North Carolina Community Health Center Association

2022 Primary Care Conference

How to Use KPI's to Manage a Health Center

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Curt Degenfelder
President
Curt Degenfelder Consulting, Inc.

- Based in Los Angeles, CA

- A national healthcare business consultant with 33 years experience

- Work with 100+ community health centers (CHCs) developing financial, operational, and strategic solutions

- Work on FQHC payment reform & alternative payment methodologies (APMs)

- Perform trainings for CHCs, state PCAs, the National Association of Community Health Centers as well as boards and foundations

- Board member at Westside Family Health Center in Culver City, CA

REPORTING IN CHCs

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Data & Report Inclusion Criteria

- How great is the impact of the specific data on:
  - Financial performance
  - Operational efficiency
  - Clinical quality
  - Compliance
  - Health center meeting its mission

- Who needs to see the data: Board, Executive Management, Line Management, Staff

- How frequently does the data need to be analyzed:
  - Dashboard: closer to real-time
  - Monthly
  - Ad hoc

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Data & Report Inclusion Criteria

- How available is the data?

  - Is it stored electronically?

  - Is it collected automatically as part of normal operations, so no new data entry is required?

  - Is it easily reported?

    - Does a report already exist or is it ad hoc?

    - Does it require integration from multiple systems?

   - Do we trust the data, or does it need to be "scrubbed"?

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Areas of Reporting

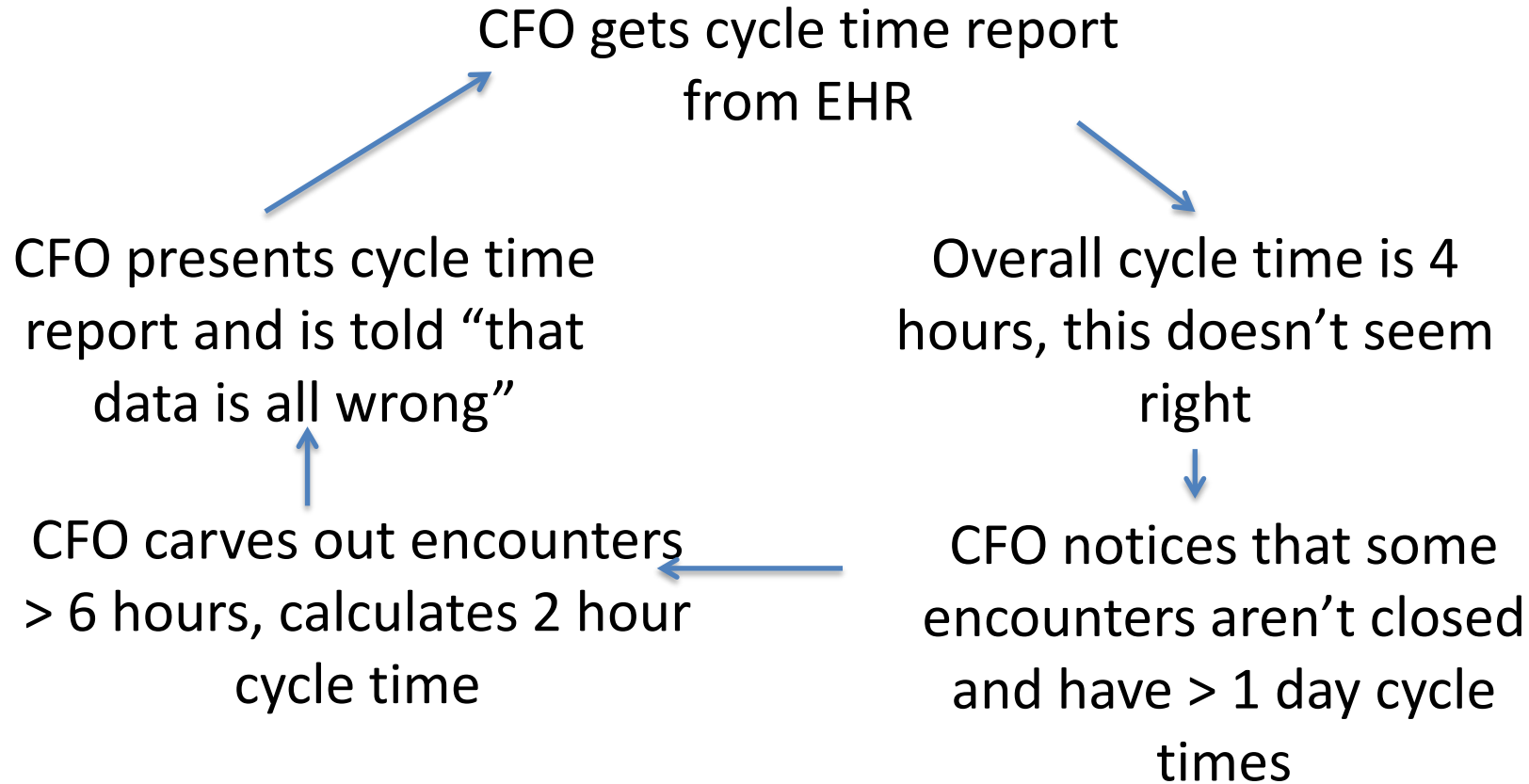| Operations	Finance	Clinical	Management/ Governance	Regulatory
Patient flow	Profitability drivers	Provider staffing	HR reports	UDS
Operational Staff performance	Income statement & balance sheet	UDS quality measures	Compliance	990
Provider productivity	Grants management	HEDIS	Board issues	Cost reports
Appointment scheduling	Revenue cycle	CQI reports		FFR
Call center metrics	Managed care membership			Licensing
	340b			

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Report Development Is Logarithmic and Iterative

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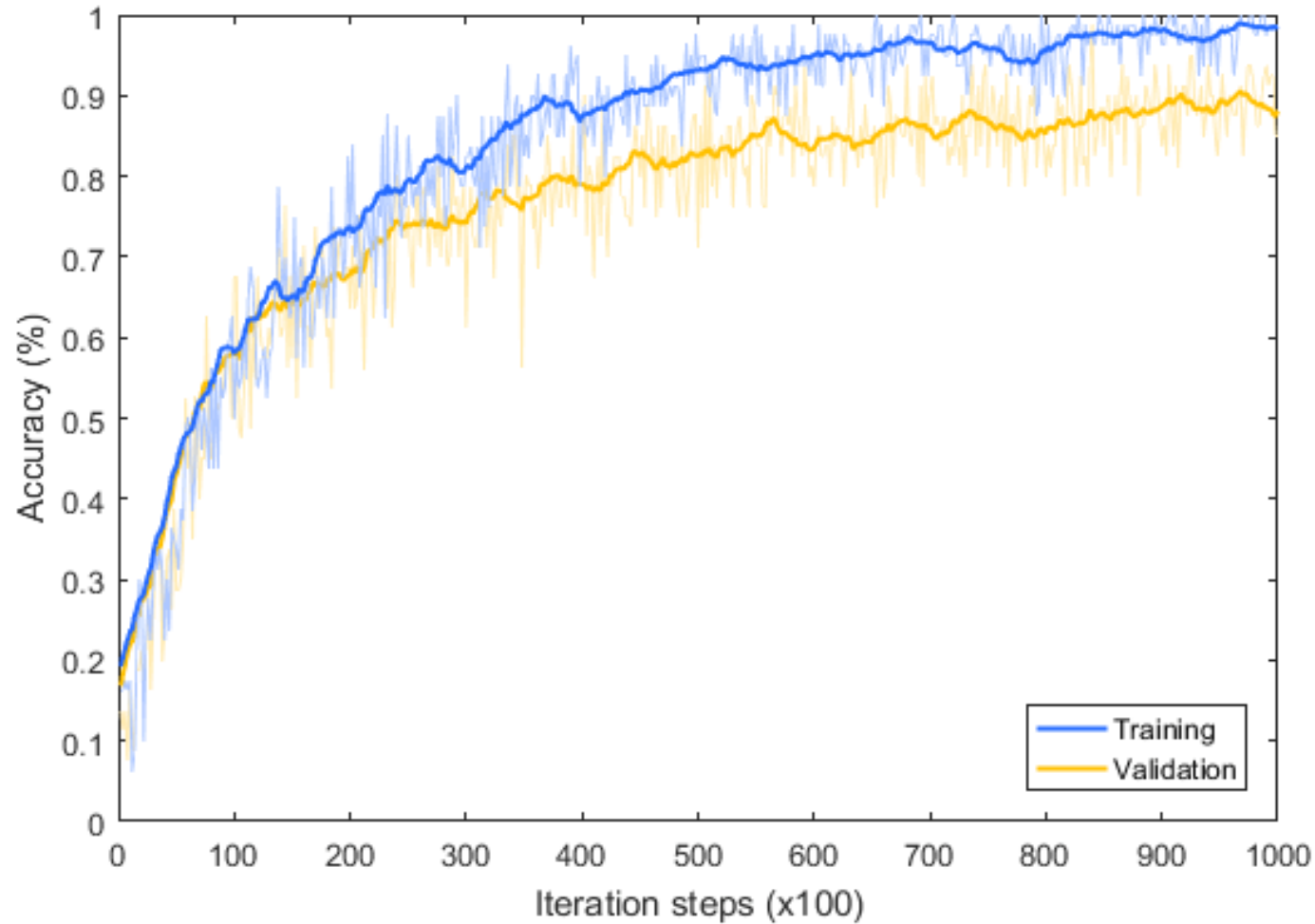
Iteration #1 – Cycle Time

Starting Understanding: Stories about long waits from Site Managers. Understanding of issue: 20%

CFO gets cycle time report
from EHR

CFO presents cycle time
report and is told "that
data is all wrong"

Overall cycle time is 4
hours, this doesn't seem
right

CFO carves out encounters
> 6 hours, calculates 2 hour
cycle time

CFO notices that some
encounters aren't closed
and have > 1 day cycle
times

Understanding at end of iteration #1: 60%

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Iteration #2 – Cycle Time

Starting Understanding: 50% from cycle time report

CFO starts with cycle time report

CFO presents cycle time report and is told "that looks better but I want to know more"

CFO separates out medical, dental , mental health

CFO runs the report by service by site

Medical 1.25 hours, dental 2.75 hours, MH 1.4 hours

Understanding at end of iteration #2: 70%

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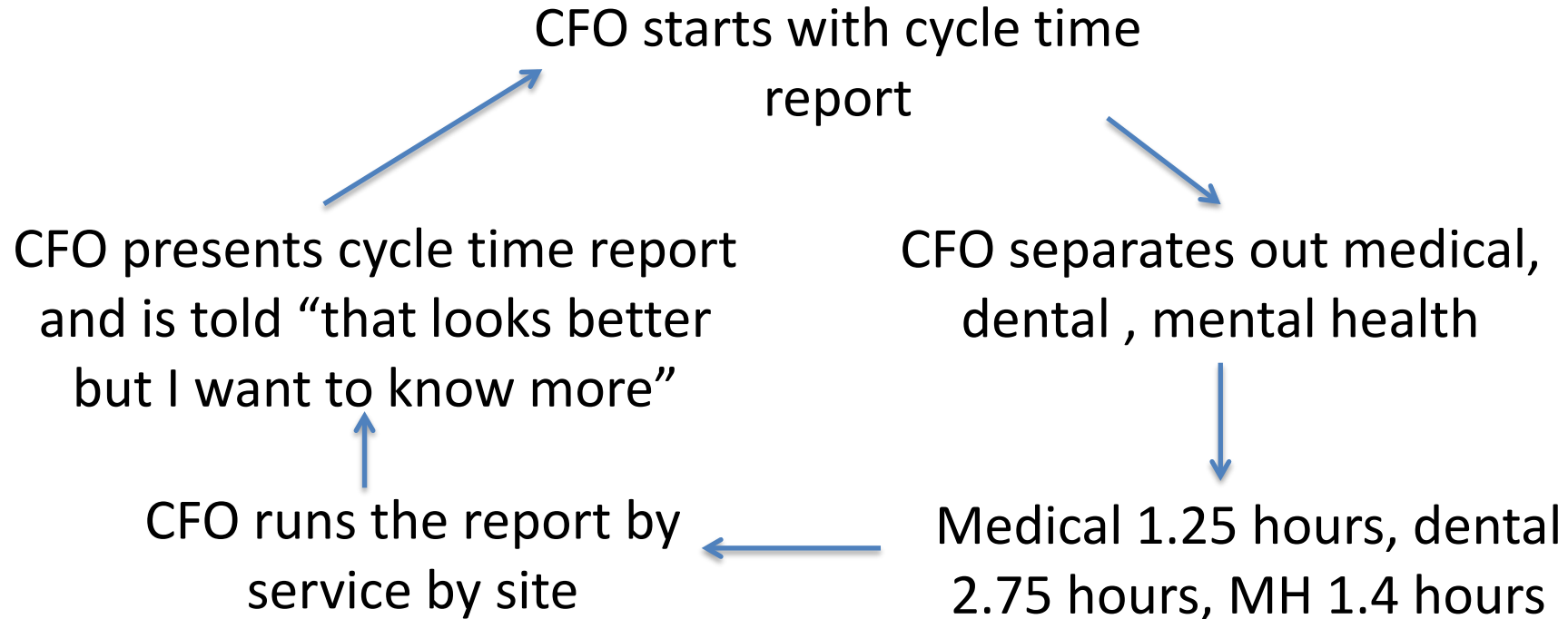
Iteration #3 – Cycle Time

