135,926	185,000	27,359	4,729	1,245,830
% of annual budget expended YTD	60%	88%	45%	49%	120%	64%	45%	65%
YTD Billing (BL110)								
Medicaid	18,365	96,000	84,359	72,350	9,743	6,700	650	288,167
Insurance	2,700	1,632	25,468	756	2,670	95	0	33,321
Patient Pay	43,850	31,733	36,000	8,350	2,200	0	2,800	124,933
Total All Billing	64,915	129,365	145,827	81,456	14,613	6,795	3,450	446,421
YTD Revenue (BL110 or AR404)								
Medicaid (102)	16,345	85,440	75,080	64,392	8,671	5,963	579	256,469
Insurance (103)	3,245	734	11,461	340	1,202	43	0	17,024
Patient Pay (103)	9,647	6,981	7,920	1,837	484	0	2,650	29,519
Total all Revenue	29,237	93,156	94,460	66,569	10,357	6,006	3,229	303,012
% of annual budgeted revenue received YTD	22%	106%	43%	55%	53%	59%	54%	51%
Current Month Visits (GC020P-T)	80	15	155	180	100	82	10	622
YTD Visits (GC020P-T)	434	157	1266	1218	724	547	85	4,431

( 89 )

## What do we measure?



- Productivity benchmarks: capacity vs. actual
  - What percent of your capacity are you filling?
  - Are there differences by program? by provider?
- Demand for services by program
  - Use tools to determine demand for services & consider the need for changes in services offered
- No show rate by program
  - Is your no show rate > 15%? If yes, what are the implications?

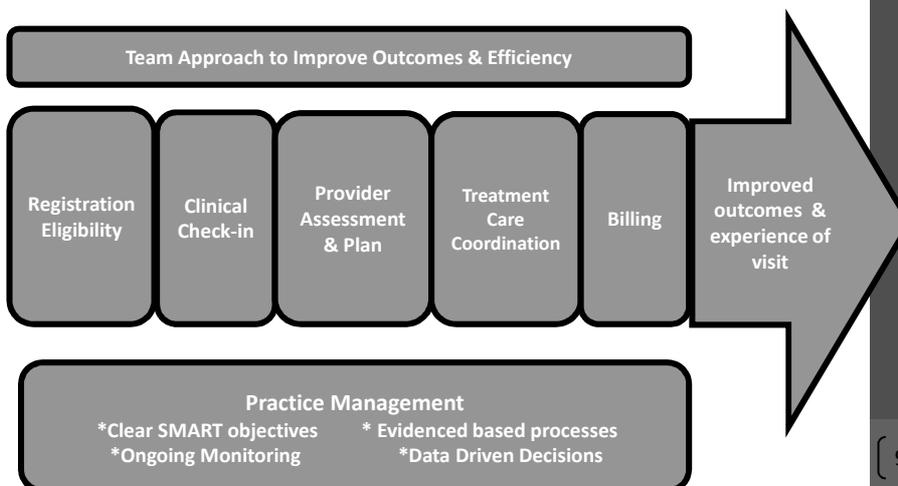
( 90 )

What changes can we make that will result in improvement?  
**BEST PRACTICE IDEAS**



[ 91 ]

## Improving Clinic Efficiency



[ 92 ]

## Organizing for Efficiency: Clinic Space

### Management Support Space

- Clear directions (signs & color coding) for check in process
- Standardize needed forms & equipment *in arms length*

### Clinic Space

- Organize provider close to exam rooms and support staff
- Standardize exam room set up to reduce staff movement
- Add flag systems to improve communication of patient status

[ 93 ]

## Organizing for Efficiency: Teams

- Management support teams work together to prepare for the visit & coordinate efficient check in processes
  - Organize staffing space & skills to limit bottlenecks
    - Map processes & organize to reduce steps
  - Create tools/capacity to reduce decision points for common tasks
    - Clear appointment guidance; clear referral policy & procedure
    - Sufficient appointment capacity to eliminate need for triage

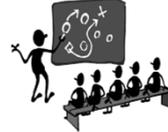


[ 94 ]

## Organizing for Efficiency: Teams

### Clinical Teams

- Create clinical team for each provider
  - The teams will “huddle” each morning and afternoon to review the schedule and pre-plan for care
  - Orders, flags & other cues will support ongoing communication in the team during care process



( 95 )

