

To Consolidate, Go Solo, or Dissolve the Extended Care/After Hour Clinic

Maj Rachel H. Lefebvre, USAF, MSC, CAAMA
Group Practice Manager, Family Practice & Pediatrics
David Grant Medical Center
Fairfield, CA

Introduction:

“Quality Medical Group (QMG) Practice”, is a seven-year-old group practice consisting of ten separate clinics, a total of 78 primary care and internal medicine physicians. Operating in the Western United States, they are strategically positioned throughout city “X “. Each clinic operates autonomously in terms of clinical revenue and expenses as well as reaps the benefits of sharing centralized billing, nurse triage functions, and administrative management (human resources, finances, etc) from the corporate office. Physician revenue is based 100 percent on productivity, essentially an “eat what you kill mentality”. Direct expenses are assumed by the corresponding physician while indirect expenses (i.e. clinical overhead, mid-level expenses, support staff, etc.) are based on a Full Time Equivalent (FTE) basis among the physicians, clinic by clinic.

In April 01, the West Clinic piloted the Extended/After Hour Care Clinic concept as an extension of their clinic (Monday – Friday 1300-2200; Saturday 0800-1300), in which they assumed all responsibility and financial risk. The rationale behind the initiation of this clinic was based on; (1) flexibility to treat QMG patients during the transition of building-up practices throughout the city (had lost nine physicians previous year); (2) anticipation of an influx of acute care patients since the nearby hospital closed its urgent care clinic; (3) the possibility of creating additional revenue as the managed care environment moved from capitation to fee-for-service (Darves, 2001), and (4) because of an increase in Emergency Department (ED) co-payments by the majority of insurance programs. The West Clinic assumed all expenses and any associated revenue for the Extended Care Clinic. The goal was to break-even in six months and in one year assess the situation in terms of solvency and mission fit for QMG.

Ten months later, the West Clinic wished to evaluate the extended care clinic to determine whether this venture would become profitable and continue with business as usual, annul them of the clinic and offer it to QMG administration to manage, or dissolve the extended care clinic entirely.

This case study includes an assessment of each of these options and offers a proposal.

Methodology:

1. Assess current situation
2. Determine mission fit
3. Develop a financial evaluation and budget for each scenario
4. Analysis
5. Outcome

Evaluation:

1. Assessment of Situation: The West Clinic opened the doors of the Extended Care Clinic in May 01, with the intent of it being profitable within six months. It was assumed since the local hospital had closed its urgent care clinic in Apr 01, patients would seek care at alternate locations, rather than an ED (Kapur, 2000). The ED average wait at hospital “A” was on average greater than five hours. Additionally, most insurance plans have increased their co-payment for ED services to \$50.00-\$100.00 whereas the Extended Care Clinic has the same co-payment as one would receive seeing their primary care physician (\$10-15 co-payment) (Darves, 2002). Furthermore when the Extended Care Clinic was initiated, access to care within QMG was difficult due to the loss of nine providers in Fiscal Year (FY) 2000. The Extended Care Clinic was seen a method to bridge the access gap and offer same day/next day care to QMG patients. QMG leadership assumed demand for the services would “catch-on” with patients via word-of-mouth. As primary care reimbursement continues to decrease nationwide, QMG was looking for “ancillary” revenue, a sideline if you will, that would bring in additional revenue (Weinstein, 2002). The overall decision to initiate the Extended Care Clinic was based on intuition versus a strategic plan. A budget, a business case analysis, nor a market assessment was completed. For better or worse, QMGs outlook in erecting the Extended Care Clinic was based on a “build it and they will come” philosophy.

The West Clinic is composed for four full-time physicians and two mid-level providers. In QMG, administrative and billing overhead is assessed by total Full-Time Equivalent (FTEs) per clinic (including mid-level providers) and then expensed to the physicians on a FTE basis. Hence, when a physician is added to a clinic, the associated clinic physician’s overhead is reduced.

As of Oct 01, the Extended Care Clinic operated with two FTEs, comprised of a salaried physician and a mid-level provider. The Extended Care Clinic occupied physical space and shared some of the same employees as the West Clinic, reducing the West Clinic physician's overhead expenses. Additionally, all profits and losses were directly attributed to the West Clinic's bottom line giving them a great incentive to create a profitable environment for the Extended Care Clinic and ensuring equity participation (Wilkins, 1999).