Starting Understanding: 70% from cycle time report

CFO starts with cycle time report

Management team can make specific changes based on report

CFO separates new from established patients

CFO breaks out entry to registration done, to roomed, to vitals complete, to provider enters room, to provider done, to patient checkout

Medical new patient 1.75 hours, established 1.0

Understanding at end of iteration #2: 90%

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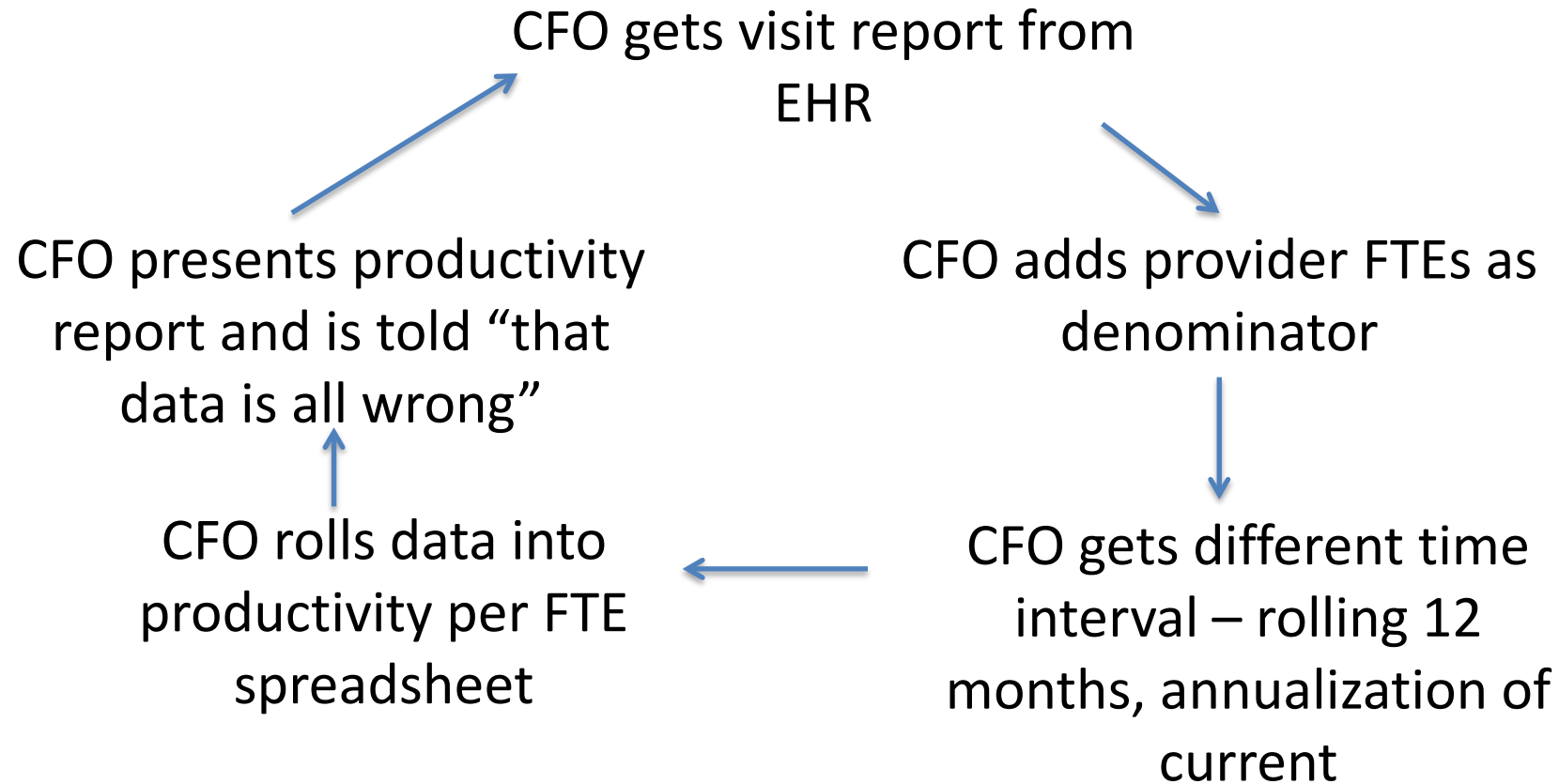
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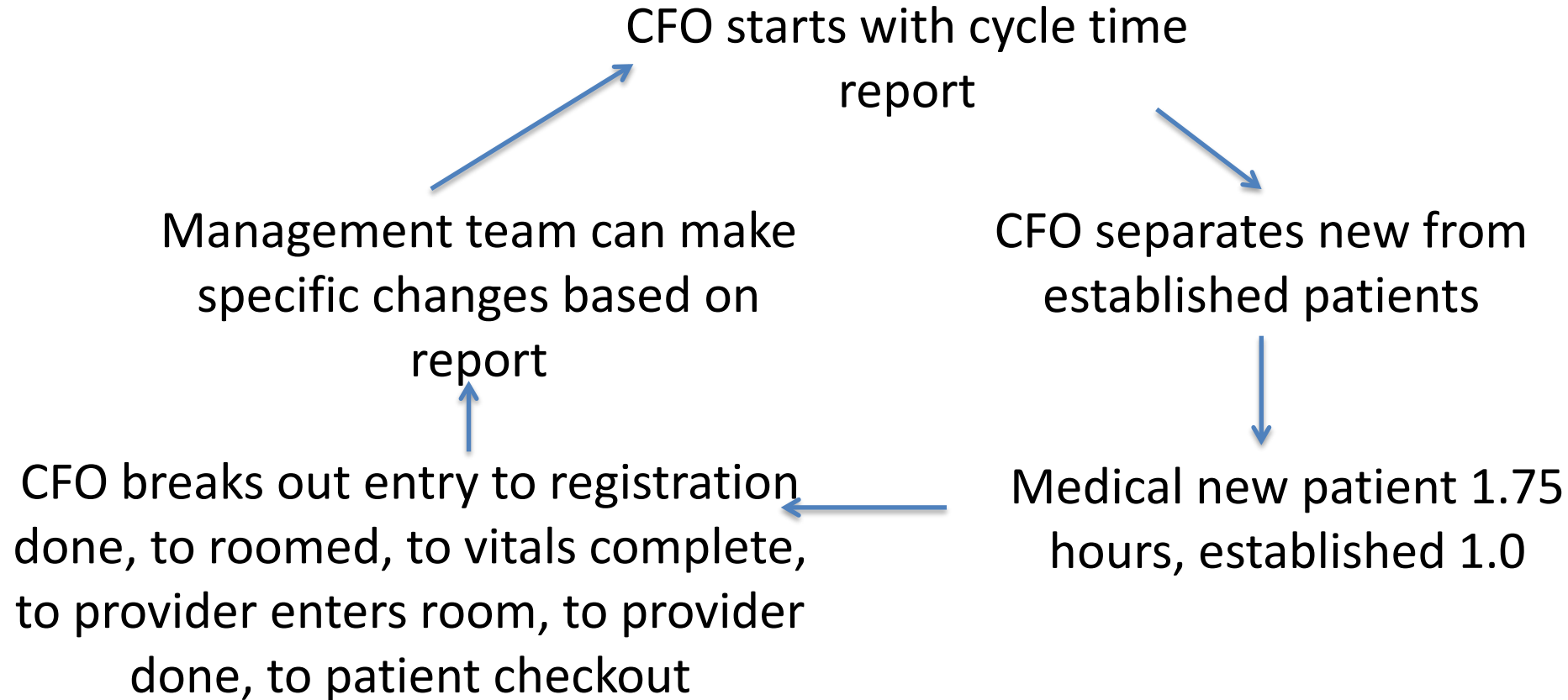
Iteration #1 – Provider Productivity

Starting Understanding: Visit report from EHR. Understanding of issue: 30%

CFO gets visit report from EHR
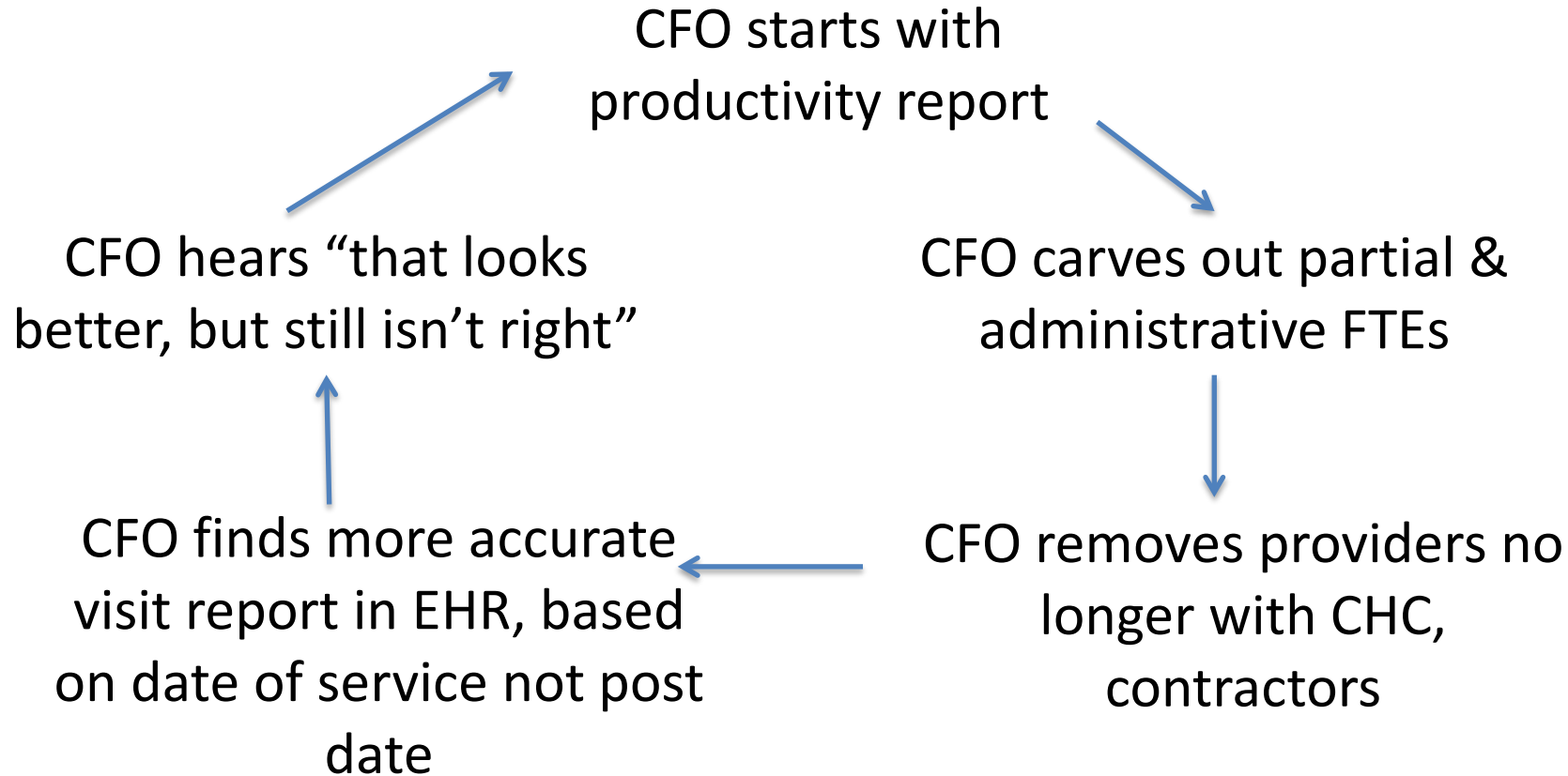
CFO adds provider FTEs as denominator

