

Staffing and Incentives

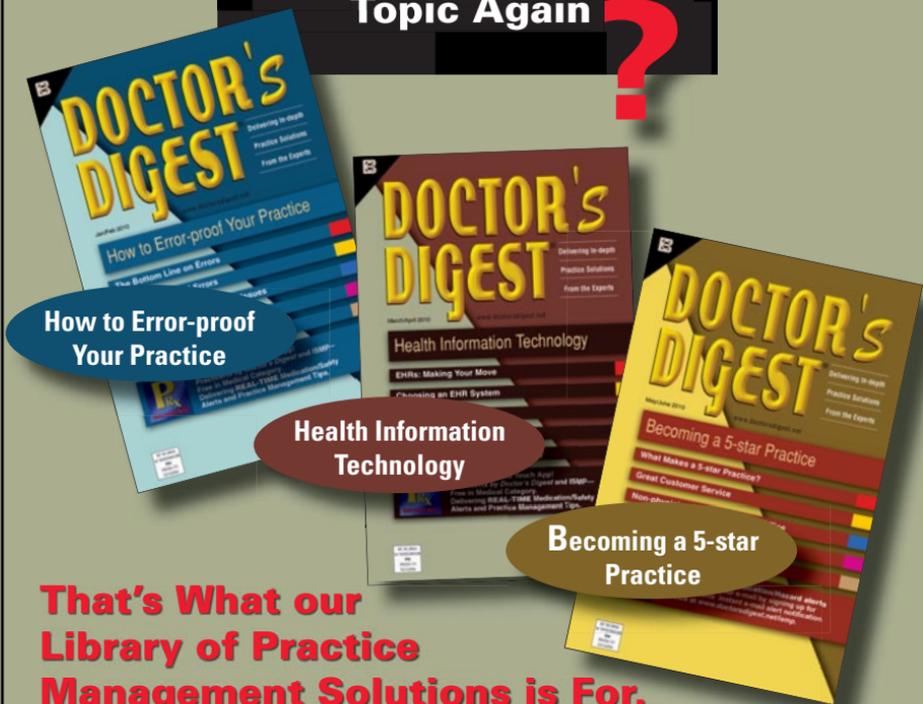
Chapter FastFACTS

- 1. Better-performing primary care practices, as judged by profitability and cost management, hire more and spend more on support staff.**
- 2. Smart staffing decisions should take into account your office's changing technology needs.**
- 3. Payment reform and new models of care have created a growing need for employees skilled in communications and project management.**
- 4. Federal- and insurer-sponsored incentive programs include payments that escalate for meeting quality and cost goals.**
- 5. Physicians may benefit financially from participating in an accountable care organization.**

Trisa Torres, MD, medical director at Flint, Mich.-based Genesys HealthWorks, a division of Genesys Health System, likes to tell the story of a 49-year-old, low-income woman who enrolled in HealthWorks' health navigator program. The woman had been diagnosed with type 2 diabetes; complained of blurred vision, excessive thirst/urination, and vomiting; and smoked a pack a day. Six months later, the same woman had lost 37 pounds, was exercising regularly, was self-managing her diabetes, and was trying to quit smoking.

Primary care physicians dream of such success stories but often fail to achieve hoped-for results in the traditional office

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setting. The difference in this case, says Dr. Torres, was the intervention of a health navigator, who engaged the patient in motivational interviewing, connected her with educational and community resources, coached her on lifestyle choices, and followed up regularly—all of which allowed her primary care physician to focus on managing clinical care and monitoring progress during regular check-ins.



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Robert Eidus, MD
 Family Practitioner
 Cranford Family Practice
 Cranford, N.J.

Although today’s fee-for-service payment system does not reward physicians for investing in team care, such as using health navigators (trained as registered nurses or health educators), well-run practices looking for smart business strategies are already doing so. According to MGMA data, better-performing primary care practices, which are judged on profitability and cost management, hire more—and spend more on—support staff (4.65 FTE or \$211,297 vs 3.51 FTE or \$153,600 per FTE physician) than practices that aren’t as profitable. At the same time, better performers have higher medical revenue than similar practices (\$277,799 vs \$128,611 after operating cost per FTE physician).

Strategic Staffing

Dr. Wolynn at Kids Plus Pediatrics knows that the success of his practice depends largely on the people he hires; so he doesn’t take chances when it comes to bringing new physicians into the group. Every physician on staff, from the two founders to the newest hire, have either taught or been trained in the same residency programs.

“People were chosen to join this group not just because they are technically good but because, philosophically, they were a

good fit,” he explains. “We really attribute a lot of our success to the fact that we view ourselves as a practice family with a lot of shared values.” Hiring former students has been a sound business tactic for the practice, he adds. “It alleviates the issue of hiring someone off an ad and recognizing a few years later that it’s a bad fit—which is a really expensive proposition.”

Dr. Wolynn also employs a communications director and a project manager to manage the group’s social media presence and strategic initiatives. After completing a master’s degree in medical management in 2008, he began to see both positions as crucial investments in order to stay competitive in the future.

Similarly, Dr. Eidus’s master’s degree in business administration has helped him make strategic staffing decisions that keep his practice profitable. Hiring a nurse practitioner, for example, was more expensive than hiring a lower-level aide, but he sees the decision as an important key to his current success. “I used to feel you had to be super efficient and keep staffing really lean and overhead very low,” he says. “But I’ve learned that there’s a sweet spot in staffing, and you have to staff appropriately. My nurse practitioner has helped in terms of quality, service, and patient satisfaction.”

