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Opinion

Rural Clinic Productivity

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Opinion

Rural hospitals face difficult financial times with rising costs and increasing demand from a low income and poorly insured population base. Many have gone bankrupt and closed in recent years although they are critical to their communities. Like much of healthcare, they are increasingly dependent on outpatient clinic services since specialty inpatient services are often limited in rural locations. In 2019 and 2020 I conducted a survey of hospital outpatient clinics focusing on productivity of their operations at over a dozen California Critical Access Hospitals (CAH). The survey consisted of the following steps:

I. Identifying the proper contact at each CAH, generally the CEO, and have a discussion of the scope and focus of the survey.

II. Arranging a one-day site visit to the specific clinic identified by the CAH. In most cases this was their primary care outpatient clinic. The clinic staff were to be notified in advance of our visit and certain clinic data was requested.

III. Site visit. Three survey questionnaires were used: an on-site interview guide and questionnaires for non-clinical and clinical staff. These were given out at the clinic and could be responded to by mailing back the paper questionnaire in a pre-paid envelope or done online. Confidentiality was promised to all. Nearly all on staff were interviewed.

IV. Prepared a written report of findings and recommendations.

V. Sent report to each clinic and arranged a telephone presentation of the report. Generally, this was with the hospital CEO and the clinic manager.

Findings

Each hospital and clinic were different, of course. However, some problems were similar among the sites. The difference between actual productivity and potential productivity in terms of patients seen vs. resources was often significant. It appeared that many clinics could achieve a 50% increase in the number of patients seen while maintaining quality. Since most CAH had patient demand greater than their current clinic capacity, revenue could also increase significantly. This would help assure the rural clinic and rural hospital's survival, which is threatened [1].

The staff responses varied, as expected, however there was a consistency in the responses within each clinic. From some clinics, I received mostly positive responses, where people felt operations were mostly satisfactory. However, some clinics generated responses which were often negative about the operation and felt that much more could be accomplished with better management and organization. In all cases, the confidential questionnaires confirmed what was seen and heard while visiting (Table 1).

Combining the answers to the questionnaires with interviews and observations, the statements common to nearly all clinics include:

I. There is no Operational Manual written as a comprehensive reference. They have some guidelines and scattered pieces of information on processes, but these need to be complete and current.

II. Individual and clinic productivity in terms of patients seen per shift is uneven, is lower than should be expected and often varies greatly from provider to provider beyond the difference in each provider's practice.

III. Productivity and related metrics are not shared with staff nor used in ongoing performance improvement efforts.

IV. For the most part, schedulers merely follow the scheduling rules providers give them, when more individualized guidance from the clinical staff would help.

V. Clinics often provide cross training to nurses and other staff, but not everyone is getting exposed to all tasks therefore

they don't develop the needed expertise. This is because some nurses think that only they know how to do certain tasks, and they are not willing to share it with others. Staff needs to be more flexible in working with all providers, helping colleagues to learn and empowering each other.

VI. A few providers see many patients a day, a high productivity, but there seems to be a lower quality of care. Too high a volume means the provider doesn't have time to follow up, sometimes records are incomplete.

VII. Team Building activities: There are often no team building activities to create a collaborative environment and in Staff Meeting there is insufficient opportunity to talk and form as a team.

VIII. Staff agrees that if all procedures were standardized, there would be an increase in productivity because currently each provider has their own separate way of doing things.

3. Common Recommendations

Observations varied at each of the clinics with each clinic having unique problems and strengths. The focus was on productivity; namely the number of patients seen in comparison to the resources used. All the clinics could improve in that regard-some much more than others. Each had certain unique issues and limitations, but all seem to have the potential of more patients that they currently were serving.

Specifically, most clinics should do the following.

I. Measure productivity: this topic is complex, and many factors influence what is a reasonable expectation. Of course, quality comes first but that does not mean poor productivity and waste are acceptable. Without accurate measurement, no improvement is possible.

II. Set specific goals; specific numeric goals can be set. This is done by the best healthcare institutions. Goals must be based on data and logic and agreed upon by all concerned. Goals for quality are obvious but goals for productivity are also critical to success.

III. Share results with providers and staff (Most hospitals agreed with this. One hospital CEO objected and said that such metrics were contentious and were harmful to provider productivity). Daily or weekly performance information is a necessity for improvement. Track results graphically and post in the clinic. Reward or recognize staff when goals are met or exceeded. Improvement must be collaborative and incremental. Many hospitals have recognized the need for so-called Lean Daily Management or having regular, at least weekly, meetings around a report card on performance and on the status of changes. This is a good idea for clinics as well as hospitals.

IV. Make patient and staff scheduling a productivity driver with intelligent scheduling rules. Start with a minimum appointment time, say 15 minutes, and adjust when specific patient attributes, such as first-time visits, justify longer times. Total daily (or per shift) numbers should keep to a goal and deviation alerts created. Management should closely monitor daily scheduling plans. Good scheduling practices may be the most important tool for improving productivity. There is a vast literature on how to best do patient appointment scheduling [2].

V. Enlist patients in the productivity issue. Waste costs them time, access and money too. They should know that an efficient clinic benefits them.

VI. Documentation of practices is important in all industries, certainly in healthcare. Having an effective operations manual will make it clear to all what is expected. New employees will have a starting point and all employees will have a reference source. Not that everyone reads such manuals every day but creating them enforces and maintains good practices.

It appears that there is significant potential at most clinics for an increase in the number of visits. Some hospitals feel that there is little additional potential, but most have unmet patient demand. Moreover, there are many additional outpatient services that could be offered. A few of the hospitals are doing so and offering such services as telemedicine, mental health, employment services, and dental. Expanding such services will likely mean additional net revenue and better utilization of resources. Thus, scheduling for increased throughput is a logical objective.

It is difficult to set a daily throughput target applicable to all providers and clinics. However, some numerical values seem appropriate. If the provider works an 8-hour shift, at least 7 hours could be available for seeing patients. Often appointments of 15 or 20 minutes were deemed appropriate unless it was a first visit for a patient or other procedures or tasks were expected. Longer appointments, of perhaps 30 or 40 minutes may be necessary but probably these would be less frequent than for normal visits. Thus, a provider should be able to see about 17 patients per shift (4 at 40 minutes and 13 at 20 minutes).

This productivity measure, of course varied by provider and clinic. Some clinics which used a Nurse Practitioner for certain types of patient visits saw considerably more. Some providers who saw patients who were usually older, or had more serious conditions, saw fewer per hour. Some providers who were part time or were specialists rather than primary care had different productivity. Also, some clinics had longer work shifts (10 hours) and many had providers who were there less than 5 days a week – which affected productivity.

Additional Notes about the Survey

Discussing the topic of productivity is problematic. It is often seen as conflicting with the professionalism and independence of the provider [3]. Since financial survival is an imperative, particularly for small and rural healthcare organizations, it seemed reasonable to involve providers in this discussion. Some providers did not agree but felt either it was not their problem or worried about a tradeoff between productivity and quality. I believe that is possible to achieve both. Quality is the first objective but within the maintenance of good quality it is often possible to improve productivity.

Recommendations were made related to the findings to each CAH but did not go into detail as to what change methods should be used. Some of the CAH were part of a larger healthcare system [4] and had access to a Performance Improvement team. However, none of these teams seemed to have provided much help to the clinics studied. Probably a key tool would be PDCA (Plan, Do, Check, Act) or incremental implementation of changes. One clinic tried to make a wholesale change at the time they were visited, and it did not go well (Appendix).

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