CFO gets different time interval – rolling 12 months, annualization of current

CFO rolls data into productivity per FTE spreadsheet

CFO presents productivity report and is told "that data is all wrong"

Understanding at end of iteration #1: 60%

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Iteration #2 – Provider Productivity

Starting Understanding: 60%

CFO starts with
productivity report

CFO hears "that looks
better, but still isn't right"

CFO carves out partial &
administrative FTEs

CFO finds more accurate
visit report in EHR, based
on date of service not post
date

CFO removes providers no
longer with CHC,
contractors

Understanding at end of iteration #2: 72%

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PERFORMANCE INDICATORS

What Are Key Performance Indicators (KPIs)?

- Key performance indicators are periodic, repeated measurement of achievement of a particular goal

- KPIs are a method of quantifying health center performance, using data collected from health center operations

- KPIs track performance over time. This tracking could include comparison against goals from the budget or strategic plan

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Two Types of Key Performance Indicators

- Outcomes – the end result of a process
- Process measurements – the inputs of a process

Today we will cover both the outcomes, as well as the process measurements as drivers of health center performance.

We will use a drill-down methodology to identify base drivers.

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Indicator #1 – Days Cash On Hand

Operating Cash x 365
(Total expenses – noncash expenses)

- Why Is This The Most Important Indicator? - because the CHC has to make payroll every two weeks

- Why else is it important? – because it represents the sum total of financial and operational activity at the health center (but does not measure mission, clinical quality, or customer service)

- Superior to current ratio or working capital because it adjusts for errors in revenue recognition

- KPI driver – Days in Accounts Receivable

- Also consider restricted cash, excess days in payables, unearned revenue

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Indicators – Level #2 – Drivers of Revenue

- Provider productivity (covered in next session)

- Payor mix

- Net revenue per visit/collection percentage

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Provider Productivity – Annual

Annual Billable Provider Visits/Annual Billable Provider FTEs

- Break into medical, dental & behavioral health

- Calculate by individual provider. Do not carve out FTE for anyone other than Medical Director. This analysis will also show the need to carve out visits by locums, per diems, volunteers, residents, etc

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Provider Productivity From UDS
When Will We Hit Bottom?

	2007	2009	2011	2013	2015	2017	2019
Family Practice	3830	3768	3492	3346	3156	2958	2835
Pediatricians	3937	3952	3681	3448	3320	3192	3147
General Practitioners	4078	3915	3921	3609	3304	3046	3035
Internists	3755	3670	3407	3189	2998	2953	2848
OB/GYN	3616	3535	3267	2997	2881	2832	2708
Nurse Practitioners	2811	2865	2804	2674	2570	2527	2515
Dentists	2669	2726	2682	2610	2623	2599	2624

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Impact of Provider Productivity Increase

Revenue

- Net revenue per visit $120 x 100 = $12,000

Expense

- Provider and staff salary - $0
- Provider incentive compensation - $40 x 100 = $4,000
- Medical supplies - $6 x 100 = $600
- Office supplies - $3 x 100 = $300

Margin

- $12,000 – 4,900 = $7,100

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Provider Productivity - Daily

- Most health centers have a target of visits per provider per day. Very few health centers actually track it. So our KPI needs to be:

    <u># of providers meeting productivity target</u>

    Total # of providers

Note that this is a binary, event driven (did the provider meet the standard or not) KPI rather than a cumulative measure. CHC target should be 80%. Measuring performance this way allows for improvement because:

- It allows the center to determine if policies/processes are successful

- It allows the center to identify if goals are realistic

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Productivity vs. Daily Target

Family Practice Rolling Year

Family Practice Visits per Day by Site

Year	Eagle Rock	East 3rd St	Echo Park	Hollywood
2017				
Jan	38.8	43.1	44.8	59.7
Feb	41.2	58.8	38.7	52.6
Mar	36.2	53.0	40.1	56.6
Apr	39.4	54.5	50.8	51.6
May	37.6	53.8	50.3	48.5
Jun	40.0	50.4	41.8	48.3
Jul	37.7	53.7	41.0	57.4
Aug	33.3	54.0	45.4	55.7
Sep	37.6	56.7	51.4	62.0
Oct	37.2	53.2	43.1	61.4
Nov	34.9	53.0	41.1	69.0
Dec	34.7	47.1	34.9	73.6
2018				
Jan	38.0	52.6	44.7	66.5
Total	**37.3**	**52.8**	**43.6**	**58.1**

Visits per Day by Provider (16)

Visit_Prov	2017 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2018 Jan	Total
	15.7	15.2	13.0	13.8	13.0	11.5	14.6	11.5	12.7	11.5	11.3	10.7		13.1
	12.8	14.1	15.8	12.6	13.3	13.9	14.7	14.7	14.5	12.8	13.6	10.2	14.8	13.7
	14.2	12.2	13.8	12.2	10.8	16.0	15.3	13.1	13.6	10.8	9.8	10.2	9.8	12.6
	3.6	4.4	2.9	3.1	3.0	2.7	2.2	4.0	4.0	8.3	8.8	10.6	10.6	5.9
	16.9	14.5	13.4	14.4	13.6	15.2	13.4	13.2	14.4	15.2	13.1	14.2	11.8	14.1
	13.0	13.5	13.4	14.6	13.6	15.2	15.7	15.2	15.8	14.9	15.4	15.3	16.9	14.7
	12.2	12.3	12.6	11.9	13.0	13.9	11.7	10.9	12.3	12.6	13.3	12.2	12.8	12.4
	12.5	14.4	15.5	17.3	15.0	17.4	16.5	16.9	16.4	16.6	17.3	14.5	11.5	16.0
										7.3	10.2	10.5	11.8	9.9
										8.4	9.8	11.3	11.9	10.3
	17.6	17.4	17.1	16.1	15.1	17.5	18.1	17.4	17.3	18.0	15.9	15.8	15.5	16.9
		12.8	13.1	13.9	18.1	16.5	16.4	17.2						15.5
	15.9	15.1	13.9	15.0	14.2	13.5	15.7	14.4	15.8	14.2	14.4	14.6	15.1	14.7
	16.2	11.7	11.3	9.3	15.1	17.0	17.1	15.3	13.6	14.9				13.8
	14.1	14.5	14.3	13.7	12.2	13.4	14.2	13.4	14.4	13.0	13.7	12.1	18.0	13.5
	14.9	16.3	16.4	15.6	14.9	14.9	17.2	19.2	17.5	17.3	17.6	17.4	18.0	16.6
	12.0	15.3	16.5	14.9	13.5	14.3	13.9	13.8	11.4	14.0	12.3	10.3	12.1	13.1
								4.2	10.7	13.0	12.2	12.0	12.6	11.6
	14.5	15.7	14.9	14.9	13.9	16.2	15.5	15.6	16.7	17.2	16.4	15.3	17.6	15.7
	16.9	15.9	16.1	14.7	15.9	16.1	15.7	15.8	15.8	15.4	13.5	13.2	14.5	15.4
	19.6	19.9	18.2	17.0	16.5	18.4	16.7	17.3	17.1	17.4	16.3	17.4	16.5	17.5
	16.2	15.0	15.7	13.4	13.6	15.8	14.1	15.3	16.3	15.1	15.4	14.7	15.7	15.0
	15.4	15.0	14.8	14.9	14.5	15.8	13.6	15.3	14.0	16.0	16.0	13.7	15.8	14.9
								8.0	10.0	11.6	11.3	12.4	12.5	11.3
	13.8	13.6	12.5	9.7		11.4	14.0		13.0		12.0	10.0		12.5

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Productivity vs. Daily Target Rollup

PROVIDERS MEETING PRODUCTIVITY

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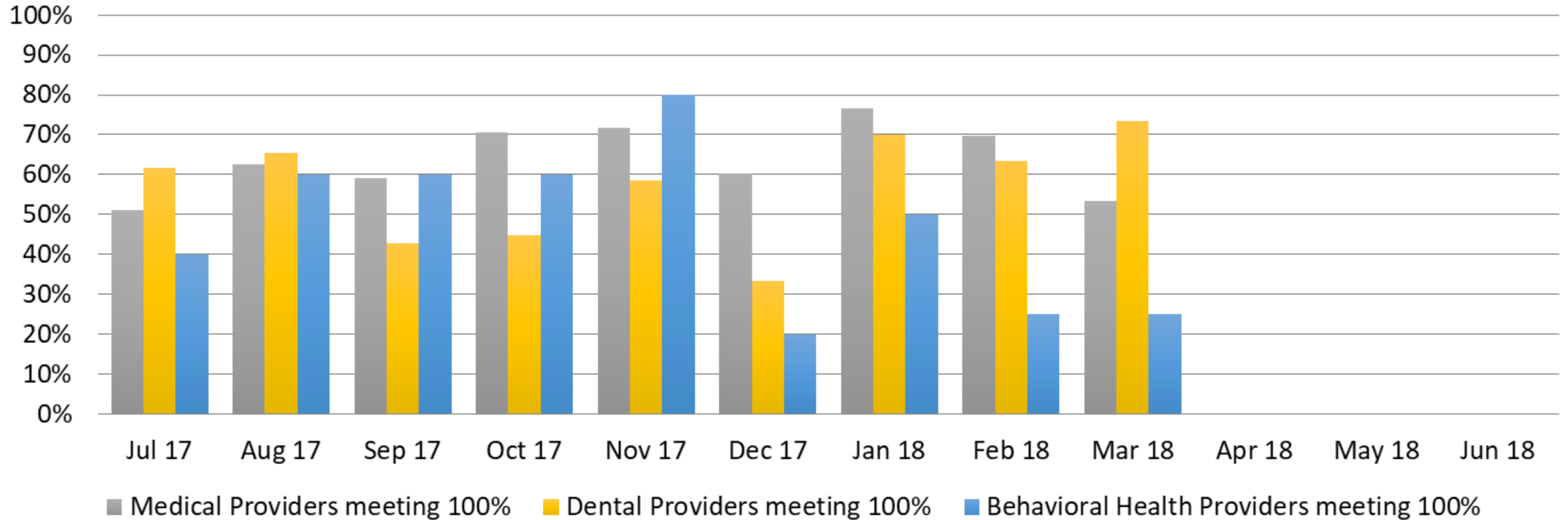
Cost of Losing A Provider

	NACHC	CHC	
Recruitment Cost	$ 10,000	$ 25,000	
Average length of vacancy	3.5 months	3.5 months	
Annual Productivity	3,600	3,500	
Lost visits in 3.5 months	1,050	1,021	
Net Revenue per visit	$ 120.00	$ 134.60	
Lost Revenue = 1,050 X $120	$ 126,000	$ 137,404	
Provider Salary saved at $180,000 + 22% benefits	$ 64,050	$ 71,400	($195,840 + 25% fringe)
Marginal Cost (revenue lost)	$ 61,950	$ 66,004	
Months to full ramp up	6	6	
Lost visits in 6 months (incl credentialling)	864	864	
Lost Revenue	$ 103,680	$ 116,294	
Total Cost for one provider turnover	$ 175,630	$ 207,299	

This analysis suggests from a financial standpoint,
retention is more important than recruitment!

