Improving Physician Productivity: The One Thing to Do First

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Physician productivity–that's a fun subject to tackle! Approach it in the wrong manner, and you can set off a firestorm. However, there is a way to improve the productivity of your employed physicians that will leave them singing your praises.

Well, I am not sure we want that as I don't know the vocal abilities of your medical staff. Let's just say you can approach physician productivity improvement in a way that is resented and seen as interference or you can approach it in a manner that actually improves their role and is viewed as a win by the physician.

In most areas of healthcare delivery, you work with employed physicians. If you work for a hospital system, you most likely have an employed physician group. Many of you work for large physician practices. If your organization delivers healthcare, you either work directly with employed physicians or your organization delivers care at their direction.

Making changes to improve productivity is not easy for any work group. It is much more difficult for your physician group.

Why is physician productivity so critical?

In a physician clinic–whether family practice or specialty–the productivity and profitability of the office ride on the physician. If you think about it, the physician practice is unlike most other business models.

In any retail store, the owner may have many employees, each of whom sell goods to the customer. These interactions by the employee make money for the owner.

A physician practice is just the opposite. Generally, most all of the income is generated by the physician interacting with the patient (customer). Until the physician sees and interacts with the patient, the overall product is not delivered and no revenue is generated.

(Yes, there are some things employees can do that generate income–injections, routine infusions in rheumatology practice, etc. However, none of these are done until ordered by a physician.)

So, the physician interaction with the patient is the critical function. It defines the quality of the patient (customer) experience and generates the revenue. Really, most of the clinic staff are overhead. Rather than all of the staff generating income for the physician, the physician is generating all of the income that pays staff salaries.

The productivity of the physician, then, will determine the profitability of the clinic. Sure, you can say improving productivity is dependent upon technology, but if you think that is all of the answer, you would be wrong. Technology will help, but a poorly performing office will use technology poorly.

Why physicians resent hearing about the need to improve productivity

Put yourself in the doctor's shoes. You are among the most highly schooled individuals in our society. You went to school longer than most, then may have had required internships or residencies. You invested a huge amount of time and money in obtaining the skills to deliver medical care.

Now, here comes some administrator telling you that "you need to work harder and produce more". As a physician, it already seems that your knowledge and skills are "disrespected" in that you have insurance companies, government agencies and hospital administrators already interfering with how you deliver care.

As non-physicians, they all seem to know whether or not a hospital admission is appropriate, how long a patient should be kept in the hospital, how long an office visit should take, and what diagnostic tests are appropriate to order. Physicians resent these third parties injecting themselves in the doctor/patient relationship.

Think I am wrong? I follow several physician-oriented blogs. When the subject of management undertaking efforts to improve physician productivity comes up, there are always comments critical based upon these nonprofessionals interfering with patient care.

These efforts are usually seen as having a negative impact on the quality of care.

With good reason. Many of these productivity efforts are nothing more than a mandate to increase patient visits by a variety of methods: extend hours, reduce individual visit time, convert in-person visits to tele-visits, etc.

Again, the subtext is that the physician: (a) is lazy and needs to work harder/longer, (b) is inefficient in scheduling/managing patients, (c) too chatty and spending unnecessary time with each patient, (d) has no financial sense and is willing to unnecessarily consume resources, (e) all of the above.

So, the initial reaction to an effort to "improve physician productivity" may not be positive-especially when coming from non-physicians.

And yet, it is not only important, but critical. I have written before, that the WEF considers productivity improvement the key to business success for years to come. It will determine the survivors in the competitive healthcare market. Being more productive than your competitors provides your organization with the financial flexibility to do what is necessary to compete.

The one thing to do first

There are many facets to improving the productivity of the clinic or practice setting. These include staffing, processes, technology, etc. A serious effort will address all of these at one time or another.

There is one step I recommend that you take first. It is a simple one that can be done inhouse: ***Analyze the actual job duties of each position in the clinic and see what tasks could be done by someone else.***

You're saying like Peggy Lee, "is that all there is?" Let me show you how to do it and the benefits that can come to you and the organization as a result of this action.

Regardless of what your official job descriptions state, the actual job as performed every day has morphed into something else. Additional tasks and duties have been added or assumed that fill up the hours of the work day.

A typical family practice clinic may have the following positions: Customer

Service Coordinator, Billing/Scheduling, Medical Assistant, LPN/RN, Physician.

Start by interviewing each person and asking them what they do in a day. Create a detailed list of all the tasks that are reported for each position. If there are multiple incumbents with the same title, so much the better. Include any task reported by any position holder.