History: In Apr 01, the Extended Care Clinic began operations with one, .5 FTE, salaried physician, which eventually expanded to one FTE in Sep 01. Due to increased demand for services, primarily through internal QMG referrals, the clinic grew to two FTEs in Oct 02 by adding a nurse practitioner.

From inception until Nov 02, patient encounters grew at a steady rate and then began a slight decline for the two following months. Nov 02 was a noteworthy month since extended care hit its peak for its greatest demand to date to total 760 individual patient encounters, however, a significant loss was still realized of \$10,652 for the month. This equates to an average of 380 encounters per month according to Medical Group Management Association (MGMA) 2001 cost study, on average the physician and the mid-level were operating at just above the 50th percentile. Additionally, the average receipt per patient encounter totaled only \$42, again below primary care national standards. At this rate the break-even point is conservatively figured at 1,142 encounters at \$42 per encounter or \$48,000 in receipts per month. The Extended Care Clinic lost a total of \$83,422 for the summation of FY01. In Dec 01 and Jan 02, patient demand declined rather than remaining constant or growing and consequentially furthered the clinic operating loss. Please refer to charts 1 and 2.

Chart 1: Historic Monthly Patient Encounters

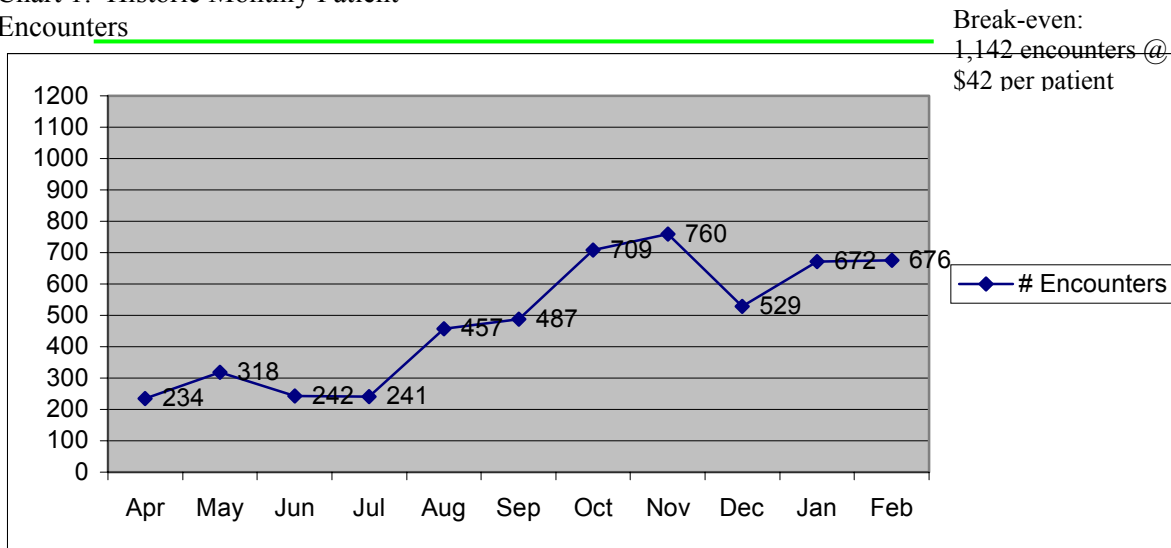
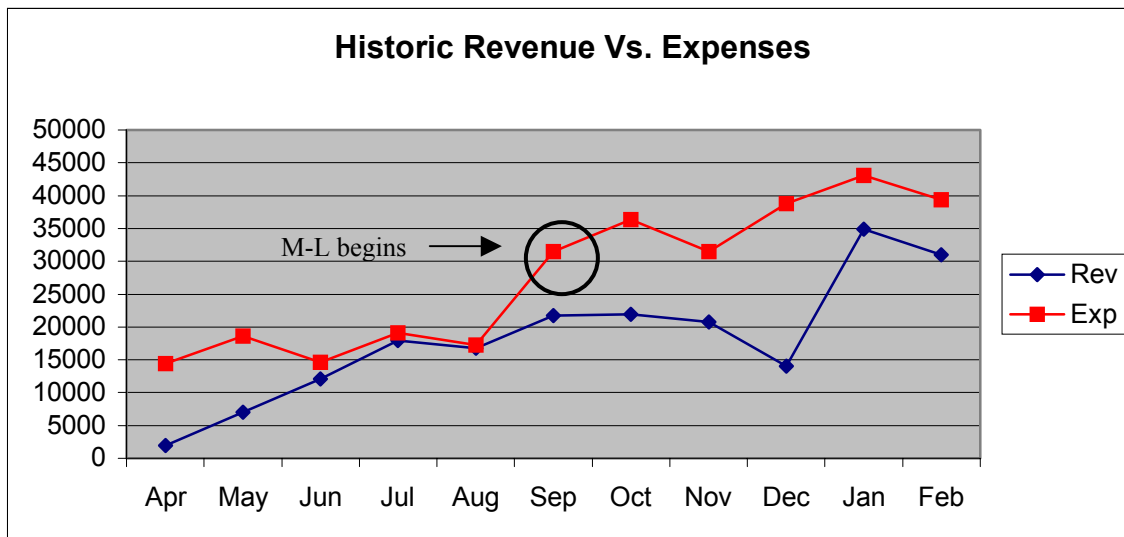