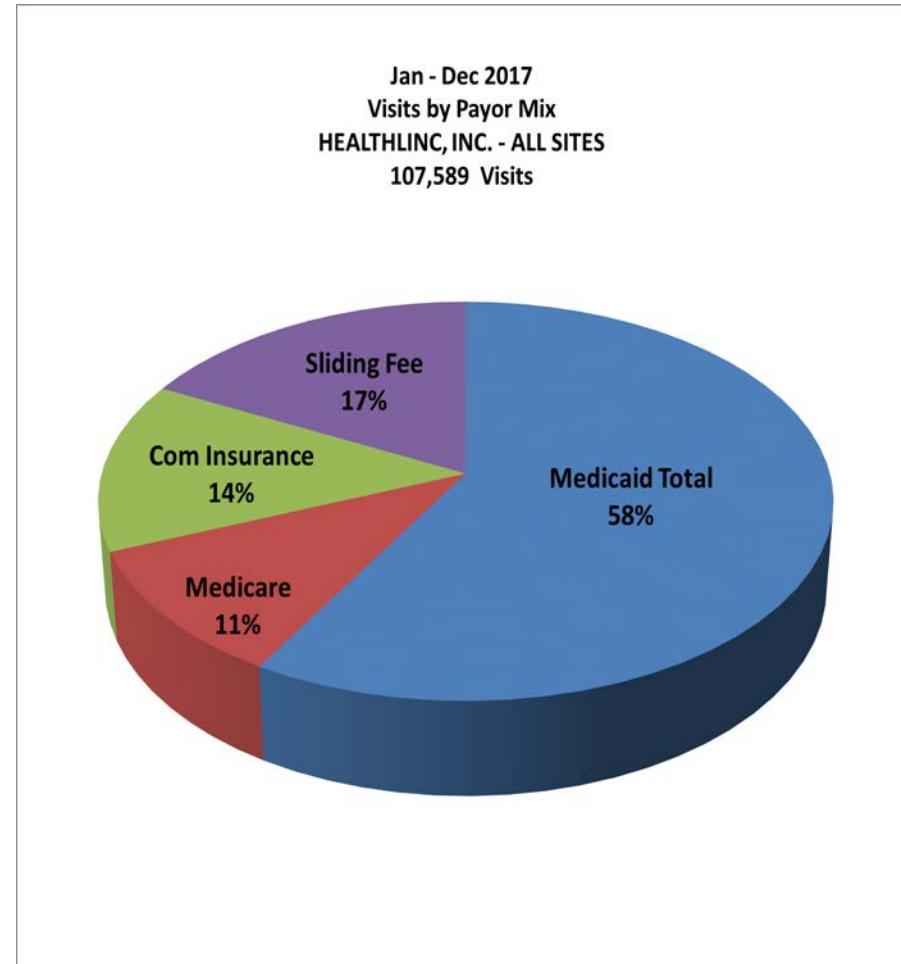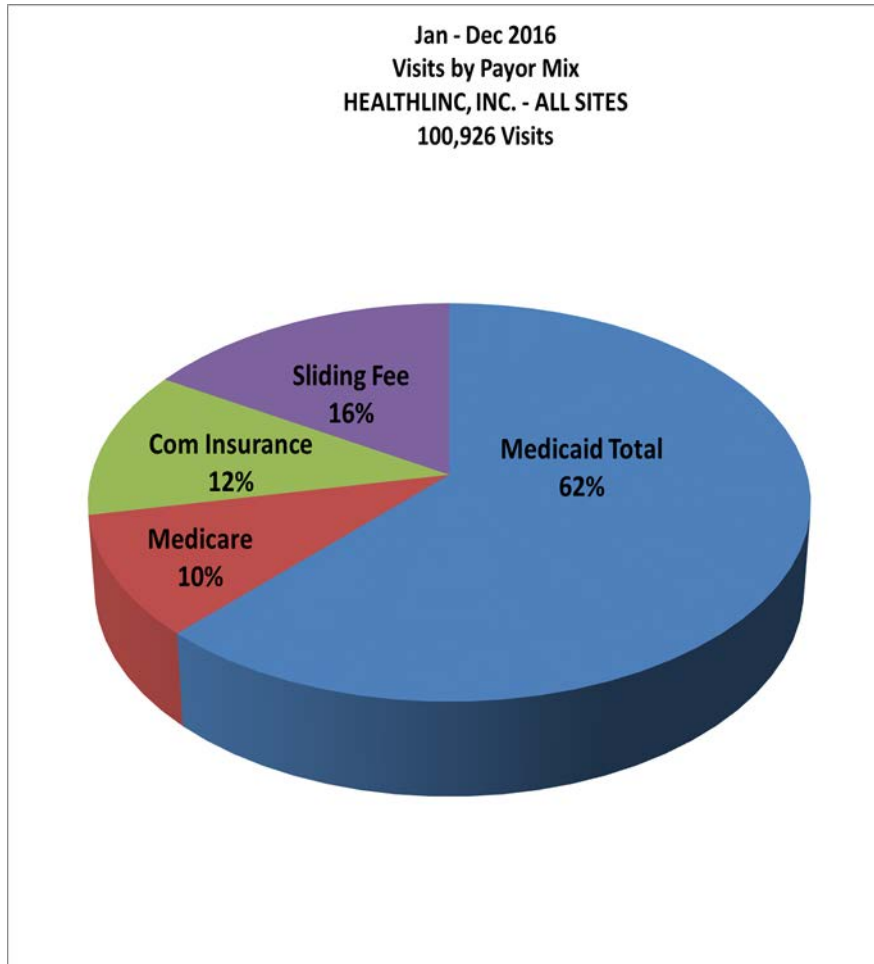Curt Degenfelder Consulting, Inc.

Payor Mix

<u>Visits by Payor Type</u>
Total Visits

- Why is this an important indicator? - because Medicaid and Medicare FQHC pays so much more than self-pay and commercials

- Why else is it important? – identifies the effectiveness of operational outreach and enrollment efforts, and how it effects revenue bottom line.

- Can also run patient payor mix (leading indicator) and patient service revenue payor mix (trailing indicator)
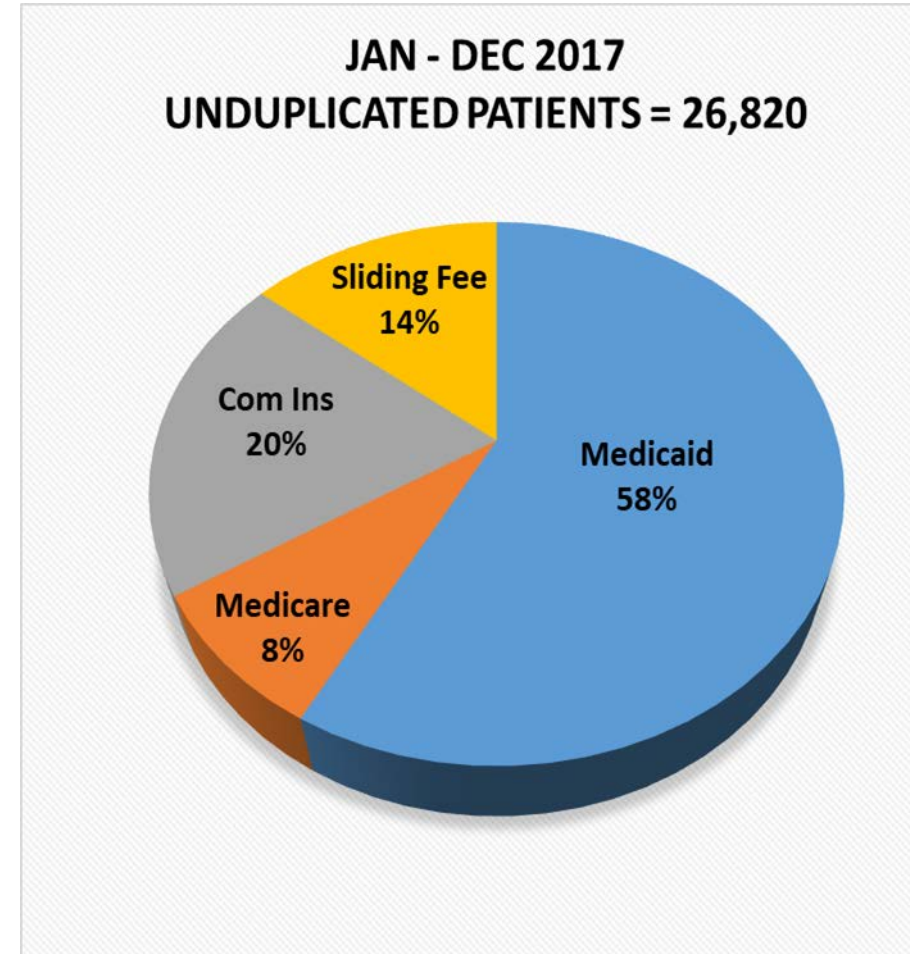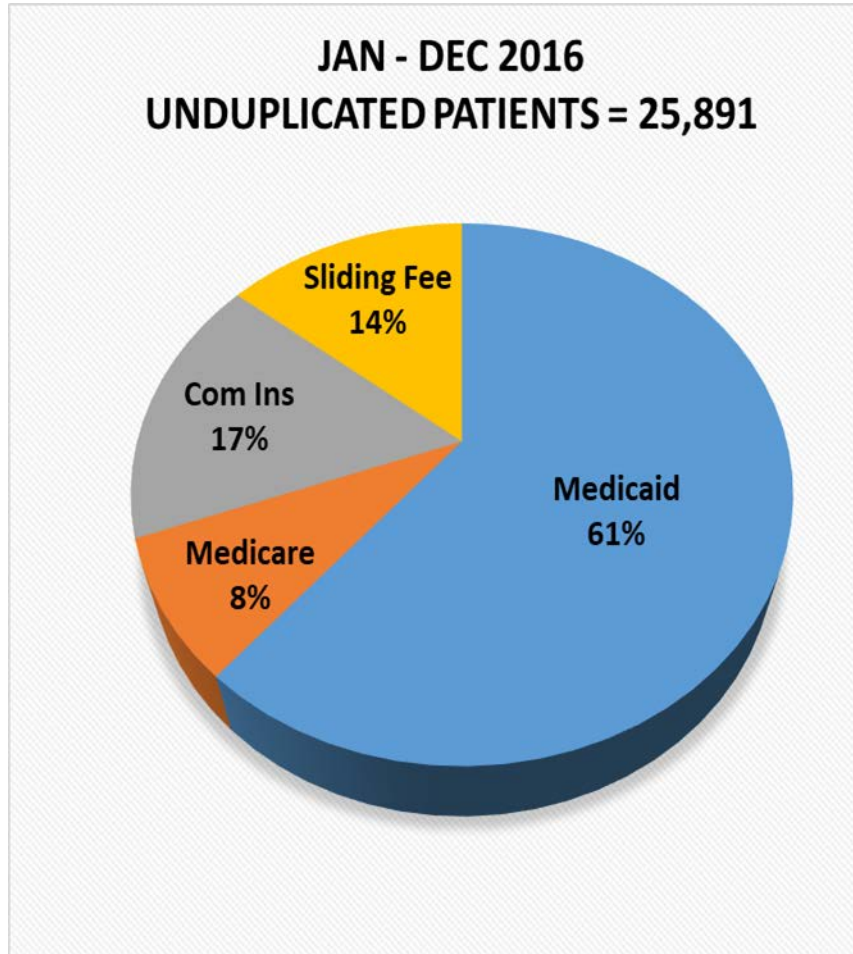
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Visit Payor Mix Over Time

Jan - Dec 2016
Visits by Payor Mix
HEALTHLINC, INC. - ALL SITES
100,926 Visits

- Sliding Fee 16%
- Com Insurance 12%
- Medicare 10%
- Medicaid Total 62%

Jan - Dec 2017
Visits by Payor Mix
HEALTHLINC, INC. - ALL SITES
107,589 Visits

- Sliding Fee 17%
- Com Insurance 14%
- Medicare 11%
- Medicaid Total 58%

What is reason for 4% decrease in Medicaid?