## Organizing for Efficiency: Schedules

- EVERY PROVIDER NEEDS A SCHEDULE
  - Combined provider & RN scheduling models increase decision points & inefficiency among providers & staff
  - Separate RN schedules allow RN to manage services under standing order or policy & procedure → frees provider schedule
    - Immunizations
    - TB Screening/Pregnancy Tests/BP checks
    - Method refills/Treatment only visits

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## Organizing for Efficiency: Open Access Schedules (OAS)

- OAS creates a system where same day appointments are available
  - Sick children & STD patients can be accommodated
- Use schedules to organize work
  - Consider New OB Enrollment & low volume STD assessments to Nurse Clinic schedule to enhance access flexibility & limit impact of no shows on productivity
  - Support CHERN to increase # clients seen & free MD/PA/NP time for problem visits

[ 99 ]

## Organizing for Efficiency: Clinic Flow Processes

- Best practice flow processes will enhance health communication & compliance with recommendations
  - Limited steps and messengers in the process
  - Avoid duplication in data review or tasks
  - Assign clinical decision making & priority health recommendations to provider



[ 100 ]

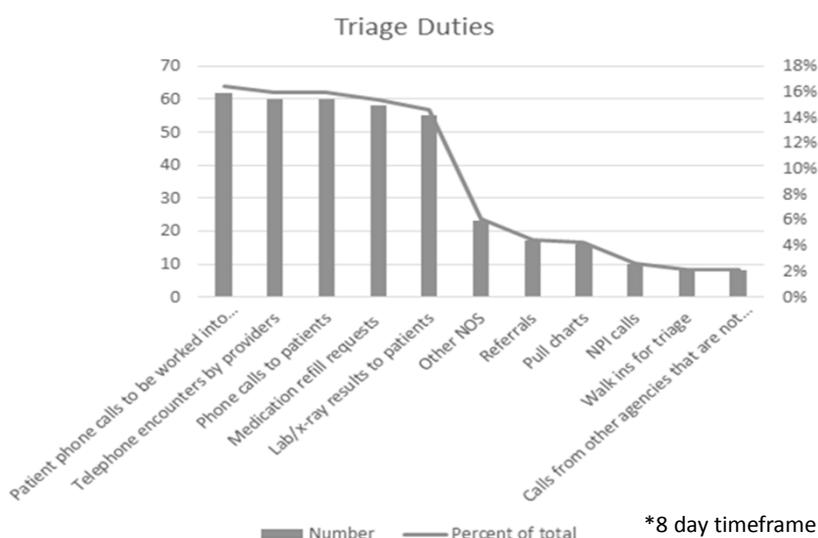
## Organizing for Efficiency: Clinic Flow Processes

- Clinic flow processes should optimize staff to fullest training and scope of practice
  - Management Support staff, non-licensed clinical staff, RNs, providers assignments meet full extent of scope of practice
    - Ex: Management Support staff completing functions which do not require clinical decision making (referral tracking, record requests)
- Schedules support availability of same day appointments to reduce need for referral to triage RN (saves RN and MS staff time)



[ 101 ]

## Assess Appropriateness of Duties



[ 102 ]

## Evidence Based Strategies

### Practice Management Examples:

- EBS : *compliance with health recommendations improved if relationship with provider → reduce steps & messengers in process*
- Examples: **best practices** tested by other agencies:
  - Individual provider-RN schedules; OAS to reduce impact of ↑ no show rate
  - Streamlined clinic flow processes
  - Organization of clinics (integrated vs. stand alone)
    - Team approach and huddles
  - Practice management dashboards to monitor trends: *measurement = improvement*



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## Evidence Based Strategies

### Practice Management Examples:

- EBS Screening: *move to risk based screening vs universal screening → focuses on risk identification & reduction vs un-necessary screening*

Resources: Programmatic guidance

*NOTE: STD requires universal screening*

- EBS Health Communication : *compliance with health recommendations is improved if there is a relationship with the provider → reduce steps & messengers in the flow process and priority messages from the provider enhance communication & clients ability to apply the recommendations*

Resources: Programmatic Best Practice Clinic Flow Models; CDC Health Literacy strategies



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## Practice Management

- Creates the structure, skills and processes to understand your clinical services practice & take data driven actions to:
  - Improve the clinical outcomes & patient experience of care
  - Optimize staff resources to highest level of skill & licensure
  - Reduce costs through system waste reduction
  - Free resources for other public health services

[ 105 ]