Chart 2



QMG as a whole was beginning to experience a shift in capitated plans to fee-for-service, as was the health care industry as a whole (Darves , 2001). Prior to Nov 01, QMG received 60 percent of its revenue from capitated plans. Initially, capitated plans were considered loss contributors for the Extended Care Clinic; co-payments were the only source of revenue. The Capitated plans did not allow a Fee-For-Service (FFS) payment under the current contracting vehicles. However since Sep 01, QMG aggressively negotiated with the capitated plans to accept Fee-For-Service (FFS) for extended care services. As of Jan 02, 90% of all capitated plans accept FFS. Of the capitated and FFS plans, 80 percent include carve-outs averaging \$55 for care after 5 PM and before 8 AM.

Strategy taken in FY01: (1) Negotiate with current capitated and FFS insurance plans to amend QMG contracts to accept extended care hour premiums. Outcome: QMG successfully negotiated five national Health Maintenance Organizations (HMOs) to consent to extended hour premiums. As an added bonus, two national insurance companies added the extended care code to their fee schedules...no negotiations required!

(2) Partner with hospital “X” to send non-emergent patients to the Extended Care Clinic (500 feet away). This would result in a “win-win” situation since the hospital was overburdened by actual emergency cases and extremely long waiting times for care. However, the Emergency Medical Treatment and Active Labor Act (EMTALA), a statute that governs when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he is in an unstable medical condition influenced this initiative. Any patient who presents to a hospital must be provided with "an appropriate medical screening examination" to determine if he is suffering from an "emergency medical condition" (<http://www.emtala.com/>). If a patient presents to an ED, the hospital is obligated to either provide treatment until they are stable or to transfer the patient to another hospital in conformance with the statute's directives. Hospital X’s legal team interpreted EMTALA to imply that referring a non-emergent screened patient, would result in a violation of this act. Thus, neither referrals nor advertising were permitted for the Extended Care Clinic, via the ED. Politically, the emergency physicians at the hospital were vehemently against referring patients to the extended care clinic for fear of losing revenue (Selby, 1997).

(3) Marketing: None. Advertisements, brochures, mailers, signs, nor an internal media blitz existed; extended care services were only conveyed by word of mouth of patients. In today's very competitive healthcare environment, a strategy must insure a consistent approach offering products or services in a way that will outsell the competition. In concert with defining the marketing strategy one must also have a well-defined methodology for the day-to-day process of implementing it (Porter, 1998). QMG operated with neither.

Mission Fit:

Originally, the Extended Care Clinic concept “fit” QMG’s mission. QMG had numerous physician gaps at clinical sites, limiting access. The Extended Care Clinic enabled QMG patients plentiful access and in a timely

manner. Same day, scheduled appointments were available which was an extremely important aspect; i.e. so not erode the current QMG patient base. Among the key ingredients of a successful practice from a patient's point of view are to assure access, quality medical care and satisfaction. The key ingredients of a successful medical group practice from the corporate view are *physician ownership, a strong strategic direction, a commitment to high-quality patient*, and ultimately culminating in retaining/gaining membership (Wilkins 1999). Hence, both of these views must be blended to encourage success. A clear benefit of the Extended Care Clinic was the addition of 105 *new patients* (not previously on QMG panels) to current QMG physician panels, primarily at the West Clinic. The lifeblood of a group practice is the addition of new patients. Finally, QMG assumed extended care services would become a highly demanded service, ultimately increasing their revenue.