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Patient Payor Mix Over Time

JAN - DEC 2016
UNDUPLICATED PATIENTS = 25,891

- Sliding Fee 14%
- Com Ins 17%
- Medicare 8%
- Medicaid 61%

JAN - DEC 2017
UNDUPLICATED PATIENTS = 26,820

- Sliding Fee 14%
- Com Ins 20%
- Medicare 8%
- Medicaid 58%

Can also be done for a rolling 12-month period.

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Net Revenue Per Visit

***<u>Total Patient Service Revenue</u>***
***Total Visits***
<u>Total Payor Patient Service Revenue</u>
Total Payor Visits

- Why is this an important indicator? – as health centers mature, a greater portion of the budget comes from patient service revenue. Total net revenue per visit is a function of both net revenue per visit by payor as well as payor mix

- Drivers of Medicaid net revenue per visit:

  - Medicaid rate (by site)

  - Medicaid billing and collection effectiveness

  - Wraparound billing and collection effectiveness

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Reporting On Denials Over Time

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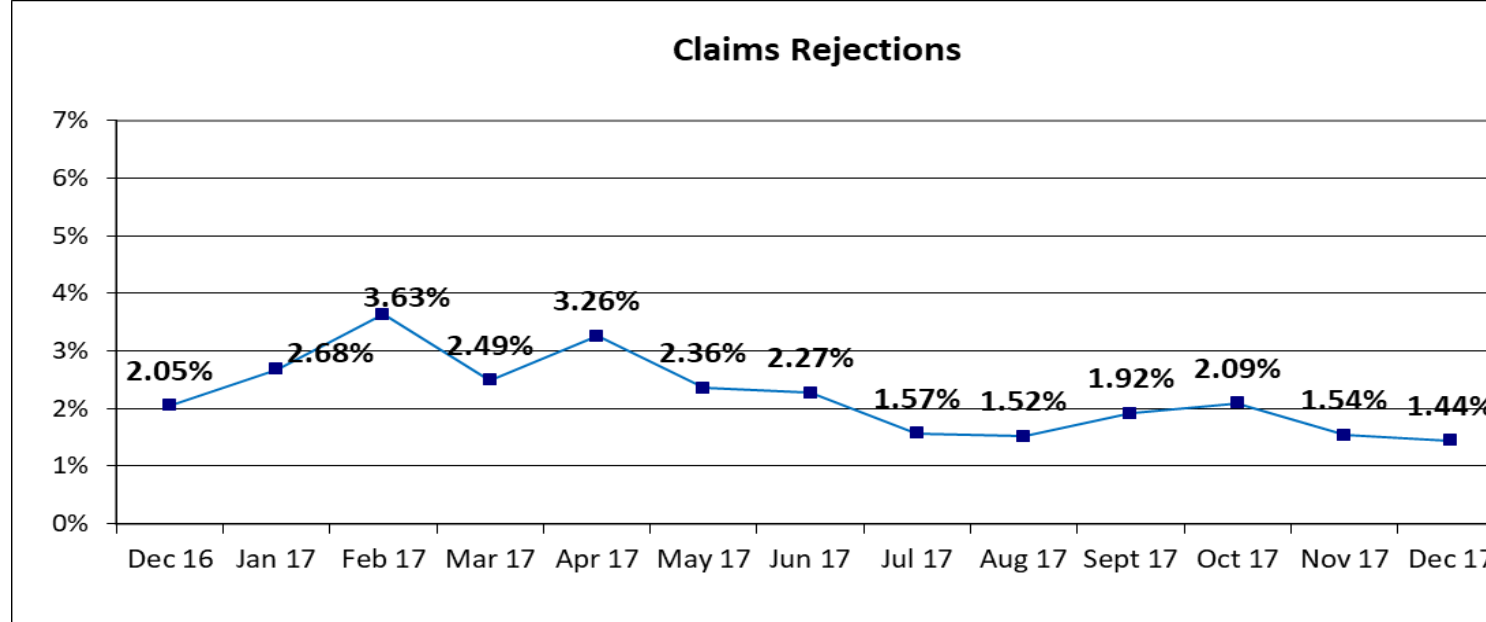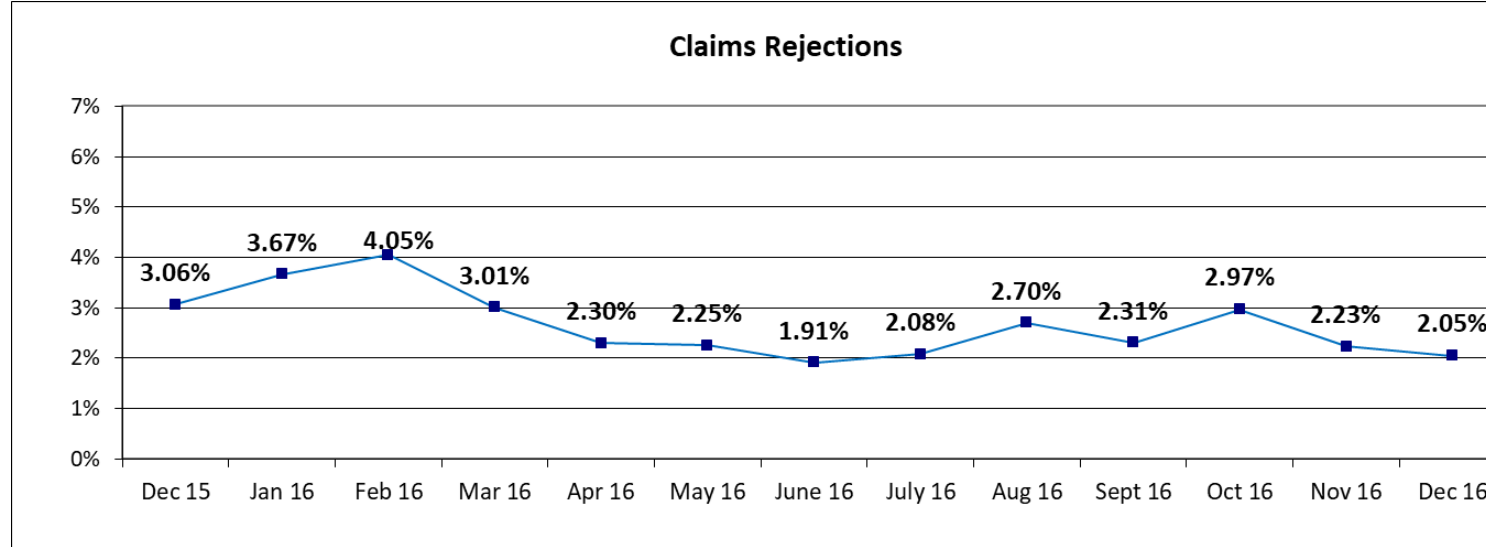
Denial Management:
Looking for Corrected & Uncorrected Mistakes

Date of Service	System User	Description	Billing Fixed	Error Type	Pended Revenue
03/17/2010	H Watkins	Patient GENDER and DOB missing from registra	N	Demographics	$ 52.00
03/18/2010	S Jorgen	Patient insurance is not entered for DOS	N	Insurance Registration	$ 160.00
03/19/2010	S Jorgen	Incorrect or No co-payment collected	N	Co-pay/Co-Ins.	$ 15.00
03/22/2010	N Vazquez	Patient's last name does not match insurance file	N	Demographics	$ 118.33
03/23/2010	S Jorgen	CMO patient was registered for Medicaid	N	Insurance Registration	$ 118.33
03/25/2010	N Vazquez	Patient's last name does not match insurance file	N	Demographics	$ 118.33
03/29/2010	T Shipley	Patient's last name does not match insurance file	N	Demographics	$ 118.33
03/29/2010	N Vazquez	Incorrect address on patient account	Y	Demographics	$ 136.00
03/29/2010	T Shipley	No Wellcare Medicare eligibility completed	N	Insurance Registration	$ 89.50
03/30/2010	T Shipley	Patient last name different in Visionary than what i	N	Demographics	$ 118.33
03/31/2010	T Shipley	Incorrect address on patient account	Y	Demographics	$ 126.00
03/31/2010	S Jorgen	Medicaid patient registered as Private Pay	N	Insurance Registration	$ 118.33
03/31/2010	S Jorgen	Medi-medi patient registered as Medicaid only	N	Insurance Registration	$ 94.17

Note: This report may be more useful than a denial report because it includes front desk errors fixed by billing. Could also use clearinghouse report.

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Denial Management – Denial Types

Reason	Total Denied Visits #	% of Total
Charges covered under a capitated agreement	890	6.7%
Claim not filed timely	506	3.8%
Correct tooth info needed	89	0.7%
Duplicate claim	5,798	43.5%
Incomplete or incorrect coding (CPT, Diag, HCPCS)	207	1.6%
Lack of authorization/referral	206	1.5%
Lacks other info needed for adjudication	1,335	10.0%
Paid current / conflicting claim	52	0.4%
Patient ineligible	181	1.4%
Patient ineligible (Another plan)	3,283	24.6%
Patient ineligible at time of service	355	2.7%
Provider ineligible	44	0.3%
Service not covered - Plan	168	1.3%
Service part of more global procedure	22	0.2%
Unknown / Other	77	0.6%
TOTALS	13,323	100.0%

Note – If possible, include denials identified by clearinghouse.

