Lean Healthcare: Physician practice

One size does not fit all

- Hospital ≠Physician Practices ≠Clinics ≠ Health Centers
- Access ≠Quality ≠Satisfaction ≠Cost
- Understanding your objectives and the size/complexity of your organization is key to determining both approach and application of the *right* Lean concepts and use of the right [Lean] *tools* to address your needs
- Practice resources are limited. Speed to value is key. Where to begin?

Lean in Physician Practices

Overview: Lean Healthcare is too often assumed to be solely about Lean in *Hospitals*. In our model, all patient *value* streams begin and end with primary care. The reality is that viewing lean from *single vantage point* (hospital, imaging, OR, specialist, ED or PCP perspective) only represents one element of the continuum of care.

Applying lean in physician practices is distinctly different from other lean healthcare applications. Resources in a practice are very constrained, practice processes often vary by provider and care team, and variability in schedule and patient acuity can range up to 3x depending on time of year, week of the month, day of the week and time of day. This variability must be absorbed internally with minimal capacity from which to draw. It is also at the practice level that the coordination of information, labs/tests, multiple specialists and multiple payers occurs. In nearly every case this coordination involves multiple facilities, office staff, systems and priorities.

Interestingly, the same factors that drive much of the complexity in one practice are often the same types of factors that challenge most practices: Access, RVU's, productivity, cancellations/ no-shows, 8am surge, new patient physicals, Medicare H&P, payor mix, shared risk, etc. are challenges that touch many physician practices. As a result, the ***opportunity*** to *learn from other practices* who may have already started to solve *their* problems and implement *their* solutions is real; provided the methodology, approach and solutions developed have been captured in a format that supports the transfer of knowledge and sharing of key points and lessons learned.

Approach: When introducing and applying lean to a physician practice, it is imperative to make effective use of your (limited) improvement resources. Focusing on key objectives (patient experience, population health, access, cost, revenue), enables a team to identify the key practice processes that impact the metrics. Examples of common physician practice lean activities include:

- Patient flow and care team coordination (registration, chart prep, rooming, check out) to impact patient experience, staff productivity and/or practice capacity (access)
- Referral process work to address quality, patient satisfaction, medical expense, and/or shared risk payments.
- Scheduling strategy and utilization to impact RVU's, productivity, patient satisfaction, and/or access
- Triage process to impact quality of care, patient satisfaction, ED visits and/or medical expense
- Care coordinator/population health RN to improve quality outcomes, CMS core measures, and/or overall medical expense

- Primary care: Coordinating care across the care continuum
- It is in the integration of information, care team and patient flow that is the key to impacting key practice measures such as: quality of care, population (patient) health, patient satisfaction, cost and revenue

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- Billing/Coding to reduce days unbilled, increase revenue, reduce denials, and improve time to collect.
- Preauthorization process to improve patient satisfaction, maximize revenue, and improve time to collect
- Check-in process to coordinate check-in activities, triage calls, develop flexible capacity to handle natural peaks and valleys, and/or increase collection of co-pays
- Pre-visit and outreach process to reduce reschedules (due to missing labs, test, information), same day cancellations, RVU productivity, improve medical expense, improve patient experience

Key Points: Practice processes are dependent upon seamless communication within and across many independent entities (specialists, hospitals, care coordinators, case managers, providers, staff, lab, pharmacists, etc.). Primary care extends far beyond the four walls of the PCP office. Seeing and understanding the importance of identifying and developing key practice processes, and building processes that flow information in *and* out of the practice is key for the patient centered medical home to become a reality.

Case Study (*Quality* of care): A 12 practice (106) provider medical group improved the % of NCQA core measures in top 90% (e.g. A1C, LDL, BP, screenings, immunizations, etc) from 40% of core measures to 80% in 12 months. Focusing on key practice processes, staff development, and operational leadership development was the foundation for improvement. Using Lean as a *management system* to align, focus and engage staff was key to creating awareness, understanding, and acceptance of the changes.

Change Management:
In our model, we start with the fundamental belief that when presented with a given scenario, our staff, providers and employees make very consistent decisions. The best decisions they know how. It is with a certain degree of understanding, awareness, data and information which our staff and providers make their decisions. To ask our people to make different decisions *without* fundamentally changing the equation presented to them is wrong. If we wish to change the *types* of decisions our people make, we owe it to our leaders and front line staff to design and build processes, which will:

(1) Enhance their awareness and understanding of the situation (business understanding, process understanding)
(2) Improve the quality, clarity, timeliness and completeness of information and data they receive.

It is with this improved understanding and improved *information flow* that our people will naturally make a more informed decision than they did before. We do not have to tell them to make better decisions, they will.

FFS vs. Shared risk: Although *shared risk* is often positioned by payers as being a financial incentive, the true value is in healthier patients and healthier patient panels *resulting in* lower overall medical expense.

What is key to understand is that the processes and measures that may have been key to success in a FFS reimbursement model may not be the same processes that are key to success in a shared risk model. Depending on your payor mix and your region, the mix of shared risk agreements will vary, however it is fair to day that regardless of geography, *shared risk* will become a larger % of your patient panel over time.

Developing the processes to identify target patient populations, identify key practice processes, influence the behavior of patients and engage business/care partners such as local hospitals, specialists, health plans, community outreach, etc. is key. Many of these resources exist today (care coordinators, case managers, population health nurses, care navigators, referral coordinators), but their specific impact on key processes and key measures is not well understood and subsequently not well synchronized.

Working with practices to develop the internal processes to reduce ED visits, manage out of area costs, utilize high quality/high value specialists, integrate active disease management/ population health, coordinate admission-discharge/ED visit information amongst practices is how we have helped practices and care teams increase access, earn top scores in CMS core measures, earn top scores in patient, staff and provider satisfaction, reduce medical expense by 17+%, and increase shared risk payments by 14%.

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