Have the employee estimate the amount of time spent on each task. If multiple employees report different times for the same task, develop a rough average of the time spent. This isn't an exact science, but will be useful at the end of the process.

After interviewing each employee, you will come up with a list of tasks performed by each job title. The list will most likely by a page length for Physician, RN, LPN, MA, CSCR, etc.

On each list, identify those tasks/duties that can ONLY be done by that job title. On the physician list you would check only the duties that can be done by a physician and nobody else. You would do the same for the RN or LPN.

What you will discover is that the more of the tasks in the higher level positions could be moved downward. The physician may be doing tasks that could be done by a nurse. Many of the nurse's duties could be done by an MA or CSC. Obviously, none of the tasks of the lowest level can be moved any lower.

This highlights how much time the physician may be spending on tasks that could be performed by others. It is true of every level. This is a huge opportunity for improvement without interfering with the actual doctor/patient visit.

Productivity can be improved by removing activities from the physician that can be done by someone else. This can be seen as a win by the physician if it results in an improvement in his/her job.

Am I saying that all activities that legally could be performed by a lower level position, be driven downward? No, There are many activities that could be done by another position that you may choose to leave at the higher level. For example, a physician prescribes a new drug to a patient. Perhaps for maximal efficiency, you would have the drug prescribed by the doctor who then turns the visit over to the RN to explain usage/effects. Even though this task could be done by someone

else, the doctor may prefer to continue doing so.

Go through the list of tasks that you have created for each position. You have already indicated which ones could be technically done by another position. Now indicate those that you want to remain in the current position by choice.

Bottom line: what's the payoff?

We did this a few years ago in multiple family practice clinics. We used internal Staffing Effectiveness employees to conduct the interviews. Our goal was to determine maximum staff mix.

Each clinic had 3 physicians but varied on support staff. Without going into detail, here are the results.

Conclusions

- Providers spend 80 to 90 percent of their time performing role-appropriate work, and they could delegate a portion of the remaining 10-20 percent of their work to nurses and medical assistants.
- RNs spend just under 60 percent of their time on role-specific work, 25 percent of their time on work that LPNs can also do and 16 percent doing MA work.
- LPNS function as MAs 70 percent of the time and perform nursing duties 25 percent of the time.
- MAs and CSCs spend all their time doing role-appropriate work.
- Nearly all the work that could be delegated by providers and nurses would have to be done by MAs.
- If all work were distributed to the most appropriate role (an unlikely extreme), a care team staffing ratio might be; 3 Providers: .7 RN: .5 LPN : 4.0 MA.

Here is our list of physician tasks that could be done by others. We also estimated the maximum amount of time consumed by that task. (based upon multiple incumbents).

PROVIDER: TASKS OTHERS COULD PERFORM	

Task	Max Time
Respond to patient messages (50% could be delegated)	%
Explain treatment plan to patients	%
Patient education	%
Review films or test results with patients (30% could be reassigned)	%
Rx refill – routine	%
Call patients to report abnormal labs and suggested actions	%
Contact patients to report acceptable labs (within normal limits)	%
Review patient charts, test results, films	%
Information gathering for appointments – annual physical	%
Track information for other providers' patients when provider doesn't dictate	%
Information gather for appointments – new patient	%
Seek out patient charts, results, information	%
Nursing home calls	%
Fill out forms for patients – DMA (02, etc), FMLA, handicap placard, jury duty, MVD, prior authorization	%
Obtain supplies that are not on hand	%

Result

The physicians spent a low of 10% to a high of 20% of their time on tasks that could be done by others. If all of these tasks could be transferred to someone else, it would provide significant additional time to the physician.

Don't think 10% is much? If a physician worked a 40 hour week, this would provide an additional half day. At the high end, a 20% improvement would equal an entire day gained.

How many additional patients could be scheduled in another day–or even a half day?

Admittedly, it is unlikely that you would go “all the way” in transferring every duty/task to a lower level. But even if you could gain another hour or two a week, this is a way to painlessly improve productivity.

The practice can either use the time to see additional patients, or reduce the worked hours which may be critical if overtime is being worked.

The advantage of starting with this step is obvious. It is low hanging fruit that not only can improve productivity but also improve the physician role by eliminating tasks that s/he need not perform.

You start by assisting the physician in the design of his/her position. You are not addressing how the physician interacts with the patient.

Try it. It is easy to do and the payoff might surprise you.

(PS – the employees in the lower job positions saw it as a positive when they were given tasks previously assigned to higher level positions. They felt that their jobs had expanded and their resume skills were enhanced.)