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Tracing Denials to the Source

- Front desk
  - Patient not eligible
  - Incorrect demographic information, or outdated insurance coverage
  - Not MCO primary care provider

- Providers
  - Incorrect code
  - Service not supported by diagnosis/documentation
  - Service not covered
  - Provider not eligible/credentialed
  - NEW EHR issue…..Provider hasn't completed Medical Record, thus claim won't show as active in PMS

- Billing staff
  - Duplicate bill
  - Missing information

- Should then look at individuals

Indicator – Revenue Recognition/Wraparound Receivable

- GAAP & HRSA want us to record visits on DATE OF SERVICE.
- Your electronic health records revenue/patient accounting module may not be attuned to date of service. It may instead focus on Prior Month A/R + New Charges – Contractual Adjustments – Bad Debt – Payments = Ending A/R, with the following KPIs:

  - Net revenue per visit by payor category

  - Allowance for doubtful accounts/bad debt/net collection % by payor category

  - Contractual allowance %/sliding fee % by payor category

  We may need to use transaction date in lieu of service date, as all services may not be recorded when we run the reports (so approximately the same number of visits roll into the next month, each month)

  These % should be re-calculated at least annually and applied monthly

- Medicaid managed care revenue should be accrued at the PPS rate, less allowance for doubtful accounts/bad debt

  - Need to check with auditor if CHC can book reconciliation receivable if audit takes more than 2 years

Indicators – Level #3 – Operational Indicators

- Front desk metrics

- Cycle time and other patient flow indicators

- Staffing ratios

- Call Center statistics

- Revenue cycle

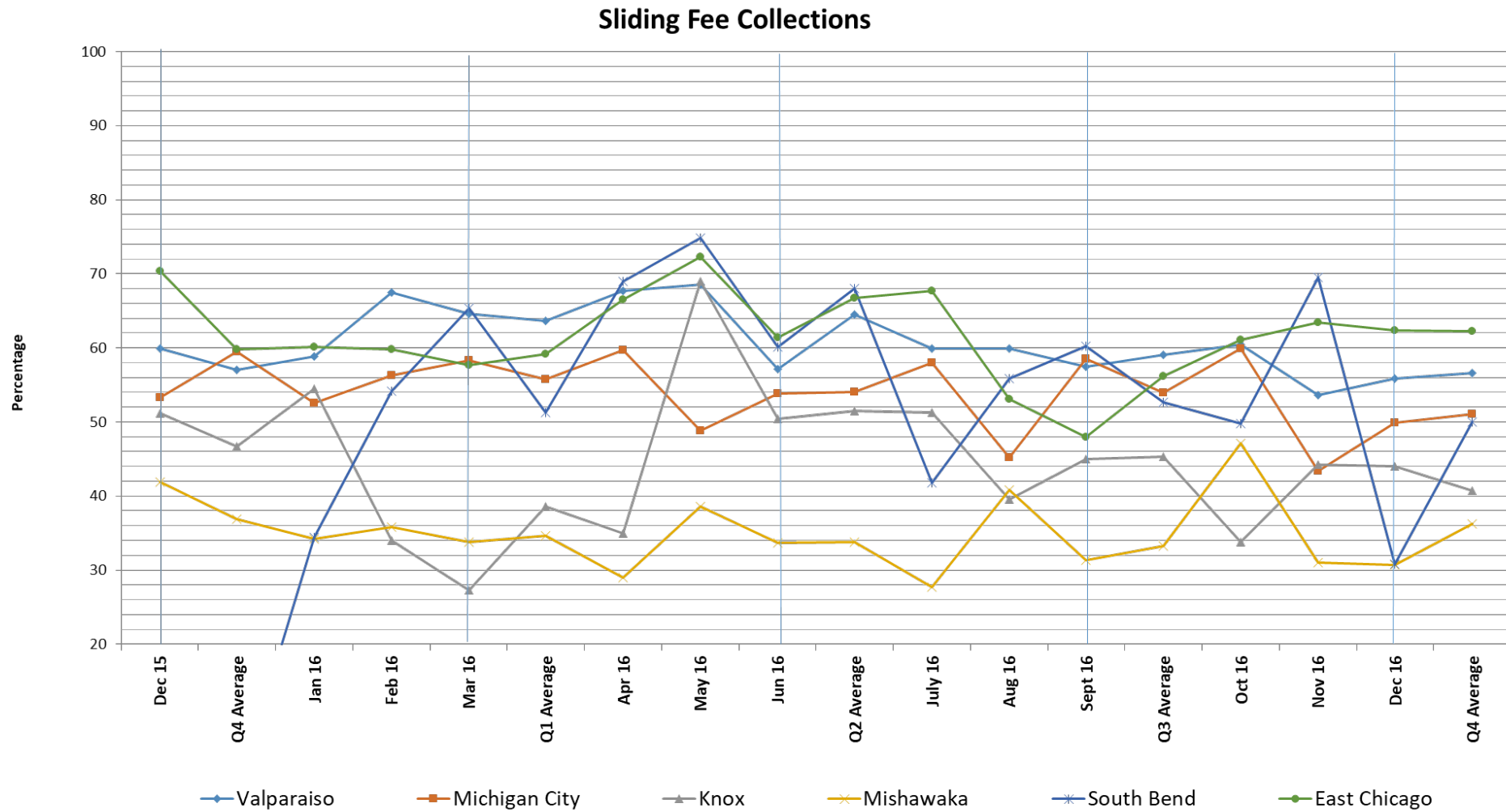Curt Degenfelder Consulting, Inc.

FRONT DESK ISSUES

Front Desk KPI - Productivity

	Reg	Hours		1st	Last Lunch	First After Lunch	Last	Rate
Adult / WHC Dept								
Altamirano, Nancy	26	8		8:10 AM	11:40 AM	12:52 PM	4:35 PM	3.25
Can, Marisol	22	8		7:51 AM	11:30 AM	1:01 PM	3:50 PM	2.75
Cordero, Gloria	26	8		7:43 AM	11:10 AM	12:34 PM	3:48 PM	3.25
Huerta, Vanessa	20	8		8:20 AM	11:02 AM	1:03 PM	3:44 PM	2.50
Jimenez, Elisa	23	8		8:18 AM	11:12 AM	12:50 PM	3:53 PM	2.88
Medina, Maria (Lead)	2	1		7:45 AM	7:55 AM			2.00
Mena, Imelda	22	8		8:15 AM	11:34 AM	1:13 PM	3:44 PM	2.75
Tovar, Paola	25	8		8:04 AM	11:03 AM	12:40 PM	3:59 PM	3.13
Velez, Rita	22	8		7:48 AM	10:52 AM	12:32 PM	3:04 PM	2.75
Total Adult	**188**	**65**						**2.89**
Pediatric Dept								
Gonzalez, Estafani (Lead)	33	8		7:56 AM	11:31 AM	12:22 PM	3:15 PM	4.13
Ramirez, Yuliana	33	8		7:39 AM	11:16 AM	12:24 PM	3:24 PM	4.13
Zamora, Belkis	28	8		7:39 AM	12:16 PM	1:02 PM	3:51 PM	3.50
Total Pediatric	**94**	**24**						**3.92**
Dental Department								
Angel, Cinthia	45	8		7:41 AM	11:15 AM	12:47 PM	3:35 PM	5.63
Robles, Hilda	48	8		7:58 AM	11:21 AM	12:51 PM	3:14 PM	6.00
Total Dental	**93**	**16**						**5.81**

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Front Desk KPI – Collections

Sliding Fee Collections

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Front Desk Quality Assessment: Manual Data Collection

FRONT OFFICE DOCUMENTATION ASSESSMENT

STAFF: DATE OF SERVICE:

PATIENT NAME: PATIENT DOB:

EVALUATOR: DATE:

EPIC fields	Circle YES if entered correctly , No if not entered correctly , N/A if not applicable, enter comments if necessary
	YES NO N/A
Appointment Scheduled	
Scheduled in parameter	
Notes – Reason for visit and insurance information	
Correct Provider	
Correct visit type	
Correct length of time	
hone number	
PCP	
Patient Registration	
Demographics Name	
Demographics SSN	
Demographics in All Caps	
PCP	
Employer	
Emergency Contact	
Patient Message – Caresource PCMH, NFP Sliding Scale Pending	
Consents listed – HIPAA NFP, NFP General	
Guarantor Account	
Correct Account Type	
Guarantor Name	
Correct Relationship	
FPL Entered Correctly	

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Additional Front Desk KPIs

Front desk dollars collected
Total amount to be collected

# of self-pay visits with >= $1 collected
Total self-pay visits

- As a compliance matter, CHCs are required to bill and collect where indicated

- As a revenue matter, self-pay and other front desk collections have a large impact on thin health center margins. This impact will grow as Marketplace and other plans increase copays, coinsurance & deductibles

- This figure is highly correlated with overall front desk quality, and should be measured for each Front Desk Clerk

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Front Desk Issue - Collections

Co-Pay Collection
2010

	Jan10	Feb10	Mar10	Apr10	May10	Jun10
Non Collected Estimation	$163,924	$160,081	$196,361	$169,725	$153,685	$168,996
% of Collections	47.9%	52.0%	50.2%	51.1%	52.6%	51.0%
Actual Collections	$150,482	$173,665	$198,167	$177,140	$170,431	$175,836

Legend: Actual Collections — Non Collected Estimation * — % of Collections — Co-Pay Goal Initiative: 80%
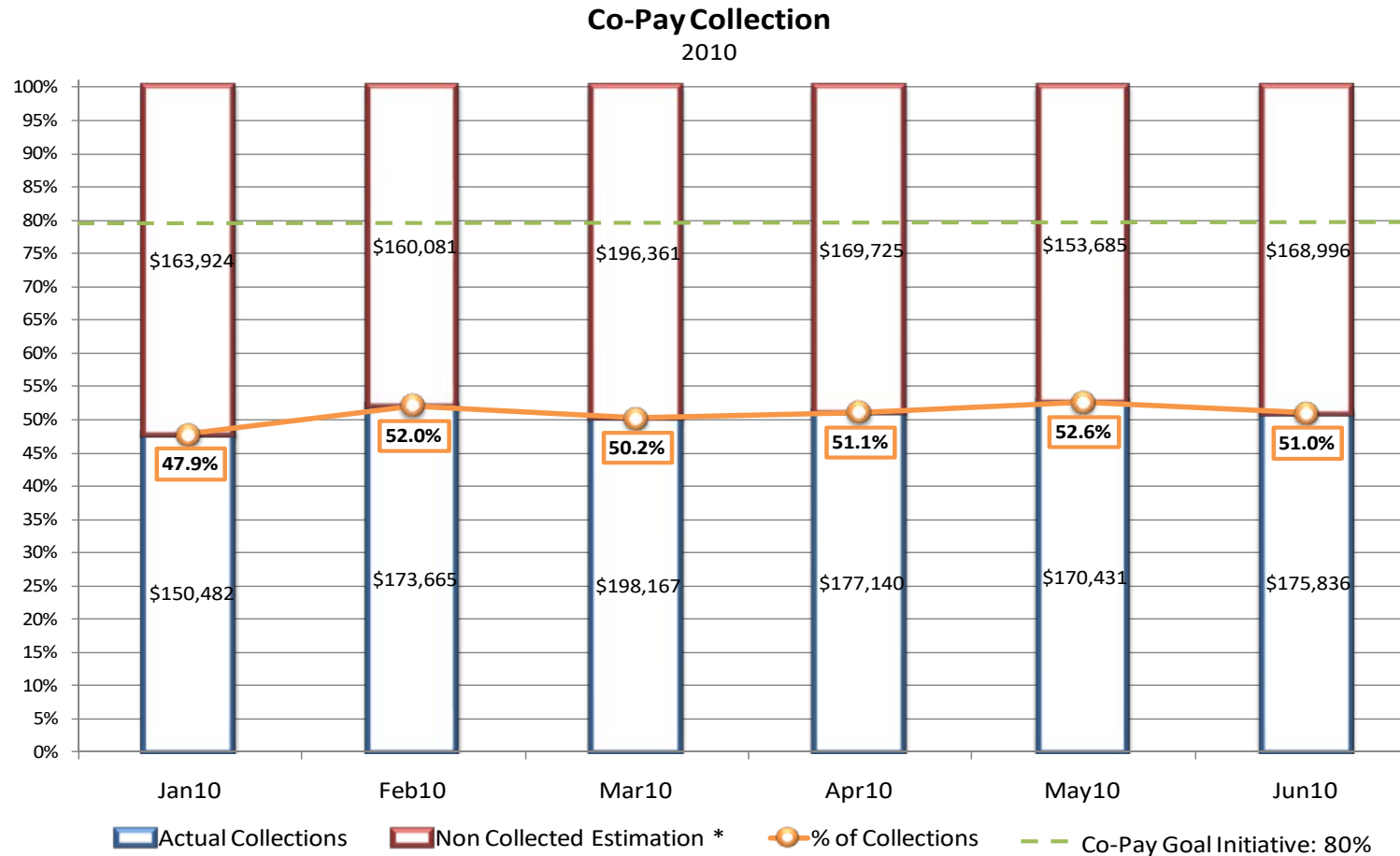
(*) Estimated through the Total Visits and the Actual AVG Collection per Visit
Note: This new report reflects Actual Co-Pays Collected for the Day of Service, if required. This report no longer includes other payments collected for future or previous balance
The goal for this initiative is 80%. Sites should continue to strive for the 5% monthly improvement as a goal utilizing the results of this first report for January 2010 as a baseline
Source: Quality Improvement Department, Co-Pay Campaign 2010