## Practice Management

- Ongoing monitoring of trends in productivity & revenue & data-based response
  - Joint performance objectives & data dashboards provide structure & information to identify issues and make appropriate improvement decisions
- Improvement opportunities:
  - Strategies to optimize revenue:
    - Billing & coding audit → training & monitoring of practice's coding
    - Maintain *current* billing & follow-up of denials
    - Accept credit & debit cards

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## Practice Management

### Improvement Opportunities:

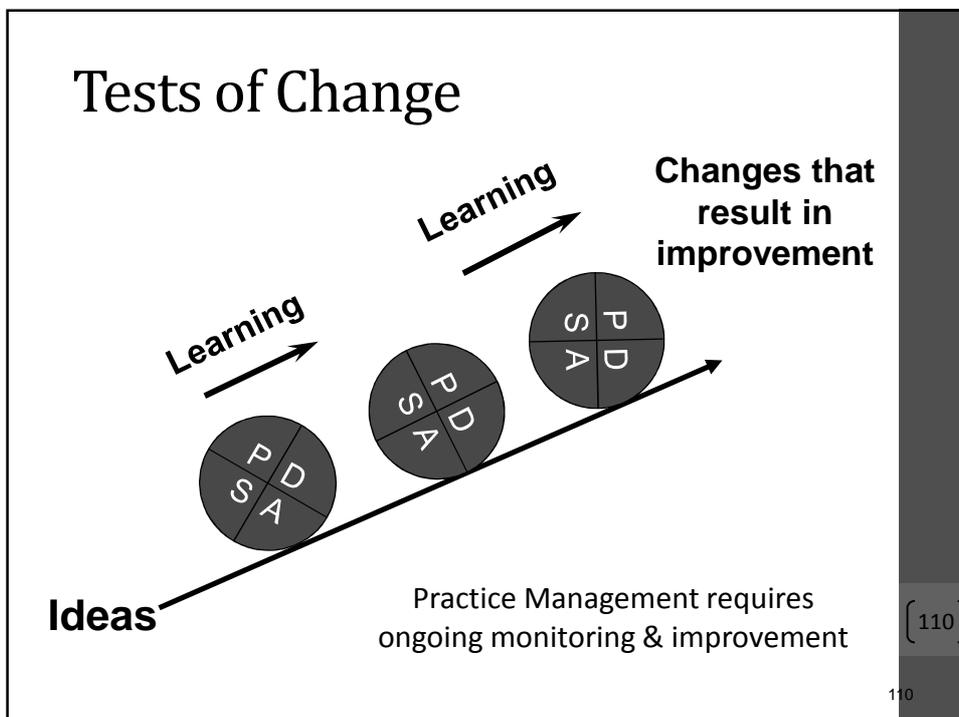
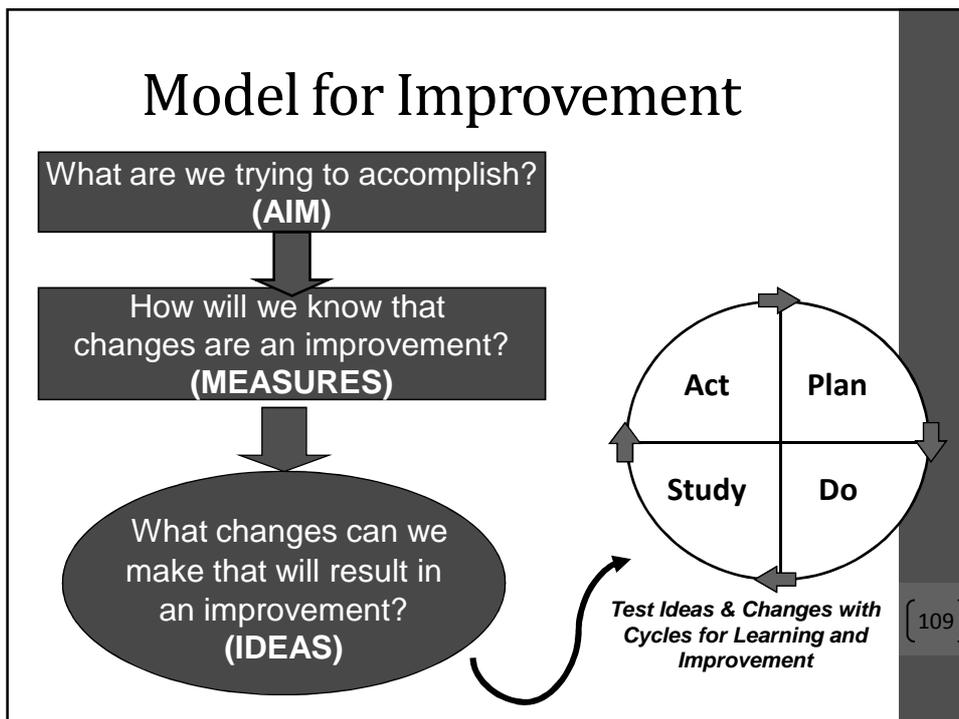
- Strategies to increase demand:
  - Market services to public and partners
  - Implement revenue producing services
  - Market use of resources to improve community health
- Strategies to reduce supply/capacity:
  - Redeploy resources
    - New services or improved services
    - Community health
  - Freeze positions/hold vacancies
  - Consider contract staffing/Cost share resources/staff with other agencies

