



## Emergency Department Physician and Mid-Level Provider Coverage Models:

**Do I Have What I Need?**



Phoenix Physicians takes great lengths to be proactive, listen, and educate our Hospital partners by offering expertise and tools that can enhance the overall success of their Emergency Departments. Phoenix conducts annual surveys of all our Hospital partners to ensure we are meeting their needs and concerns. These surveys have helped us learn that many key issues are on the minds of all Administrators. Thus, we have created a series of White Papers to address these issues:

- Throughput in the Emergency Department: What is the Responsibility of Your ER Physician Group? (Released February 2011)
- Emergency Department Patient Satisfaction: The Emergency Physician Group's Role (Released April 2011)
- Mid-Level Providers in the Emergency Department: How Much is Too Much? (Released July 2011)
- Emergency Department Physician and MLP Coverage Models: Do I Have What I Need? (Enclosed)

On Thursday, December 8<sup>th</sup> 2011, at 11:00 am EST, Phoenix will be holding a conference call led by Phoenix's CEO Dr. Rob Scott, and Phoenix's President Mr. Chris Lutes, to review the material presented in this White Paper. The purpose of the call is to answer any questions and discuss the content further.

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In addition, if you would like to receive an electronic version of this document or a previous White Paper, please do not hesitate to contact:

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Creating Emergency Departments of Excellence

# Emergency Department Physician and MLP Coverage Models: Do I Have What I Need?

Selecting the proper amount of Physician and Mid-Level Provider (MLP) coverage for an Emergency Department today is a very important decision that has the potential to either positively or negatively impact the Hospital's reputation within the surrounding community. Having "too little" daily Physician and MLP coverage in an Emergency Department can adversely impact important ED metrics such as patient throughput and turn-around-times, core measures scores, and patient satisfaction surveys. In addition, an insufficient amount of ED staffing will increase malpractice exposure for the Hospital through prolonged wait times and treatment delays. Even more, a limited coverage model can create a "negative practice environment" for the current ED Physicians in the group, resulting in higher than average provider turnover and ineffective recruiting.

In a similar fashion, having "too much" daily Physician and MLP coverage in an Emergency Department is not cost effective for the ED group or the Hospital. Given the challenging economic times we face today, elimination of any Physician or MLP coverage "excess" without sacrificing high quality care and outcomes is the ideal scenario for all stakeholders involved in the ED practice both financially and operationally.

At Phoenix Physicians, we are frequently asked by Hospital Administrators the most appropriate way to staff an Emergency Department via the use of both Physicians and MLPs. Based on our experience managing multiple Emergency Department practices across the U.S., our organization has identified five key factors that the Emergency Department Physician group and Hospital must consider before implementing a final optimal staffing model for their ED. These five important factors that must be considered include:

1. How much daily, monthly, and annual patient volume does the ED project to have?
2. What kind of patient acuity mix does the ED patient population currently have?
3. How are the ED Physicians to be compensated?
4. Are the use of MLPs acceptable for this ED practice and Hospital?
5. Are the monthly ED metrics and dashboards trending in the right direction?

Taking into account these five factors alone will not lead you to the ideal Physician and MLP staffing model in all circumstances. However, gathering and using such information analytically will greatly increase the likelihood that a Hospital will institute an ED staffing model that achieves all desired economic and operational goals for the department.

## ED Volume Considerations

As was discussed in great detail in our first White Paper of 2011, an appropriate coverage model for any ED must first be based on patient registration volume trends. As a first step to arrive at a "ballpark" number of ED Physician hours required each day to properly staff an Emergency Department, one must remember that any ED Physician's maximum individual work capability is typically measured by the number of patients they can disposition per hour of clinical work in the ED. And as one should expect, the number of patients a typical ED Physician can treat on average per hour of work in an ED is impacted by numerous outside forces. Such forces include the patient acuity mix for that Hospital, the Physician documentation mechanism now in place (paper system vs EMR vs scribe program), as well as all other things that effect

overall ED patient throughput. Most importantly however, no matter what unique set of circumstances may exist in a specific Hospital Emergency Department, one must always remember that ED Physicians are “only human”, and at some point they each reach a maximum productivity level and they can go no faster without the potential for unintended consequences. Thus, a goal for any ED Practice Manager should be to create a staffing model that approaches the maximum productivity threshold for the ED Physicians on-duty on any given day, but never crossing that threshold where quality and patient outcomes could be compromised.

