Utilizing Physician Extenders to Achieve Group Practice Initiatives
Your presenters

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The presentation

• Rationale
• Application
• History and development
• Data
HealthFirst Medical Group

• MIMA was an independent 150 provider multispecialty group practice, recently acquired by HealthFirst Inc.

• HealthFirst, Inc combined their 130-provider HealthFirst Physician group with MIMA physicians to create HealthFirst Medical Group.
HealthFirst, Inc.

• Integrated healthcare delivery system in Melbourne, FL:
  – 4 hospitals (900 beds total)
  – Commercial and Medicare Health Plan
  – Ancillary services: home health, hospice, physical therapy, DME, etc.
  – HealthFirst Medical Group: 246 physicians, 66 mid-levels, 35 specialties
Why utilize physician extenders (mid-levels)?

- Plentiful supply of candidates
- Short time from recruit to start
- Often reside locally; familiar with available health services, residents, organizational culture
- Extenders are malleable, provide support for evolving practice initiatives
How to use physician extenders

• Improve timely access to care
• Expand intake points in system
• Increase provider face time with patients, improving patient satisfaction and potentially compliance and outcomes
How physician extenders support the physicians

- Allows PCP to expand panels
- Provides an intake point for preventive care, screening services
- Generates referrals to diagnostic modalities and medical specialists as indicated
- Facilitates work-up and referral of surgical patients
How physician extenders support the group practice

• Quality initiatives
• Cost saving initiatives
• Patient access
• Referrals
• Adherence to compliance and regulatory requirements
• Fast recruitment process
• Easy dissolution if not a match
How we use our extenders

• Company funded:
  – Walk in clinic providers (base rate only)
  – Cardiology testing (base rate only)
  – Clinical practices (base rate and productivity bonus)

• Physician funded:
  – Dermatology (base & bonus at MD discretion)
From pilot program to profit center

• 2009: MIMA was competing for short supply of Primary Care Physicians
• Felt physician extenders might be a solution
• Successful pilot with one employed Internal Medicine ARNP
• Next IM ARNP not successful
Lessons learned

• Developed clear protocols and disclosed expectations in interviews

• Productivity bonus and sharing of quality awards provides motivation

• Bonus based on a share of profits contributed to entrepreneurial behavior; extenders were productive and became good stewards of resources
Lessons learned cont’d

- New graduates are often easy to train and adapt well to group culture
- Working with educational institutions to supervise clinical rotations provides insight into suitable candidates for employment
2012

• As an independent group practice, MIMA had 31 physician extenders total, 13 in clinical practice settings: primary care, GYN, Pain Management, Endocrinology, Orthopedics, Vascular Surgery and Neurology.

• Extenders provide service, stimulate the group practice, and generate a good net profit
## Pilot Program Revenues:
Company funded extenders with clinical practices

<table>
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<th>2012</th>
<th># extenders</th>
<th>Change from prev. qtr</th>
<th>profit</th>
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Other advantages

• Primary care extenders provide valuable screening
• A primary care extender averages 500 specialist referrals per year
• Our primary care and specialty extenders ordered over 21,000 ancillary services; injections, labs, and imaging, which generated over $500,000 in ancillary fee for service payments
The role of the supervising physician

- Provides clinical oversight
- Mentors and trains as needed, signs off on orders and documentation as indicated
- Receives 15% of revenue as a supervising stipend
Contract vs. No Contract

- Either model works
- Contracts should be relatively soft
- Non-compete is specialty and market dependent
- Strive for consistency, note variances in addendum
Compensation model A

• ARNP/PA:
  – Base salary just below market
  – Plus productivity bonus, calculated at a rate per wRVU bonus, paid quarterly

• Supervising Physician
  – 15% of collected revenue paid as stipend
Compensation model B

• ARNP/PA:
  – Base salary at low end of market
  – Plus productivity bonus; calculated as a percent of profit. Two tiers based on net revenue

• Supervising Physician
  – 15% of collected revenue paid as stipend
Compensation model C

• ARNP/PA:
  – Base salary at low end of market
  – Plus productivity bonus, $15 per wRVU beyond target

• Supervising Physician
  – 15% of collected revenue paid as stipend
Discussion