Since inception, the extended care environment has changed. First, QMG is currently "growing" their nine new physicians. They are in a mode of building their panels, filling their schedules, and making profitable/productive physicians. The new physicians emphasis is in retaining their client base, not referring them to the Extended Care Clinic. Additionally, the new physicians are experimenting with a modified open access concept. Hence, in theory all of their patients should be able to be seen the day they need an appointment (Jacob, 2001 & Lorio, 2000). This leads to a decrease in referrals to the Extended Care Clinic, internally. Presently, QMG no longer is experiencing a gap in access. In fact, many of the "tenured" physicians are having trouble filling their schedules. Is this shift due to the change in managed care policy allowing patients to seek specialty care directly versus needing a referral from the primary care provider (Kapur, 2000)?

Generally, QMG's internal demand for health care is not as prevalent as in the summer months (migrating population) and referrals to the clinic are expected to remain constant or slightly decrease. Secondly, the hospital is not/will not send non-emergent patients who present to the hospital emergency department to the extended care clinic because of EMTALA. However, it is expected as patients become more aware of their high ER co-payments, they will seek alternative care. The key is making the population at large aware of the Extended Care Clinic.

Financial Analysis/Forecasts:

A financial forecast was developed for three scenarios; (1) Consolidate the Extended Care Clinic and West Clinic (“as is”); (2) West Clinic becomes a solo group practice and QMG manages and assumes all risk of the Extended Care Clinic; or (3) Dissolve the Extended Care Clinic all together.

Assumptions: If the Extended Care Clinic is to remain a viable entity of QMG in any scenario, marketing efforts must be developed and employed immediately. As stated above, little to zero emphasis was placed on marketing efforts to date. Due to the fact that very limited dollars are available for marketing efforts (\$6K), recommend a strategy, which focuses on low cost and high returns. A brainstorming session was held which resulted in the following initiatives; (1) Ideas on how to educate triage nurses via a written schematic of illnesses that providers were capable of treating/procedures they were capable performing; (2) A professional looking pamphlet for each of the clinic waiting rooms to include: General types of illness the clinic could care for, emphasis on *same-day* care, frequently asked questions & answers, a clinic map, and biographies of the providers. Additionally, each QMG clinic received a large poster containing the above information for their waiting rooms. It was assumed an aggressive marketing strategy would be initiated immediately and the clinic would break-even by Jun 02 and become profitable by Oct 02.

Additionally, the clinic is functioning at 48% capacity with two FTEs, below acceptable levels. Until volume increases the Extended Care Clinic must be reduced to 1.5 FTEs, with the physician operating as one FTE and the nurse practitioner as .5 FTEs. The forecasted financials take this fact into consideration.

As seen in the average receipt of \$42 per encounter, an audit was performed and proved the providers were under coding in 65% of their cases. An intensive, on-going educational coding plan was developed to raise coding knowledge and address deficiencies. It is assumed in the financial analysis the average charge per encounter will equate to \$62 per encounter. The audits showed this level of effort was already present via documentation in the medical records.

In the solo option, clinical expenses are allocated based on FTEs, equating to 21% of expenses assessed to the Extended Care Clinic and 79% to the West Clinic. Additionally, clinical and support staff are expensed by the hours worked in each individual area.

The West Clinic has one new physician who comes off guarantee in Aug 02. To date, the new physician has not yet made a profit, though is forecasted to become profitable by Jun 02. All losses are consumed by QMG according to policy and are not required to be paid back by the physician (unless they depart the corporation).

Financial Highlights:

Table 1: Annual Forecast for FY02

Annual Data	Consolidate	West-Solo	Ext. Care-Solo	Dissolve Ext Care
Revenue	\$2,010,202	\$1,879,233	\$461,668	\$0.00
Clinical Overhead	\$987,389	\$942,611	\$240,559	\$0.00
Provider Direct Expenses	\$843,791	\$775,809	\$156,541	\$0.00
Billing Overhead	\$118,029	\$94,867	\$24,185	\$0.00
QMG Overhead (Mgmt)	\$183,617	\$147,579	\$37,629	\$0.00
Profit/(Loss)	*((\$122,624)	**(\$81,632)	*\$2,754	***(\$83,400)

*Due to prior Ext Care Clinic losses incurred in FY01 (\$83.4K) and projected losses for the new physician in the West Clinic