[ 107 ]

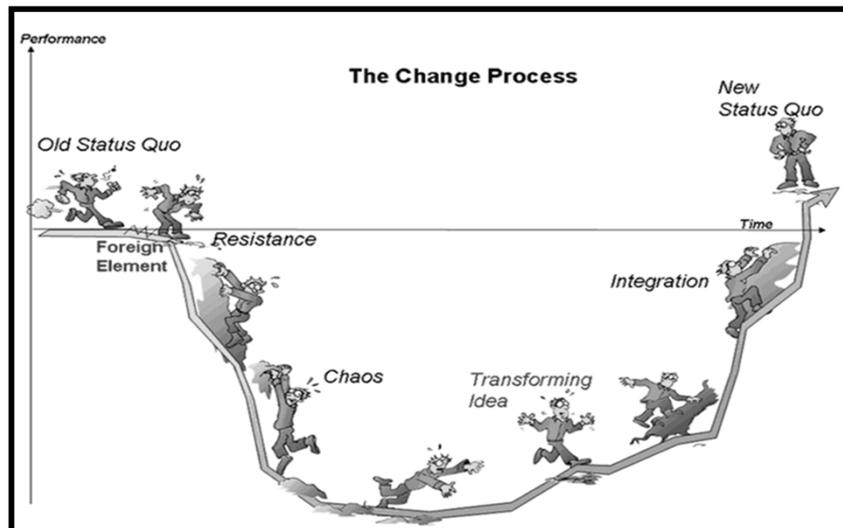
## Next Steps: Improvement Structure & Planning



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## Change Management Process



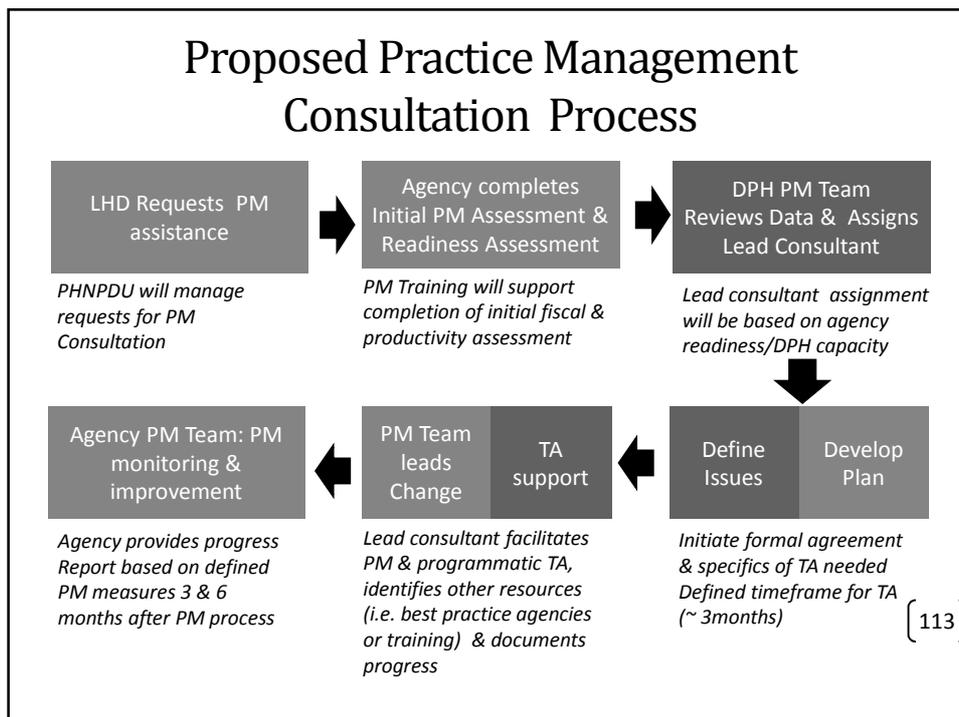
(111)