Practically speaking, in most ED's today one can generally assume that an Emergency Physician can treat and disposition in an effective manner between 2.0 and 2.25 patients per hour of clinical work. In the most extreme cases, this number can approach 2.5 patients per hour. These staffing ratio benchmarks should be kept closely in mind when analyzing any Hospital's hourly, seasonal, and annual registered volume trends as compared to a proposed ED Physician staffing arrangement. Furthermore, it is important to note that most nationally recognized ED governing bodies typically recommend that 2.5 patients per Physician hour not be exceeded. Thus, the 2.5 patients per clinical hour metric arguably is the threshold that should not be exceeded in most cases.

### ED Patient Acuity

Average ED patient acuity at a Hospital is a second key data element that must be considered when determining an optimal ED staffing model for Physicians and MLPs. Average ED patient acuity represents how clinically complex the average ED patient generally is, and this assessment is a very good predictor of how much ED Physician time will be required to treat each presenting patient throughout a shift. Very obviously, as the average ED patient acuity at a Hospital increases, the number of patients an ED Physician can treat per hour of clinical work decreases.

An assessment of average ED patient acuity for any Hospital can be gathered from ED nursing triage data, ED Physician coding data, or from the admission/transfer rate of the facility. Once this data is gathered and thoroughly analyzed, one can use this information in combination with ED volume data to further profile the practice and better determine the daily Physician staffing requirements necessary. As an example, in a very low acuity ED setting where complex patients requiring admission or transfer are generally uncommon, the 2.5 patients per clinical hour threshold may be acceptable. However, as the ED patient acuity increases due to more admissions/transfers and extensive patient diagnostic work-ups, the patients per clinical hour threshold acceptable for that Hospital and ED Physician group should decline.

### Physician Compensation Considerations

A third very important factor that must be considered when selecting an ED Physician staffing model is clear knowledge of how exactly the ED Physicians working at that Hospital will be compensated. As we have detailed in past White Papers, in order to get maximum value out of any ED Physician staffing plan, the ED Physicians in the group must all be compensated via an effective, transparent, and easy-to-understand incentive pay system. In our expert opinion, at least 50% of the total compensation for each ED Physician should be tied directly to the RVUs generated by them individually. In essence, 50%+ of the ED Physician pay should be “at risk” each pay period based on their individual RVU production.

Over time our Company has learned that if a Hospital or ED group compensates their ED Physicians via an “at risk” incentive pay system with 50% or more of their pay dependent on individual RVU production, one will rapidly see a measurable increase in overall Physician productivity within the group. This desired increase in Physician productivity will never be realized if these same ED Physicians are paid via an

hourly rate pay system. Even more, as the proportion of “at risk” RVU pay continues to escalate for the ED Physicians (up to 100% at risk pay in extreme cases), the Physicians will continue to increase their productivity. To further support this point, we have found that adding additional Physician coverage in an ED currently operating under a very high “at risk” RVU pay system is generally “frowned upon” by the ED Physicians. This reaction is because adding additional Physician hours will dilute down the number of RVUs available to each ED Physician on-duty that day. Thus, by implementing an RVU pay system with significant “at risk” RVU compensation, a natural “check and balance” system is essentially created that guarantees that additional coverage will not be requested by the ED Physicians unless it is truly necessary. In contrast, in an hourly rate pay model where no clinical pay is at risk, most ED Physicians working in that kind of arrangement will typically desire more daily coverage so as to lessen their daily patient workload, while keeping their hourly pay fully intact.

To summarize this key third point, an effective “at risk” RVU pay model in an ED will allow the practice to achieve and sustain a very high level of ED Physician productivity. It also guarantees minimal ED Physician staffing “waste.” In contrast, hourly rate Physician pay models generally encourage staffing “excess” that may not make financial sense for the Hospital or ED Physician group.