**Loss is due to the new physician at the West Clinic

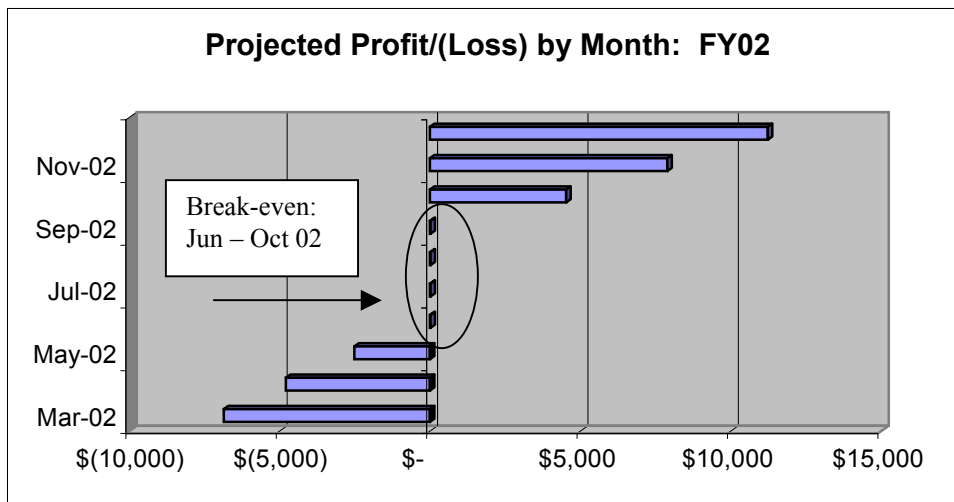
*** Prior losses incurred in the Ext Care Clinic in FY01 (\$83.4K)

Table 2: Physician’s Third Checks:

- Third check is defined as left over revenue after paying all expenses, minus draw (80% of revenue)

	Consolidate	West-Solo
Physician A	\$48,016	\$62,557
Physician B	\$50,840	\$72,790
Physician C	\$56,543	\$81,189
Physician D	\$12,275	\$22,619

Chart 3: Solo-Extended Care



Scenario Analysis

Consolidation:

Pros:

- Once the Extended Care Clinic begins to generate a profit, the West physicians will reap 100 percent of the financial benefits
- The Extended Care Clinic provides great visibility to the West Clinic; patients may wish to enroll in QMG medical services
- Do not experience difficulties sharing and accounting for staff and supply expenditures—one operation

Cons:

- Physician's take on 100 percent of financial risk
- Clinic is required to pay back the prior Extended Care Clinic loss of \$83.4K incurred in FY01
- Physician's third check is lower in the consolidated option since they take on Extended Care's losses and increase their overhead

Solo Options:

Pros:

- QMG retains the Extended Care Clinic; great for when demand is high (flu season, vacations, after hour care)
- Any losses are spread among the 78 providers within QMG, significantly reducing physician risk
 - West Clinic physicians no longer feel a financial burden...now each assumes 1/78 of the risk; higher morale
- Any profits are retained with QMG corporate to build up their cash reserve; physicians still "profit"
 - Increase QMG credit line with banks; eventually funds for capital projects, software/hardware, etc.
 - Reduces the West Clinic physician's overhead; Physician's third check is higher

Cons:

- QMG corporate must pay off the FY01 debt, decreasing the Extended Care's profit margin in FY02
- Must appropriately deal with the delicate issue of sharing support/clinical staff and expenses since the offices are co-located
- Physician's third check is lower under the consolidated option

Dissolve the Extended Care Clinic:

Pros:

- No further Extended Care financial losses for QMG

Cons:

- No outlet when demand increases within QMG (i.e. flu season, after hour care, vacations)
- No additional revenue for the QMG reserve fund
- No alternative facility for patients with urgent care needs when they do not require an ER
- West physicians receive lower third check
- No longer a source for new QMG patients

*If the clinic dissolves, the West Clinic remains constant as in West-Solo scenario

Outcome

Each scenario was presented to the West Clinic physicians in detail. Their greatest concern was assuming risk for a small reward and an unknown future. As seen in Chart 2 (page 4), the West Clinic physicians have not profited from the extended care clinic but rather have incurred losses all along. The overhead and clinical expenses exceed revenue incurred from the Extended Care Clinic, based on the FTE allocation. If the Extended Care Clinic does not meet the financial forecasts, the West Clinic physician's third check would substantially decrease even further. Based on the data at hand, the West Clinic physicians determined it was in their best interest to practice solo and *not* solely share in the risk of the Extended Care Clinic. Additionally, they no longer have the burden of paying off the \$83.4K loss.