111

## DPH Support for Practice Management

- Our work with LHDs in the trials has demonstrated that the current resource intensive model for DPH consultant assessment & support is not sustainable
- New Model:
  - Training for health directors Dec 2013 & March 10, 2014
  - Update for Section Chiefs January 27, 2014
  - Training DPH Consultants February 13 & March 19 & 20, 2014
  - Training LHD PM Teams March 13-14, 2014

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## Role of the DPH Consultant

- Joy Reed will assign a Lead Consultant
- The lead consultant will:
  - support the agency's PM assessment
  - facilitate identification of change strategies based on the agency's PM assessment
  - link the agency with other consultants & agencies who have trialed recommended strategies
  - support development of an implementation plan & support through initial implementation (~3 months)

(114)

## Role of the Health Director

- Designate & sponsor the PM Team
- Define clear SMART objectives for the PM Team
  - Joint objectives and clear expectation the all staff will need to commit to change
- Assure resources for PM Team and strategies
- Communicate need for change, expectations for staff and PM Team, and how change will promote public health services for community
- Complete Readiness Assessment & request for consultation

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## Role of the agency PM Team

**Jointly assess agency current context for clinical services → build on the data collection and assessment begun with the training**

- What is the overall fiscal health of your clinical services? Are there specific programs you have concerns about?
- How close to benchmark is your productivity by program/provider?
- How does your staffing cost/hour compare to the staffing model?



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## Role of the agency PM Team

- **Jointly define improvement strategies to address identified fiscal, productivity & staffing issues**
  - Develop strategies based on the defined objectives & timelines outlined by the health director
  - Develop strategies tailored to the identified issues:
    - Fiscal: ability to sustain services
    - Productivity: balance supply & demand
    - Efficiency: improved organization of space, staffing, schedules, processes
  - Your Lead Consultant can provide support in identifying strategies



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## Role of the agency PM Team

**Develop an implementation plan which includes detailed steps, resource requirements, accountabilities, and monitoring data set**

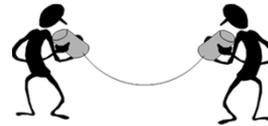
- Organized detailed plan and timelines communicate intent and resource commitment
- Expected outcomes & measures reinforce the why for change
- Build change capacity on continuous PDSA cycles & early successes on “low hanging fruit”

**Monitor & communicate progress toward objectives with health director, staff, & lead consultant**



[ 118 ]

## Change Communication



### Communication must:

- *Clearly define* impetus for change & objectives, timelines, expectations
- Clearly define assessment process & how changes will be decided & made
- *Be consistent* from health director to middle managers to front line
  - Communication structure: all staff meetings, team meetings, huddles, data reports re: progress toward objectives

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## Change Communication



### Communication must:

- Recognize change process → implications for all stakeholders:
  - Example: the goal of the clinic efficiency is to optimize use of resources: staffing resources “freed” by reducing duplication & increasing efficiency & productivity will be redeployed to other value added services
  - **What will your staff hear?** *“they don’t think we are working hard enough” or “if they reduce FTE assigned to clinic, they will RIF my position”*

[ 120 ]

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## Change Communication

### Communication must:



- Address anxiety & resistance re: multiple changes in status quo (their work life)
  - Help staff see new vision for clinic & public health for your community → working “smarter” increases value to community
- Repeat **clear & consistent** messages often
- Celebrate small successes & progress toward goals
- *Identify and reframe resistance messages & messengers*

[ 121 ]

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## Key Messages re: Practice Management

How will you share the information  
from this training?