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Front Office Scorecard

Site: M Month: February 2018 Employee	Demographic opportunities	Demographic Error % (Goal < 5%)	Goal 90% Co-Pay collection	FrontEnd Goal 5% or less (Goal < 5%)	Denial Goal 5% or less (Goal < 5%)
Employee 1	206	5.3%	84.0%	8.3%	1.9%
Employee 2	495	2.6%	95.3%	2.6%	0.6%
Employee 3	408	3.2%	95.8%	0.7%	0.5%
Employee 4	327	4.0%	96.3%	4.9%	0.9%
Site: I Month: February 2018 Employee	Demographic opportunities	Demographic Error % (Goal < 5%)	Goal 90% Co-Pay collection	FrontEnd Goal 5% or less (Goal < 5%)	Denial Goal 5% or less (Goal < 5%)
Employee 1	73	1.4%	96.0%	20.5%	0.00%
Site: L Peds Month: February 2018 Employee	Demographic opportunities	Demographic Error % (Goal < 5%)	Goal 90% Co-Pay collection	FrontEnd Goal 5% or less (Goal < 5%)	Denial Goal 5% or less (Goal < 5%)
Employee 1	289	4.8%	87.5%	5.5%	1.7%
*Employee 2	524	8.0%	77.8%	8.8%	0.6%
Employee 3	544	4.6%	100.0%	6.4%	1.1%
Employee 4	358	1.4%	100.0%	5.9%	1.4%

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Monthly Front Office Productivity (not FTE based)

Site	Count of # Employees	Sum of Demographic opportunities	Average of Demographic opportunities
Site A	11	3,879	353
Site C	5	2,330	466
Site B	4	1,642	411
Site G	4	1,300	325
Site K	9	4,915	546
Site F	2	827	414
Site H	13	6,908	531
Site Q	1	73	73
Site J	23	9,504	413
Site E	14	6,984	499
Site O	2	412	206
Site P	4	1,004	251
Site D	1	273	273
Site M	1	382	382
Site N	4	1,715	429
Site L	4	1,436	359
Site I	4	1,194	299
Total	106	44,778	422
Median			419

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PATIENT FLOW & PROVIDER PRODUCTIVITY ISSUES

Goals of Patient Flow Optimization

- Start and end on time

- Avoid non-productive provider time because they done have a patient. Fill all appointment slots/provider time with a patient

- Open up unutilized capacity to additional patient visits

- Complete all required administrative/patient eligibility/collections activities

- Avoid unequal flow of patients based on:

    - Time of Day,

    - Patient Acuity,

    - Walk-ins vs Appointed,

    - New vs. Established

- Reduce cycle time, in total and reducing specific bottlenecks

- Align patient needs with health center staffing

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Operational Issue:
We Don't Start on Time Data Points

Pediatric Dept							
Date: 05/10/11							
Provider: Xavier Jackson MD							
Arrival Time___8:20am_____				Departure Time _____			
				Charts	**Vitals**	**Placed In**	**Provider Enter**	**Patient**
Patient Name	**Appt**	**Signed In**	**Checked In**	**Delivered**	**Complete**	**Exam Room**	**Exam Room**	**Released**
Patient 1	7:40 A							
Patient 2	8:00 A		8:20 AM	8.33	8.45	8.47	8.50	9.10
Patient 3	8:20 A		8:54 AM	9.02	9.10	9.10	9.27	9.42
Patient 4	8:20 A							
Patient 5	8:40 A		8:37 AM	8.52	8.59	9.00	9.15	9.25
Patient 6	9:20 A		9:26 AM			9.42	9.45	9.55

- Patient arrival time may be difficult to capture. Consider greeter recording time, or patient sign in sheet (with clock)

- Patient who showed up late still seen, but after patient who showed up early

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Operational KPI – Cycle Time

***Cycle Time = Time Patient Check Out – Time Patient Check In***

- Why is this an important indicator? 1. Measure of effectiveness (getting the patient in and out, avoiding bottlenecks), 2. Customer service indicator

- Initially, cycle time can be measured in total. As the CHC gets more sophisticated (or better learns to use its PM/EHR), additional metrics can be added

Community Clinic Cycle Time, Minutes	Q4				
	Site A	Site B	Site C	Average, Minutes	Average, Hours
New Patients	105	96	105	102	1.70
Establish Patients	95	88	95	93	1.54
Walk-Ins Patients	103	90	98	97	1.62

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Cycle Time Report By Site

Total Processing Time excluding Outliers (time>6hrs)
by Department June 2010
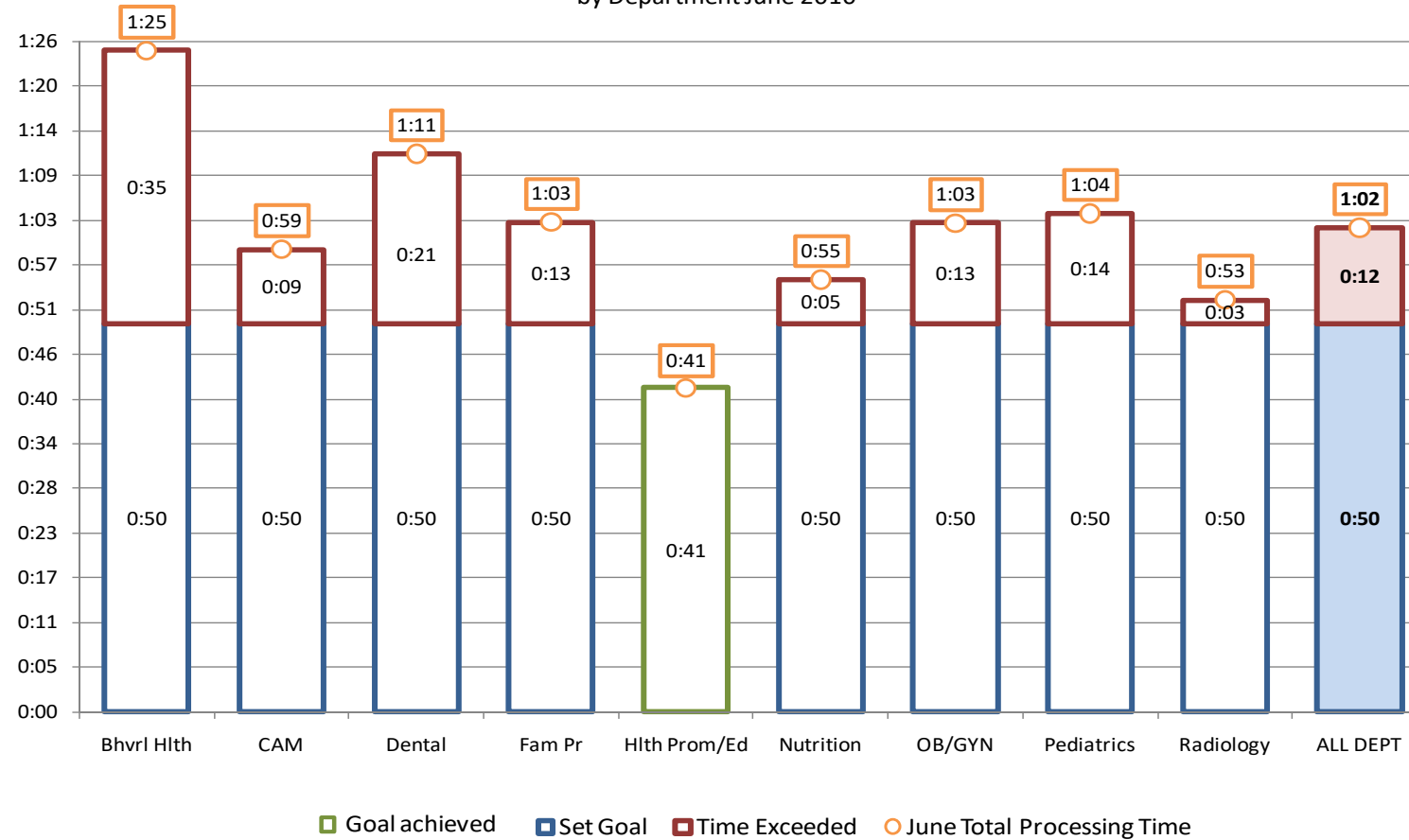
Legend: ☐ Goal achieved ☐ Set Goal ☐ Time Exceeded ○ June Total Processing Time

Assessing the Impact of Patients:
Visit & Insurance Type

F/U		
	Anthem/Blue Cross Medical	21 minutes 28 seconds 750 milliseconds
	Care First Medical	1 minute 16 seconds
	Health Net Medical	23 minutes 35 seconds 333 milliseconds
	Healthy Way LA Matched	37 minutes 47 seconds
	Healthy Way LA Matched Pending	22 minutes 31 seconds 500 milliseconds
	Healthy Way LA Unmatched	7 minutes 43 seconds
	L A Care Health Plan	1 hour 0 minutes 3 seconds
	Medical EDS	11 minutes 37 seconds
	Medicare - FQHC	1 hour 12 minutes 2 seconds
	PC CCEP Primary Care Claims	8 minutes 44 seconds
	PE Presumtive Eligibility EDS	23 minutes 25 seconds
	S4 STRATEGIC INITIATIVE	48 minutes 49 seconds
	Sofp Family Pact	24 minutes 53 seconds

We know it takes longer to register/enroll patients with certain insurance types – do we plan accordingly? What will this mix look like in late 2013/early 2014 when you need to help newly eligible Medicaid patients sign up?

Assessing the Impact of Time of Day

Hour	Period1
7	22 minutes 50 seconds
8	25 minutes 0 seconds 357 milliseconds
9	27 minutes 15 seconds 714 milliseconds
10	45 minutes 24 seconds 363 milliseconds
11	35 minutes 9 seconds 666 milliseconds
13	12 minutes 44 seconds 250 milliseconds
14	22 minutes 5 seconds 833 milliseconds
15	1 minute 58 seconds
	28 minutes 34 seconds 122 milliseconds

We know we get backed up at certain times of day – do we plan accordingly?
Is provider lunch a rarity at your health center?

Rebuilding Provider & Clinic Productivity from COVID: Scheduling

- The schedule is always an issue for health centers

- Thinking about schedule by service line:

  - Medical – if currently operating below normal scheduling, which of the previous milestones need to be met to move to the previous schedule, in terms of appointments per day?

  - Dental – might be a question of scope of procedures, rather than visits per day

  - Mental health – need to evaluate how much telehealth, and what the transition plan is, if any

- Is there pent-up demand? Would number of visits increase above prior levels, for a certain period of time?

- What is the impact of the pandemic on payor mix? Has there been a shift to more Medi-Cal? Redetermination may have been waived by the State (and so patients stay on Medicaid for a longer time)

Impact of Appointment Scheduling on Productivity

- Management should:
  - Maximize the amount of time providers are in clinic seeing patients
  - Conclude provider schedules (i.e., availability) <u>and</u> scheduling templates (i.e., standard time slots by clinical specialty for each appointment type) as policy
    - *Deviation from this policy should require the Chief Medical Officer's approval*
    - *Don't put Schedulers in the unenviable position of debating scheduling issues with providers*
    - *Time slot length is impacted by operational efficiency*

Managing Walk-Ins

- Determine how walk-ins will be treated

  - Designated urgent care provider(s),
  - Designated appointment slots
  - Worked in between scheduled patients
  - Scheduled into empty slots

- Determine the distribution of new, established, appointed and walk-in patient visits over the course of a typical day in order to match provider availability

- Determine the impact of walk-ins on patient flow

- How much de facto triage are front desk staff performing? How much de facto triage are operators performing?

Operational Issue:
We Don't Start on Time Data Points

- Do the patients show up on time?

  - Line at the door before the clinic opens

  - Time of clinic opening

  - Patients present at opening – appointed for first appointment, appointed for later appointment, walk-ins

- If/when patients show up on time, do we get them ready in time?

