Surgeon Staffing Ratios

"Let the debates begin!"

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Michael R. Gagnon, MBA
Executive Director, Duke University Orthopaedic Surgery
Founder, Academic Orthopaedic Consortium
Michael.Gagnon@duke.edu

Duke Orthopaedic Surgery
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Our approach to this and experience to date…

Infrastructure Support

Key Goals

1. **Provide faculty the ability to reduce workloads and to optimize their time taking care of patients, educating, and pursuing research**

2. **Deploy effectively as possible all Department and Clinic resources to that end**

3. **Evolve infrastructure that encourages & supports innovative models of care delivery, research, and education**

Phased Approach

Infrastructure Support

Phase I: *Clinical and Administrative support*

Jan - June 2014 Implement an infrastructure model that will:

- Decrease work being done by faculty to shorten workday and improve productivity
- Improve cash position
- Get faculty and staff working to top of skill set
- Optimize use of Epic system
- Optimize utilization of personnel and non-personnel resources (i.e. exam rooms)
- Transparently communicate costs of this model with specific "spending allowances" and let faculty decide how to staff/purchase these functionalities.
- Increase accountability of clinical operations to the Department and its faculty

Infrastructure Support

Phase I: *Clinical and Administrative support*

Let's do our homework:

- Quantify the infrastructure within the Department and in the clinics
- Inventory the functionalities of the personnel employed in clinic and in the Department.
- Understand workflows of faculty and those serving them to determine if the personnel and the systems (Epic) are being optimized to reduce the work being done by faculty.
- Survey "best practices" and national experts (workflows and Epic)
- Examine the allocation of residents, fellows, and exam rooms

Key Concepts

After operationalizing the workflow corrections and Epic optimization, move forward to position the faculty with options to staff desired functionalities clinically and administratively.

1. Identify an FTE allocation and let faculty decide how they wish to use that allocation to support their work. (i.e. *"You can have 60 hours per week of employed help, which equates to 1.5 FTE. How do you wish to staff your office and clinic?")*

2. Examine pooling certain functions in specific areas to provide seamless customer service (i.e. call center to handle all patient calls)

3. Use technology to lower costs and improve service wherever possible (Telcom; Epic; Scanners; etc.)

4. Meet with every single faculty member in person to discuss his/her desires and to answer questions…as well as options we have to decrease their workloads and use of Epic system.

Understand the workflows of post-epic environment

"we need to pull work out of faculty and assign it to the staff around you"

	Didn't include as an opportunity Do you personally complete your progress notes most of the time? - If "no- other" please explain	Do you personally enter Orders in Epic (ie labs, XRay, referrals, studies, MRI, CT)?	Do you personally order Medications in Epic?	Do you personally enter the Review of systems in Epic?	Didn't include as an opportunity Technically, you are only required to "mark as reviewed" 1) the problem list and 2) the medications. If you are marking anything else as reviewed beyond this, you are doing more than you are required to do. Are you marking as reviewed more than these 2 items? If so, please explain why.	Do you print and personally give the patient their AVS report?	Presently, faculty are responsible for entering the LOS and charge capture. Would you prefer it if this work was handled by the clinic staff at the close of each day? This may be a way to reduce your workload, improve timeliness of charge submission, and do a better job globally of appending modifiers. - If "no," please explain why.	Inbasket can take a lot of time to manage. It can be managed by other people besides the faculty member. Please choose one response below.
FOOT								
ADAMS	YES	NO- my CMA usually does it.	YES	NO- my CMA usually does it.	YES- Thought I had to and I don't really know what all I need to do to get paid. Duke should have someone telling me what I need to do to	NO	YES- please handle my charge entry	I do most of this now, please assign elsewhere.
DEORIO	NO- my resident or fellow usually does it.	NO- my CMA usually does it.	NO- my CMA usually does it.	NO- my resident or fellow usually does it.	NO	NO	Too important to give away	I do most of this now, please assign elsewhere.
EASLEY								
KERZNER	YES	YES	YES	YES	NO	NO	YES- please handle my charge entry	I do most of this now, please assign elsewhere.
NUNLEY	YES	NO- my PA usually does it.	NO- my CMA usually does it.	NO- my CMA usually does it.	YES- I mark all that come up as "mark as reviewed"	NO	this is the easiest thing to do and then the fee is always correct	I already engage others to manage this.