### **Incorporating MLPs Into the Emergency Department Coverage Model**

In order to set an optimal coverage model for any Emergency Department, another key decision that must be made is whether Mid-Level Providers should be utilized in the ED. As our third 2011 White Paper discussed in great detail, the use of Mid-Level Providers in Emergency Departments today is very common. Given that there are now widespread MLP training programs in the United States which graduate numerous clinicians every year who have the proper medical training and experience necessary to function at a high level in the Emergency Department setting, recruiting these clinicians and incorporating them into an Emergency Department practice is very manageable. Thus, it is of our opinion today that the use of Physicians “exclusively” in an ED setting is now the unconventional approach to clinically staffing it. Excluding very small Emergency Departments (treating less than 14,000 annual visits) and dedicated Pediatric Emergency Departments, essentially all other Emergency Department coverage models should include and embrace the daily use of Mid-Level Providers.

Despite the many positive operational and financial benefits of MLPs in the ED such as throughput improvements, patient satisfaction gains, and financial cost savings for the Hospital or ED Physician group, at some point the use of MLPs in the Emergency Department setting can become excessive and begin to negatively impact operational metrics. Although MLPs are extremely valuable in Emergency Departments today, one must always remember that MLPs are not clinically equivalent to ED Physicians. As talented as MLPs are, they do not have as much medical training as Physicians nor do they possess as much clinical knowledge as Physicians. Given this reality, a key reminder for everyone is that as the clinical acuity of patients in an Emergency Department increases, the role of MLPs in such patient care should diminish.

If a Hospital ultimately determines that MLPs will add overall value to an Emergency Department staffing model, the next question becomes how to modify (reduce) the Physician staffing hours requirement when the MLPs are incorporated. Quite obviously, adding MLP hours in addition to existing total Physician hours will increase overall clinical productivity and ED throughput. Importantly however, one must realize that one additional hour of MLP coverage in the ED is not equivalent to one hour of Physician coverage in the ED. Because an MLP has to work under the supervision of a Physician and they do not possess as much training as a Physician, an MLP clinical hour cannot be viewed as equal to a Physician hour.

At Phoenix Physicians, we count one MLP hour in the ED as equivalent to 60% of a Physician hour in the ED. Thus, as an example, one 12 hour clinical MLP shift would be the equivalent of 7.2 Physician clinical hours (12 MLP hours x 60% = 7.2 “Physician Equivalent” hours). By using this 60% conversion factor, the 2.5 patients per Physician hour maximum can be modified depending on how many MLP hours are added to the existing Physician coverage model each day.

To review a clinical example that was presented in our first White Paper of 2011, if an Emergency Department sees 45,000 annual patients per year, one should expect that the Emergency Department coverage model should have between 55 and 62 equivalent hours of Physician coverage. That would correspond to between 2.0 and 2.25 patients treated per provider hour. Furthermore, if 60 hours of “Physician Equivalent” coverage each day is what is desired, one could choose to staff the Emergency Department one of the following ways:

Physician Hours Per Day	AHP Hours Per Day	Total "Physician Equivalent" Hours Per Day
60	0	60
48	12 (12 x 60% = 7.2)	55.2
48	20 (20 x 60% = 12)	60

In the green scenario, the Hospital has an all Physician coverage model that amounts to 60 clinical hours per day. This equates to 2.05 patients per physician hour (45,000 visits/365 days/60 “Physician Equivalent” clinical hours each day), which is very acceptable based on the 2.0 to 2.25 patients/hour benchmark. This would be a “gold standard” staffing model.

In the pink scenario, the Hospital has 48 hours of Physician coverage and 12 hours of MLP coverage each day. This equates to 2.23 patients per physician hour (45,000 visits/365 days/55.2 “Physician Equivalent” clinical hours each day). In this scenario, the coverage is also adequate (it falls between 2.0 and 2.25), but it is not as ideal as a gold standard model with all Physicians. It will however, be more cost effective.

