

# **IMPROVING THE OPERATIONAL EFFICIENCIES OF SMALL HEALTH CLINICS**

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## **ABSTRACT**

Despite a lot of fear, controversy and opposition, the Patient Protection and Affordable Care Act (ACA) has succeeded. Millions of uninsured got insured now. But the costs are still very high and the quality is not up to par. ACA also created winners and losers. Hospitals and large groups seem to be the winners, and some small specialty practice clinics are the losers. They are struggling to survive. The operational efficiency and supply chain efficiency seem to be the next logical focus. This paper presents the case of a small clinic and its efforts to become efficient.

## **INTRODUCTION**

Since the Patient Protection and Affordable Care Act (ACA) was signed into law in 2010, the United States is in an unprecedented era of health care reform. Its purpose is to provide uninsured Americans a means for affording health insurance, improve the quality of coverage, and help eliminate inefficiencies in the health care market (Schoonvel, Coyle and Markham, 2015). It also contains legislation reforming how providers and healthcare institutions are paid by Medicare. It is pushing medical professionals to evaluate the future of their patients, careers, and the field of medicine.

Owning and operating an independent medical practice has never been easy, but in the last decade or so the number and complexity of the challenges have grown exponentially (Bendix, 2015). Between mandates for tracking and reporting quality data, the growing shift towards value-based payment models, the need to stay abreast of new technologies, growing competition from new types of providers such as walk-in clinics, and reimbursement levels not keeping up with operating costs, the obstacles to keeping a practice afloat can seem insurmountable (Bendix, 2015). The Physicians Foundation releases its Physicians Watch List every year. Its list for 2014 include (Bouchard, 2013):

1. Consolidation leading to monopolization.
2. Continuing growth of regulatory burdens.
3. Confusion -- health insurance exchanges, reimbursement rates, collecting out-of-pocket charges.
4. Health information technology.
5. Stalemates -- inability of Congress to operate.

All of these issues are having a major impact on small independently practicing physicians. According to the 2014 Physicians Foundation Survey of American Physicians, these independent practice owners decreased from 62% in 2008 to 35% in 2013. “In addition, the survey found that 53% of doctors now describe themselves as hospital or medical group employees, compared with 38% in 2008” (Bendix, 2015). The Association of Independent Doctors point to a similar trend. The percentage of total doctors has dropped from 57 percent in 2000 to 36 percent in 2013. According to Marni Jameson, executive director of this national group, "More than 100,000 independent doctors have exited the practice or become hospital-employed" (Callahan and Shoemaker-DeBree, 2015). It is the same case in Pennsylvania. “Between 60 percent and 70 percent of all physicians are employed by a hospital or large health system. That's up from an estimated 30 percent of doctors a decade ago,” according to Dennis Olmstead, chief strategy officer and medical economist for the Pennsylvania Medical Society (Callahan and Shoemaker-DeBree, 2015).

Physicians are facing not only regulatory burdens, but also compensation problems. The disparity in physician compensation rates has one of the biggest issues. Primary care providers, which include family practitioners, internists, and many geriatricians, got a 10% increase in their pay by 2016 (Clark 2015). A look at the combined impact of adjustments to various billing codes over the last four years reveals that psychiatrists and geriatricians getting an 8% increase, and chiropractors getting a 14% increase. On the other hand, “pathologists, radiation oncologists, and neurologists have taken a hit over the same period, with cuts of 13%, 11%, and 7%, respectively” (Clark, 2015).

Many doctors who closed their practice and now work for hospitals say that they can focus on treating patients rather than running a business. Being a hospital employee means they don't have to worry about selecting and installing the electronic health records system. They also don't have to worry about tasks like ordering supplies, hiring employees or billing insurers (Callahan and Shoemaker-DeBree, 2015). On the other hand, a quarter of hospital-employed doctors said they were unhappier after leaving their own practices than they were when being on their own (Callahan and Shoemaker-DeBree, 2015). Staying afloat in a solo practice, though, is becoming harder with mounting changes in healthcare (Callahan and Shoemaker-DeBree, 2015).

By turning independent doctors into hospital-employed physicians, hospitals increase their bargaining power, giving them leverage to negotiate higher reimbursements from insurers and government payers such as Medicare. For example, Medicare pays \$1,100 for a heart catheterization in a freestanding center and pays \$4,000 for the same procedure in a hospital outpatient center, according the Medicare Payment Advisory Commission. The 2014 annual report of this Commission “found that Medicare rates were 81 percent higher in hospital outpatient departments and hospital-owned clinics than in independent practices. The report acknowledged that, in 2013, Medicare paid 141 percent more for a level II echo-cardiogram in a hospital than in a freestanding physician's office” (Callahan and Shoemaker-DeBree, 2015; Groves, 2013). As stated earlier, some specialties such as pain physicians had a significant cut in fees schedule. This paper describes the efforts of a pain clinic to survive against the odds. The paper is organized into the following sections: Organizational Situation; Study of the Areas for Possible Improvement; Future Research and Conclusion.

## **A CASE STUDY**

This paper is based on a detailed study of a clinic to improve its efficiency and effectiveness. This clinic has been in operation for over five years and has grown at a steady pace to about 450 patient visits per month. Major expenses are nurse salaries and supplies. Nurses' expenses are trending down in recent months. Yet there was not much financial improvement due to overhead expenses and other areas of concern. This study focused on various areas to find possible improvements.