[ 122 ]

## Key Messages developed by Training Participants

### Messages we plan to share:

- We must try to improve our clinical services
- Work smarter not harder (everyone one is working but is the work value added?)
- Increase revenue
- “lean, mean, fighting machine”: reduce wastes in the system
- Increase efficiency = decrease stress (staff & clients)
- There is no “I” or “U” in TEAM
- Together Everyone Achieves More = TEAM

[ 123 ]

## Key Messages developed by Training Participants

### Messages we plan to share:

- 40-60% of what we do is not value added (see “wastes” in system slide #70)
- Redeploy resources → improve community health outcomes (support full scope of public health)
- Partnerships: internally & community
- Stewardship of resources
- Time = Money
- Theme song: “Lets Stay Together”

[ 124 ]

## Key Messages developed by Training Participants

What we **will not** say:

- “it won’t work”
- “we’ve always done it this way”
- “well it was required 20 years ago”
- “we tried that and it didn’t work”
- “it’s not my job”

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## Practice Management Resources

<http://sgiz.mobi/s3/Public-Health-Practice-Management-Resources>

### Practice Management Readiness Assessment for Download

The Readiness Assessment must be completed and submitted to Joy Reed at [joy.reed@dhhs.nc.gov](mailto:joy.reed@dhhs.nc.gov) to request assistance from H Consultants after the March Training.

- **DPH Readiness Assessment**
- HRSA Readiness Assessment & Download: <http://www.hrsa.gov/quality/toolbox/me> [html](#)

Health Director will submit to request consultation

### Additional Practice Management Resources (To be added after the March Training)

- [LHD PM Implementation Grid \(Word doc\) and \(Excel xls\)](#)
- HRSA Quality Improvement: <http://www.hrsa.gov/quality/toolbox/introduction/index.html>
- [Public Health Staffing Model Spreadsheet](#)
- [Demand Tool](#)
- [Management Support Task Matrix](#)
- [Clinical Task Matrix](#)
- [Patient Flow Analysis Spreadsheet to determine lead and process](#)
- [Simple Lab Tracking Tool](#)

Updated Regularly with New Tools

### NC Center Public Health Quality Resources:

<http://www.centerforpublichealthquality.org/index.php/resources-and-publications>

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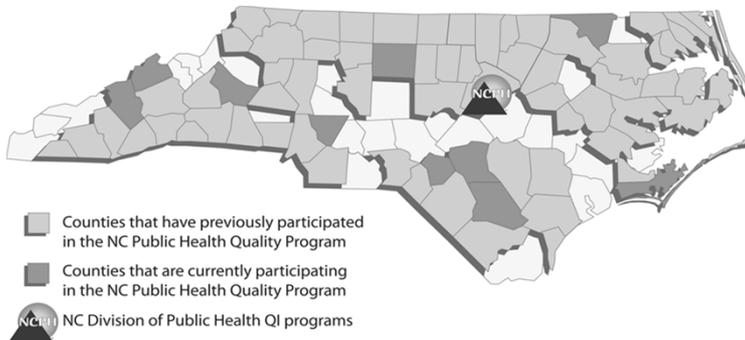
# Practice Management Resources

<http://www.hrsa.gov/quality/toolbox/methodology/index.html>

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# Practice Management Resources

- Institute for Healthcare Improvement: [ihi.org](http://ihi.org)
- NC Center for Public Health Quality



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## Next Steps

- Convene your PM Team
- Complete your PM assessment using the data worksheets & the questions you generated during the training
- If you need DPH Consultant support, the health director should complete & submit the **Readiness Assessment**
- Communicate key messages to agency staff



[ 129 ]



Final Questions & Comments

**PARKING LOT:**  
Issues to be addressed

[ 130 ]

## PARKING LOT

- Create on sheet handout for productivity and staffing model calculations
- Directions for calculating No Show rate (including HIS option for getting No Show report)
- CDSW Reports:
  - Need definitions for programs, data in reports, and specifics for how to pull usable reports (summary vs full report)
- Create & post Staffing Model for ERN only practice
- Create & post Staffing Model for RN clinic only

[ 131 ]

## PARKING LOT

- Provide recommendation for Practice Manager position & training
- Provide/recommend training on Open Access Scheduling
- Post programmatic Best Practice Flow processes
- Participants will complete training evaluation to include assessment of follow-up training (potential webinars)
- Provide training certificate (see PM Resources webpage)

[ 132 ]

## PARKING LOT

- Program guidance:
  - **FP:** History--what's required and what's recommended for each visit; add supply visit tools to PM Resources webpage
  - **MH:** provide guidance re: billing E&M for non-Medicaid clients & presumptive Medicaid
  - **CH:** Personal Data Sheets are not required by any program
  - **Repost Memo (2012) re LU codes:** LU code cannot be used if the service is not significantly different than the CMS definition of service code (ex: KHA form requirements meets the CMS definition)

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