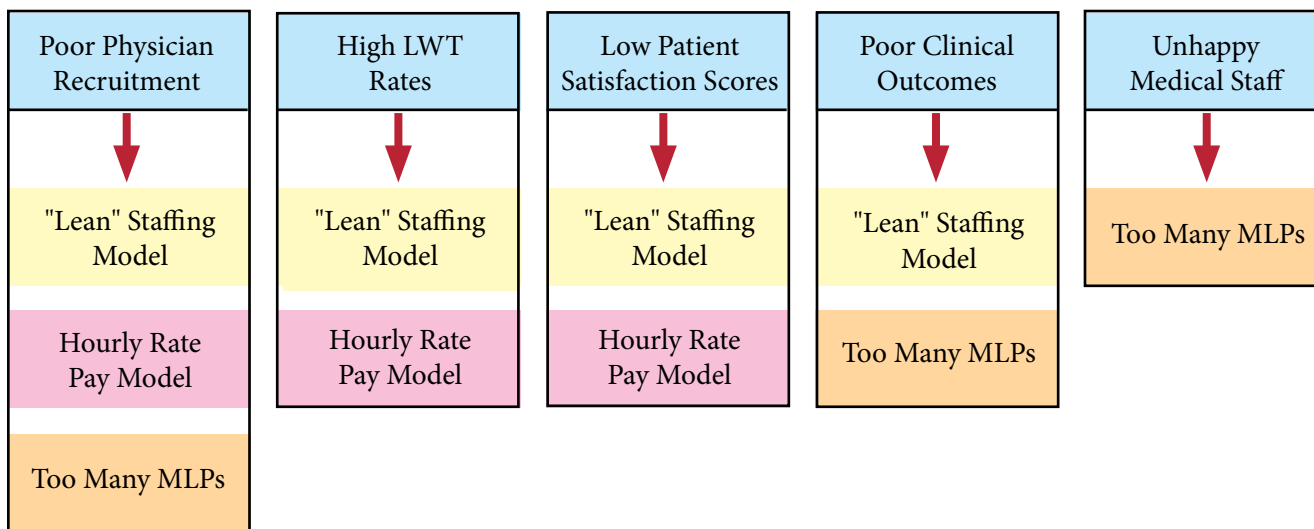
In the blue scenario, the hospital has 48 hours of Physician coverage and 20 hours of MLP coverage each day. This equates to 2.05 patients per physician hour, just as in the top scenario (45,000 visits/365 days/60 “Physician Equivalent” clinical hours each day). The important difference between the green scenario and the blue scenario is that more patients will be seen by an MLP in the bottom scenario. This fact must be weighed against malpractice risk, medical staff concerns, and necessary clinical oversight protocols.

Of course, as economic pressures on both Hospitals and ED Physician groups have continued to escalate, it has become increasingly commonplace for MLPs in today’s Emergency Departments to venture out of the traditional “Fast Track” setting, and additionally be utilized in the areas of the Emergency Department where the highest acuity patients are treated. From a strictly economic perspective, this may make some sense. However, if we respect the fact that MLPs are not equivalent Physician substitutes and they are not trained as extensively as Physicians, there are significant potential negative ramifications that must be considered and managed proactively if an expanded role for MLPs in the high acuity sections of an ED is to be considered by the Hospital or the ED Physician group.

Very importantly, if a Hospital and an ED group do agree that MLPs can be used in the higher acuity sections of their Emergency Department (in addition to the typical Fast Track treatment area), one must make certain that the MLP oversight by the ED Physicians is very good. As stated prior, MLPs do not have the same level of experience or as much clinical training as Physicians. Thus, the Emergency Physicians, the MLPs, the ED nurses, and the Hospital Administrators must all accept this MLP limitation and manage it proactively through extremely tight MLP supervision protocols enforced by the Physicians. If such supervision is not done well and instead the Physicians let MLPs work largely unsupervised in the high acuity treatment areas, clinical outcomes will suffer, malpractice risk will greatly increase, and medical staff satisfaction will decrease.

### ED Metrics Tell the Full Story

In the end, it is the Hospital's monthly ED dashboards that will indicate whether the ED Physician and MLP staffing model is working effectively. The following grid highlights some of the more common ED operational problems (noted in blue), as well as possible root causes of these problems that a Hospital and ED Physician group should be able to impact (noted in yellow, pink and orange).



### Summary

As we have outlined in this White Paper, there are five key factors that must be considered when determining the proper ED staffing model (or making changes to an existing one). Taking into consideration the current and projected ED volumes, average ED patient acuity, the current or proposed ED Physician pay system, the role of MLPs in the ED, and current and desired dashboard metrics should assist the Hospital and ED Physician group in selecting an ED staffing model that is most operationally and financially appropriate for their institution.



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