## **AREAS OF STUDY**

Since reducing overhead expenses is extremely difficult, the study is focused on improving efficiency. Areas of study included patient no-shows, waiting room, length of waiting, efficiency of the process, procedure room layout, procedure tasks, paper work, patient load, personnel, transcription, marketing and strategic partnership.

### **Appointments:**

Patient no-shows is a problem. Reminder calls can help minimize this problem. Currently an office receptionist is making calls to remind the patient. A computer-based system for appointment reminder calls can be more effective and less expensive. This system could be used for follow-up calls as well.

### **Waiting Room:**

When considering quality improvement of healthcare practices, patient flow, wait time, and satisfaction are important factors to monitor. One of the most common and vexing problems at health clinics is the patient waiting time. It can be frustrating to patients. Patient wait time can affect satisfaction with the care received, and it can be dependent on many different factors (Medway et al., 2015). There have been many studies and solutions on this issue. These studies include simulation and queuing techniques (Santibáñez et al., 2009; Tang et al., 2013). A study using 171 patients in an outpatient clinic tested for any significant differences in wait time and satisfaction for patients that arrived early, on time, or late. Late, on time, and early arriving patients spent 18.2, 30.7, and 38.8min in the waiting room, respectively. Late, on time, and early arriving patients had a total visit length of 57.4, 68.6, and 81.9min, respectively. There was a significant difference with total time spent in the clinic and for overall satisfaction with the total length of the visit between late and early arriving patients (Medway et al., 2015). Since the results indicate patients arriving late had shorter wait times and were more satisfied with the visit, the study suggests that patients should arrive late.

### **Procedure Room:**

Layout can be very important in improving the productivity. There have been many studies on layout improvement (Eagle, 2014; Eagle, 2014; Eagle, 2015; Freihoefer, Nyberg and Vickery, 2013). The tasks and interactions in the procedure room was observed to find any opportunities for improvement.

Layout of the procedure room was a problem, especially the location of the surgical supplies, including the trays. Having all the surgical supplies needed for the session near the physician saves a lot of time and effort. The temporary solution implemented recently without incurring any costs is good for now, but it should be further improved with more countertop space and cabinet space in the corner.

### **Procedure Tasks:**

Workflow and job design can have significant impact on efficiency and effectiveness. The procedure tasks were observed to see who is doing what and how much time is spent on each task. The inefficiencies were apparent. The physician was over working and the RN is being underutilized during the procedures. RN was standing idle during most of the procedure. Many of the tasks that the physician was doing currently could be done by the RN. For instance, the RN can replenish the cart with surgical supplies needed for the procedure. She may even open the tray and prepare injections. She, of course, should be trained to do it. The physician can then complete the procedure. Once the procedure is finished, the physician can leave the room. An assistant can bring in the stretcher and move the patient to the Recovery room. The physician can go on to the next patient.

### **Paper work:**

A great deal of inefficiencies in the healthcare system can be removed through technology (Adler-Milstein and Bates, 2010). That is why the government is mandating the use of Electronic Health Records (EHR) or Electronic Medical Records (EMR). There has been resistance to change. The federal government is using the carrot and stick approach (Asan et al., 2015; Paré et al., 2014; Paré et al., 2014; Terry, 2013; Manchikanti et al., 2014). There is a need to invest in a better EMR system that frees up the physician's time.

### **Patient Load/Mix:**

Since the government has cut back on payments for this specialty and there are more patients than this practice can handle, one needs to look at optimal mix of patients to accept. Since 30%-40% of the patients are routine ones with addiction problem (Cheatle et al., 2014; Chelimsky et al., 2013), consider if a Nurse Practitioner can handle these patients. The doctor's time could be better spent with other patients.

### **Patient Flow:**

Scheduling patients optimally can have a significant effect on efficiency and throughput. More patients can be seen and their waiting times can be reduced. Study of the Patient Flow revealed that the doctor's average time with the patients for procedures is 14 minutes and for non-procedures is 9 minutes. An additional worker could have made it more efficient and effective.

With an effective mix and use of the employees, these times can be cut by at least 30%, and as much as 50%. Scheduling of patients at 10-minute intervals should be considered on non-procedure days.

### **Strategic Partnership:**

Since the payment per patient has gone down and the overhead expense is fixed and significant, the logical step is to find a partner to share the overhead expense. It works best if the partner is not in the same field, but a complementary field who could refer patients to the pain physician. If the physician want to be independent and does not want to sell out to hospitals (Pursell, 2012), partnership is the best choice (Donoghue, 2015; Twiddy, 2013).

### **FUTURE RESEARCH AND CONCLUSION**

ACA has disrupted the system. There was a lot of fear, controversy and opposition (Bechtel and Hasson, 2010; Ritchie, 2014; Meyer, 2008; Alper, 2009; Nordal, 2012; Rozensky, Celano and Kaslow, 2013). Yet ACA has succeeded. Millions of uninsured got insured now. But the costs are still very high and the quality is not up to par. The building block is operational efficiency, such as optimizing staffing and managing the supply chain efficiently (Kohn, 2014). That is the next wave. There are significant opportunities for research in this area. The clinic described here is a work in progress.

### **REFERENCES**

Available upon request.