Now QMG needed to decide if they wished to operate the Extended Care Clinic independently or dissolve it all together. QMG was in a cash crisis due to the fact they hired nine new physicians in FY01 during quarters two and three. All nine "new" physicians were operating on a guaranteed salary and were struggling to fill their schedules and become profitable. In fact, only one "new" physician was currently profitable in Feb 02. Hence, large losses were still being incurred. In the short term, the \$14K loss in quarter one (Mar – May 02) was very troublesome for QMC since available cash was scarce. All available credit from the banks had been consumed.

In the long term, the Extended Care Clinic was predicted to be a cash generator to build up cash reserves, provide an access outlet for providers on holiday, flu season, and generate new QMG patients (Weinstein, 2002).

QMGs past strategy of creating a profitable Extended Care Clinic was not attacked aggressively. Marketing was non-existent, communication was lacking internally and externally, even QMGs own central nurse triage did not “push” patients to the Extended Care Clinic. QMG relied entirely on “pull” marketing strategy (Kotler, 1992).

Many long night discussions took place on whether or not QMG should take on the Extended Care Clinic. In Jan 02, two other local hospitals closed their acute care clinics leaving little choice for treatment after hours. The QMG Extended Care Clinic was nearly the only game in town. Reviewing national trending, recent moves even in the West suggested further fee-for-service trends (Darves, 2002). Additionally, one would anticipate that here insurance plans would begin to see expenses climb if patients began to use the ED as access after hours. The Extended Care Clinic potentially can further negotiate higher rates and more care-outs with those plans not yet participating. Additionally, the potential of further generating new QMG patients was extremely attractive.

QMG presented all available data (i.e. cost data, usage rates, profit information, etc.) to the Finance Committee and the Board of Directors for an ultimatum. Based on the financial forecast, QMG decided to maintain the Extended Care Clinic, monitoring progress closely. The decision was based on favorable reimbursement rates, aggressive marketing strategies, rigorous coding education/audits, and the fact that minimal after hour care exists in the area. Additionally, assuming that the clinic would become profitable in FY03 it would be a great source of QMG reserve fund revenue.

Update:

In Mar 02, the Extended Care Clinic experienced their first profitable month greatly surpassing all forecasts!

The clinic treated a total of 839 patients were treated at the average rate of \$61, resulting in a profit of

\$3,180.00, in addition, 73 new patients enrolled in QMG. To date, all marketing and coding efforts have been extremely effective.

References:

1. Darves, B. (2002). “*A Better Way To Practice , Forward-Thinking Physicians Find a Better Way*”. January/February 2002 issue of *Physicians Practice*.
2. Darves, B. (2001). “*Rediscovering Fee-for-Service*”, *Physicians Return to Traditional Reimbursement*. November/December 2001 issue of *Physicians Practice Digest*.
3. Jacob, A. (2001). “*Same-Day Appointments Catching on with Doctors*”. AMNews.
4. Kapur K, Joyce GF, Van Vorst KA, Escarce JJ. (June 2000). "Expenditures for Physician Services under Alternative Models of Managed Care," published in the journal, *Medical Care Research and Review*, 161-181.
5. Kotler, Philip. (1992). *Principles of Marketing*, 3rd Edition, Prentice-Hall, Inc., pages 503-504.
6. Lorio, A. (2000). “*Advanced-Access Scheduling With an Open Mind*”. July/August 2000 of *Physician’s Practice Digest*.
7. Medical Group Management Association (2001). “*Physician Compensation and Productivity Reports: 2001*”.
8. Porter, Michael. (1998). *Competitive Advantage: Creating and Sustaining Superior Performance*, First Free Press, *June 1998, pages 123-142*.
9. Selby, J. (1997). “*Cost Sharing in the Emergency Department—Is It Safe?*” *The New England Journal of Medicine*.
10. Weinstein, S. (2002). “*Revitalize Your Practice with a new Sideline*.” BiblioMed.
11. Wilkins, Jeffery, H. (1999). “*Developing a Successful Medical Group*”. *American Academy of Family Physicians*.
12. Retrieved from the world wide web on 4 April 2002: <http://www.emtala.com/>

Copyright 2002© American Academy of Medical Administrators. All rights reserved.