Like Dr. Wolynn, Dr. Francis sees a growing need for employees who are skilled in communications and project management as the industry moves toward payment reform and new models of care, such as accountable care organizations. “Electronic media will become more central to our management of patients, and that will change our staffing needs,” she explains. As a result, new staff must be more technologically savvy than their predecessors: “You can’t come in without significant computer skills, and that is a big change in qualifications for our staff,” she says.

Profiting From Incentives

One full-time health navigator working within Genesys’s PHO handles a caseload of about 6,000 patients spread across several providers at a cost of approximately \$72,000—a cost shared by the PHO and the partnering hospital (Genesys Regional Medical Center), according to Dr. Torres. Sharing the cost of a navigator is a tangible benefit in terms of staffing costs, but physicians are also reaping incentives from a program that rewards practices for

improved health outcomes.

Genesys's PHO participates in Blue Cross and Blue Shield of Michigan's Physician Group Incentive Program, which provides financial support for practices to set up and measure performance goals, as well as performance incentives, according to a report by the Commonwealth Foundation. Blue Cross has devoted \$100 million in annual funding to the program, with \$75 million going into a reward pool, \$20 million for increased payments to physicians participating in a medical home trial, and \$5 million to reimburse providers for using mid-level practitioners, such as health navigators. For example, a provider is reimbursed \$60 for each 30-minute session with a care manager.

The program gives awards based on a practice's engagement in building a PCMH and achieving cost and quality targets, according to the report. Those physicians who participate in the PCMH pilot initially received a 10% increase in fees; that increased last year to 20% for practices that reached certain cost-containment goals.

Other Incentive Programs

Financial incentive programs managed by government or private insurers typically require physicians to report on a set of quality measures and sometimes include escalating incentive amounts for meeting quality and cost goals. Following are a few of the largest programs open to primary care physicians:

The **Physician Quality Reporting System (PQRS)**, formerly the Physician Quality Reporting Initiative, was launched by Medicare in 2007 to reward physicians for voluntarily reporting data on quality measures. To get started with PQRS, physicians select which quality measures to report on and a method of reporting: either directly to CMS via Part B claims or a qualified EHR, or through a qualified registry (a list of qualified registries can be downloaded from the CMS Website). This year, physicians who successfully report data are eligible for a payment equal to 1% of their total Medicare Part B allowed charges, down from 2% last year. Incentive amounts will continue dropping to 0.5% in 2012 to 2014, after which non-participants will incur penalties (a Medicare payment reduction of 1.5% in 2015 and 2% after that). New in 2011: Physicians can boost their

incentive payment by another 0.5% by participating in a Maintenance of Certification program for their specialty.

Meaningful use of EHRs: Physicians may receive as much as \$44,000 from Medicare and/or \$63,750 from Medicaid towards an EHR purchase if they meet meaningful use requirements, but they must enroll by 2012 to get the maximum payment (physicians can register online before they purchase a system). To qualify for incentives in 2011 and 2012, providers must meet 20 of 25 Stage 1 objectives: 15 mandatory core objectives and five selected from a list of 10 other objectives. Eligible providers also must report on six clinical quality measures (three core measures and three additional measures from a list of 38). They must demonstrate meaningful use for 90 consecutive days in the first year of participation and a full year after that.

PCMH incentives: A growing number of insurers are offering financial incentives to practices that are recognized as medical homes by the National Committee for Quality Assurance's (NCQA) Physician Practice Connections—PCMH™ Recognition Program. The NCQA offers three levels of recognition, depending on how high a practice scores on a set of six standards and 27 associated elements. In 2011, practices will be evaluated on the following standards, according to the NCQA's Website: access and continuity; identify and manage patient populations; plan and manage care; self-care; track and coordinate care; and performance measurement and quality improvement.

A national study reviewing 26 PCMH demonstration sites at practices of various sizes found that over half of the demonstrations provided upfront funding for practice transformation, ranging from lump-sum payments up to \$6,000 per practice to grants of over \$100,000 for infrastructure improvements. Individual physicians earned a median of \$22,834 annually in additional revenue. The study, sponsored by the Commonwealth Fund, was pub-

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lished in the June 2010 *Journal of General Internal Medicine*.

Joining an ACO Could Pay Dividends

Other savings are possible by becoming part of accountable care organizations (ACOs). Created by the ACA as part of the Medicare Shared Savings Program, ACOs are healthcare delivery organizations made up of different combinations of providers—including primary care physicians, specialists, and hospitals—that agree to collaborate in order to provide more effective and efficient care, and to share in any resulting savings. ACOs have the potential to break down barriers to affording information technology, expanded staffing, and other elements necessary to creating a medical home. The HHS released proposed rules on ACOs at the end of March; a final version is expected later this year in advance of the January 2012 official launch date.

Why You Should Get on Board Now

Converting to a medical home or joining an ACO may seem premature to some while physicians are still laboring under a fee-for-service payment system. But physicians like Dr. Mambu contend that payment system change hinges on the willingness of some practices to become early adopters.

Converting to a new style of practice based on team care and technology can take years, but “That’s the future,” he says. “And once [insurers] start paying better, others will join the early adopters.” Dr. Mambu, who has achieved level 3 PCMH recognition by NCQA, hopes to be selected to participate in an upcoming CMS medical home demonstration slated to begin in October in Pennsylvania and seven other states.

For Mr. La Penna, the mark of a profitable practice is getting out in front of new trends instead of waiting and running the risk of being forced into them. “Some practices are sitting in a foxhole wondering when people are going to attack, but the only thing they did is build a foxhole,” he observes. “That gets you below the line of fire, and then—whatever happens—you react. But there are other practices that are taking the initiative and recognizing where they can complement a moving market.”