  - Order of patient registration at the beginning of the day – who gets registered first?
  - What is the average time it takes to register a patient? – this is probably the wrong measure. Instead in what time interval are 90% of the patients registered?
  - Does the clinic open early enough? Patient arrival time/time to register
  - Do staff show up early enough? Need to show up before clinic opens
    .

STAFFING

Rebuilding Provider & Clinic Productivity from COVID: Staffing

- Vacancies
  - Analyze current level – is it higher than normal?

  - What is the impact of enhanced unemployment benefits on the lower end of our pay scale – i.e. front desk, medical assistants, call center staff, etc.?

  - What is the impact of school closures on our staff's ability to work?

  - Has competitor pay been increased during the pandemic? How about pay at retail stores/fast-food restaurants?

All of these factors may combine to make filling vacancies slow, which would have both revenue and expense impacts.

Recruiting Challenges 2022

Difficulty to Recruit - January 2022

Categories (left to right): Front Desk Clerk, Call Center Staff, Primary Care MD, Nurse Practitioner, Experienced NP, Spanish speaking MH, Pharm Tech, Medical Assistant, Dental Assistant

March 2020 | April 2022
- Front Desk Clerk: 2 | 6
- Call Center Staff: 2 | 5
- Primary Care MD: 6 | 8
- Nurse Practitioner: 4 | 7
- Experienced NP: 6 | 10
- Spanish speaking MH: 8 | 9
- Pharm Tech: 6 | 7
- Medical Assistant: 3 | 5
- Dental Assistant: 4 | 10

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Thinking About Staffing Ratios

	Average	Median
Total Providers	122.0	132.2
Operations Staff per Provider FTE	1.7	1.6
Administrative Staff per Provider FTE	1.4	1.4
Non-Provider Staff per Provider FTE	3.1	2.9
Non-Provider Staff per Provider FTE w/UDS	4.3	4.0
Enabling Staff Per Provider	0.67	0.56
Total Visits	422,105	349,174
Visits per Operations Staff FTE	2,381	1,990
Visits per Administrative Staff FTE	2,827	2,848
Visits per Non-Provider Staff FTE	1,262	1,257
Visits per Non-Provider Staff FTE w/UDS	782	711
Visits per Enabling Staff FTE	6,846	6,906
Calls per Call Center FTE	18,091	20,000
Revenue per FTE	$ 219,476	$ 198,488
Revenue per FTE w/UDS	$ 138,886	$ 136,658

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Thinking About Staffing Ratios

	Average	Median
Visits per Medical Provider FTE	3,541	3,766
Visits per MA & RN FTE	1,665	1,557
MAs per Provider FTE	1.9	1.8
RNs per Provider FTE	0.3	0.3
Total Direct Support per Provider FTE	2.2	2.1
MAs per RN	19.1	5.2

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Correlating KPIs

Medical	Annual Visits	Provider FTEs	Visits/ Provider FTE	No Show Rate	3rd Next Available	Visits/ Direct Operations FTE	Visits/ Nursing FTE	Visits/ Indirect Ops FTE	Visits Per Sq Ft
Dindbruce	30,828	7.65	4,030	8.29%	12	2,973	3,705	6,304	3.14
Caropays	23,079	4.3	5,367	13.68%	38	3,321	4,749	7,517	5.34
Goldtown	25,027	8.23	3,041	9.42%	2	2,756	4,822	8,600	2.58
Panville	9,639	2.9	3,324	5.15%	29	3,109	3,003	7,472	3.01
Iftown	9,373	2.01	4,663	3.38%	16	2,540	2,314	7,683	1.41
Alexander	4,561	1.21	3,770	7.93%	9	2,281	3,329	25,341	2.95
Lagusa	7,653	1.8	4,252	4.42%	8	2,639	5,068	3,733	2.39
Grande	43,783	8.65	5,062	8.73%	17	3,043	4,150	17,870	3.40
Southside	23,836	4.5	5,297	10.35%	22	3,940	4,523	6,306	3.84
South Peds	18,145	4.5	4,032	9.30%	12	3,091	4,971	4,629	12.84
Medical Median			*4,142*	*8.51%*	*14*	*3,008*	*4,336*	*7,495*	*2.98*
Dental									
Dindbruce	20,487	4.5	4,553	12.74%	15	5,096	3,252	40,973	6.40
Goldtown	20,492	4.69	4,369	8.98%	17	4,605	2,823	40,984	4.51
Iftown	10,773	2.01	5,360	10.21%	44	4,489	2,707	26,933	4.67
Lagusa	5,827	1.2	4,856	6.85%	24	4,018	2,369	17,657	3.24
Grande	16,793	3.6	4,665	6.03%	28	4,757	2,794	55,978	5.46
Dental Median			*4,665*	*8.98%*	*24*	*4,605*	*2,794*	*40,973*	*4.67*

Correlating Site Report

- Low provider productivity – long 3rd next available appointment: need to fix the schedule (also look at slots, no-show rate, walk-in %)

- Low provider productivity – short 3rd next available: site has too many providers

- High provider productivity – long 3rd next available: site needs more providers (also look at visits/sq ft & exam rooms per provider to see if site is maxed out)

- Long 3rd next available – high no-show rate: your patients don't want to wait that long for care

- Poor site performance because of low demand may help drive rightsizing efforts (although access considerations may prevail)

- Low provider productivity – average visits per patient flow FTE: provider does NOT need more support to be more productive

Indicators – Level #4 – Other Indicators

Note, these are not "lesser" indicators, but rather less focused on finance and operations

- Employee indicators

- Managed care

- Quality

- Continuity of care

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Employee Turnover KPI – Employee Tenure

Median
All employees: 2 years, 3 months and 15 days
Non-providers: 2 years, 6 months and 26 days
Providers: 1 year, 8 months

Mean (Average)
All employees: 4 years, 5 months and 18 days
Non-providers: 4 years, 7 months and 22 days
Providers: 3 years, 7 months and 8 days

Need to measure by position, especially high turnover positions such as front desk clerk and MA. Also need to measure percentage of employees who don't make it past the probationary period

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Other KPI – Managed Care Membership

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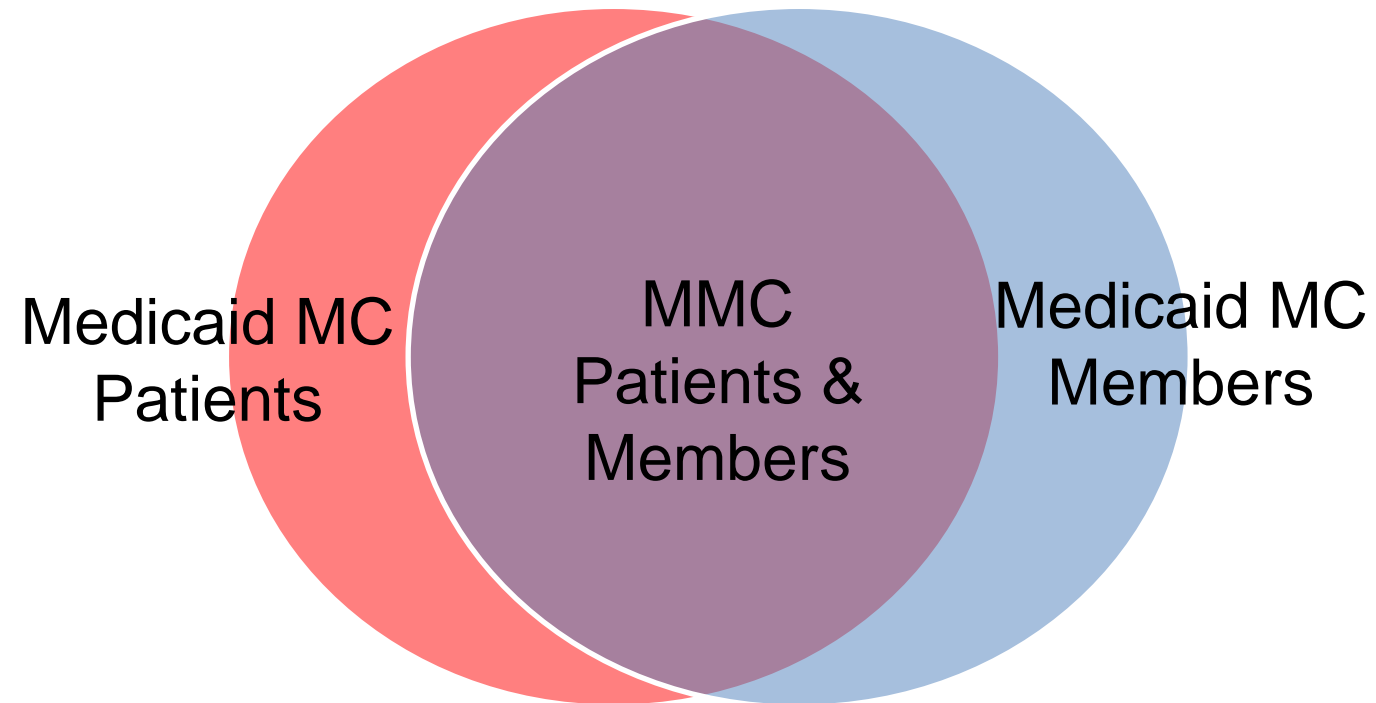
Other KPI – Managed Care Membership

Arroyo Vista Family Health Care
IHA Medi-Cal Enrollment Trend 2017

	Total New Patients Reported	Total after Duplicates	New Patients to AVFHC *see notes	Total Pts called	% Surveyed	Total Responses	Appointments scheduled	Wrong #	No Phone #	Disc #	No Answer/ voicemail	Own Dr./ Distance/ Moved	Refused IHA / WCB	Dissatisfied w/ Clinic	Others *see notes
JAN	679	398	218	186	35%	76	5	5	32	14	91	35	25	0	11
FEB	776	444	228	199	46%	104	12	14	31	24	81	38	15	0	10
MAR	542	541	261	216	36%	93	9	8	45	23	92	54	19	0	11
APR	748	429	221	184	34%	76	6	5	37	28	92	31	19	0	3
MAY	643	611	343	269	36%	124	20	7	66	25	121	70	28	0	6
JUN	694	630	305	225	40%	121	23	16	69	16	81	62	26	0	10
JUL	751	418	213	163	31%	65	7	2 / 18	43	24	76	32	17	0	9
AUG	680	628	328	271	26%	85	43		54	16	157	16	20	0	6
SEP	722	427	215	186	32%	68	16	12	27	12	86	14	11	0	27
OCT	438	316	125	123	36%	45	12	3	19	6	38	29	15	0	1
NOV	396	396	161	161	25%	40	7	4	30	10	70	31	4	0	5
DEC	378	326	133	133	24%	32	5	10	19	6	61	14	18	0	0
Total	7447	5564	2751	2316	40%	929	165	104	472	204	1046	426	217	0	99
AVG Totals	621	464	229	193	33%	77	14	9	39	17	87	36	18	0	8

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PCMH KPI – Patient Turnover

> For period: 7/1/11 - 6/30/12
New patients= 10,527
All patients=   21,909
Percentage=   10,527 / 21,909 = 48%

> For period: 7/1/12 - 6/30/13
New patients= 9,709
All patients=   21,416
Percentage=   9,709 / 21,416 = 43.3%

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Operational KPI – Quality

	Attributed Not Seen	Timely Entry Into Prenatal Care		Childhood Immunzation*	
		UDS	HEDIS	UDS	HEDIS
Health Center A	11%	74%	48%	68%	1%
Health Center B	11%	85%	66%	93%	0%
Health Center C	12%	86%	60%	84%	0%
Health Center D	9%	56%	53%	97%	1%
Statewide Administrative			59%		4.7%
Statewide Hybrid					64.7%

*Combination of Dtap, IPV, MMR, HiB, HepB, VZV, PCV

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