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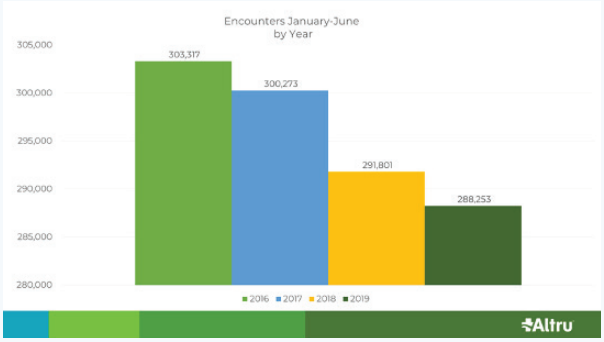
Background

Over a period of three to five years, Altru Health System saw a steady decline in total outpatient encounters and a subsequent decrease in profit margin. Below is a graph that depicts the decline over a period of four years.



When I transitioned into my role as chief clinic operations officer in February of 2020, I began exploring the potential causes of the decline in patient volume. I reviewed changes in local competition, national competition (such as new virtual care options) and referral patterns, and nothing supported the change. I engaged our support teams to study changes in the number of providers in certain specialties, recruitment patterns and any possible correlations to inpatient volumes. In reviewing total number of providers in each specialty area and with a thorough understanding of the our recruitment patterns, the decline in volumes did not correlate.

While there were not any obvious answers, we knew we could not remain financially sustainable with the decline in volume and we were not improving the access to care for our patients. These two system priorities led me to choose this for my project.

Approach

After determining none of the above was directly affecting the steady decline in outpatient volumes, I engaged a diverse team made up of operations, planning, EPIC and front-line providers. Before we could begin acting on solutions, we had to start with understanding the specific barriers and challenges impacting access and volumes. We began by reviewing data specific to the issue I was trying to resolve. We created a graph to identify the then current state of access through measuring the average lead time for new patients, which supported that access was not improving.

With the support of our planning team, I reviewed the productivity of each provider, analyzing it by individual provider, regional location, clinic and specialty. Our "Productivity Summary to Date" graph showed the baseline with minimal improvement of productivity prior to the implementation of any action steps.

We used this information to identify numerous action steps. We kicked off the project with a group meeting of operational directors and medical directors. Here we agreed to targets and goals for the

entire medical group practice. We established practice standards of 35 patient-facing contact hours, provider vacation time that maintained appropriate access, changes to templates, reductions in visit types and adjustments to time blocks. The team of leaders presented this information through monthly department meetings and in various other settings to help the providers understand the "why."

Next, I conducted meetings with dyads (director and medical director) over each division and we reviewed individual providers' productivity, template use, patient-facing contact time and block utilization. We established a productivity target at the 65th percentile of MGMA and created plans for steady and appropriate increases in each individual's productivity to reach the target. From there, the dyads scheduled individual monthly meetings with their providers to review progress and help remove any barriers.

Outcomes

Throughout the last 12 months, with the action steps taken as described above, we saw a steady increase in productivity, patient encounters and improved access to care. While our efforts were undoubtedly impacted by COVID, we saw further declines in 2020 before we realized any benefit of the work. We have since been able to measure great success. Currently, the YTD average productivity is at the 64th percentile for all providers with an MGMA benchmark (see Figure 1) and our first half of the year encounters are the highest they have been in six years, contributing to a **4.8% system-wide profit margin**.

Lessons Learned

I've learned several lessons along the way from both our successes and our failures. Communication and education were critical to our success. Both the leaders and providers needed to understand why we were making the changes and how those changes would impact both access for our patients and the health system's financial viability. Our first mistake and most valuable lesson came when we let go of assumptions about individual productivity. Not only did we communicate to help providers understand our "why," we also started to listen to theirs.

The strength of the leadership team balancing standard practices across the organization with meeting the individuals where they were was key to making incremental improvements. This wasn't a sprint but required gentle pressure. Early recognition of this allowed for sustainable progress.

Next Steps

While we have made major improvements in productivity, there is still significant room for improvement in access. We have now set system goals that set out to decrease the average lead time for new patients and continue to improve access. While our encounters have increased, so have the lead times, requiring additional steps to achieve our original goal.

While we established practice standards throughout the project, we are now working on leader standards work that will drive sustainability. In addition, we will look more specifically at access, prioritizing recruitment efforts based on such. Finally, we will consider new and additional access points to care where appropriate, adding extended hours of service and improved virtual care options. I'm confident the leadership team will continue improving on the success of this project through nimble adjustments to meet evolving consumer expectations.

Figure 1