Framing the FTE needs based on workflow

NEW MODEL TO CONSIDER (with salary of the position identified)							
Hospital Based faculty are allocated .20 Admin (same) and .60 CMA to account for what hospital/PSA already provides							
		$35,000	$42,000	$35,000			
	# FACULTY IN MODEL (see listing for detail)	ADMIN ALLOCATION	SURGERY SCHEDULERS	CMA/ATC	TOTAL FTE/MD	*PA*	CMA Allocation in clinic for independent clinics
FOOT	5						
ADAMS		0.20	0.25	1.00	$52,500		
DEORIO		0.20	0.25	1.00	$52,500	*Bonham*	0.4
EASLEY		0.20	0.25	1.00	$52,500	*Turner*	0.4
KERZNER		0.20		0.60	$28,000		
NUNLEY		0.20	0.25	1.00	$52,500	*Malaguti*	0.4
		1.00	**1.00**	**4.60**	**$238,000**		

Individual allowances set to 58 hours

"How do you wish to use this staffing allowance?"

INFRASTRUCTURE CONVERSATION

Each full time surgeon will have up to 58 hours of infrastructure support available to use to support his/her practice clincially and administratively.
This is essentially putting 1.5 FTE at the discretion of eachfull time surgeon. How this is utilized is decided upon by the surgeon.
It is an option to employ more effort and this can be decuted from faculty pay. Alternatively, if the faculty member employs less this will be added to pay.

Here are some examples of how this might be employed:

	CLINIC	OR	CLINIC	OR	ADMIN	TOTAL HOURS	
CMA/ATC	12	5	12	5	6	40	
PA	8		8				
Fellow	?		?				
Resident	?		?				
Med Student	?		?				
Surgery Scheduler	2	2	2	2	2	10	
Admin	1.6	1.6	1.6	1.6	1.6	8	*General admin: calendaring, travel, typing*
						58	

1.5 CMA on day of clinic and employing another 16 hours of a CMA/week on top of this to do patient calls and forms

One more thing…surgeon staffing ratios 58 hours per week per MD?

EMR have forever changed the workflows tied to physicians in the management of patients, shifting much of the work formerly done by admin assistants to the clinical side of the house and falling almost squarely on the surgeon himself/herself. This provides a natural opportunity to examine the employed workforce in the Department and in your clinics to consider:

1. ***Based on our workflows TODAY, do we really need each of these individuals to provide the functions they are currently providing?***

Your answer is likely "no" if you have not done such an assessment post EMR implementation. What we are seeing is a shift to reduce the FTE employed in Departments who have historically provided general admin functions and instead see an increase in those who are performing clinical support functions. Transcription costs are now gone, as are employees who did that work (along with file clerks). Many academic Departments are moving toward shared secretarial models of 2, 3, or more doctors being supported by 1 admin assistant…but now requiring more help to get through clinic.

If you assume that each doctor will require at least 1 CMA type person in clinic to help get through clinic, and if that doctor has clinic twice per week, this requires a minimum of 16 hours per week of employed labor (in this case via CMA or ATC). A high volume provider who does not have the support of a midlevel in clinic and who is seeing 40+ patients per day may require 2 CMA helping each day in clinic, equaling 32 hours of employed labor per week. From here, also consider the following:

2. ***How many hours per week are tied up in managing patient phone calls among your employed workforce?***

3. How many hours per week are required to do surgery scheduling for a surgeon?

4. How many hours are required to perform the general admin that is not addressed in above (basic calendaring, updating CV, travel, letters, etc.)

This topic of surgeon staffing ratios is indeed a hot topic and it is not one size fits all…but in the interest of starting some debate…let me throw a number out there… 58. That 58 hours per week is a number that may work for a full time academic surgeon who works 2 days in clinic and 2 days in the OR with 1 day of admin/research and who works 48 weeks per year. This can be optimized when the personnel are employed and then utilized among partners and then used to cross cover when the faculty member is out those 4 weeks per year. Some are using CMAs in this model some are using ATC. Some are using 10 hours of surgery scheduling functions per week, 8 hours of general admin per week, and then using the remaining to employ 40 hours of help to run clinic and respond to the patient phone calls. 58. Of course on top of this it is likely that busier faculty will also have some level of fellow, resident, and even possibly med student in clinic to help. What do you think? Let the debates begin!

Thank you