



## Pooling in Specialty – Q and A

### Question:

In our practice, there are currently nine surgeons who follow a template where they work ½ days in the clinic either mornings or afternoons. This is dedicated time for them that they have carved out from their other commitments, like OR, on-call etc. They will, throughout the year, cancel their clinics for vacation, a conference, or are on call the day of their pre-determined schedule in the clinic.

From reading the material on using FTE, we did not understand that the FTE calculation was to be done retrospectively. We actually understood it to mean that we could distribute the demand (average 33 “news” a week for this clinic) prospectively based on FTE in the clinic and then have the remainder of the appointments for follow ups based on visit rate. If there are more “news” than expected, there are surgeons who want more work and we could provide it to them when this happens. We then proceeded to build a new template based on distributing the new demand per FTE.

Our strategy is to schedule “news” one week in advance (that is why we wondered if we should batch) giving each surgeon their FTE share of the new demand and reconciling retrospectively to ensure equality. Please provide further comments.

### Answer 1:

Having nine surgeons all committed to a ½ day of clinic per day is a rare advantage. Seldom do we see the supply in a specialty practice distributed so equitably and regularly. Are they each the same FTE? This is very helpful in trying to save time for “news.” Let me check that I am understanding correctly - it would seem then that each of the nine surgeons has five ½ days per week over which to distribute their “fair” share of the projected 33 new patients per week (or about 4 spaces each per week). However, I have to say that a demand of 33 new patients per week for a group of nine surgeons seems low. Is that 33 for the group, or 33 per surgeon? Also, with nine surgeons, it would seem that between call, conferences and vacation, at least one would be “gone” in any given week. With all this being said, you could test whether your plan results in equitable distribution of new patients by clinical FTE, by looking at that distribution retrospectively. Since your supply is so regular, it may work. If you find that this plan does not result in equitable distribution of new patients, you could tweak it a bit until it does work.

To fill one week ahead (which is good), you have to have held/carved out those appointments from the time the schedule opened, and it seems you are doing that. And you have to reconcile the supply and demand in that one week box (no “leftovers”) but it seems there is a plan for that also. Good!

In addition to “losing’ supply for vacations and conferences, there is another item to consider, that could effect the regular flow and distribution of your clinic supply. As a surgeon sees patients in the clinic, he/she generates demand for another venue or queue (surgery). The rates at which this happens may differ by surgeon and by week. For example, one surgeon may generate a surgery from 50% of his/her new patients, while another may end up with a greater % than that. Since the demand for clinic and surgery is balanced by the same supply (the surgeon), it is important to be able to move the supply from one venue to the other, to make sure that the bolus of patients from the clinic venue does not result in a backlog of patients in the surgery line. What I am saying is sometimes it will be necessary for a surgeon to use his/her supply from the clinic to work down the backlog in surgery that has developed from perhaps a greater surgical yield from the clinic appointments. That means he/she may have to be able to move his/her supply from a clinic ½ day to a surgery ½ day, making him/her absent and not able to take on the appropriate number of new patients for that part of their week. This then affects the way patients can be distributed equitably among the nine surgeons, as they will be missing from the clinic supply for various reasons.

There are many moving parts to be considered, and you are off to a good start. This is not easy to do, and sometimes you just need to just get in there and start working through all the issues.

## **Answer 2:**

I am not sure that all nine surgeons contribute a half day each day or even each week. We ought to clarify that. FTE is the term that describes work contribution - and is used to budget and compare workers doing the same work. As you mentioned, the surgeons’ total FTE is far different than the clinical office FTE. We want to see just how much each contributes to the work. In other words how much supply do we have to meet demand when we measure both? FTE is commonly used to standardize contributed work time and, as such, uses a base of ten, (five days each with an AM and a PM session). Thus the “full time equivalent” is considered a 1.0 FTE while a half time is considered .5 etc. A person working one half day per week is a .1 (one tenth of a full time equivalent).

In your practice the FTE framework can be used to determine capacity or supply. Looking retrospectively (to the past) can give us some hint about how much capacity we will have in the future if we expect the same behaviors and the same coverage over time. On the other hand, we can also look to the future schedule for a determination of capacity (how many half days do we have scheduled into the future?). You live in a system where random cancellations are allowed and the determination of capacity by looking to the future has challenges (and is actually another reason to not have any delays).

Once you use retrospective (past) and prospective (future) determinations to derive the capacity (and this **has to be** standardized) then you can determine just how much demand your system can tolerate. If you have five half-days of worker, and you can see ten patients per half day,

your supply or capacity is 50. You can see 50 new and no returns, or 25 new and 25 returns, etc.

You then compare this capacity to the projected, measured and predicted demand. Demand can be determined for now by “counting” the number of new patients + return patients scheduled per day, rolled up to a per week number. This is not an activity measure (what was actually seen), but rather the number of appointments generated (appointments made).

If your supply is balanced by the current demand, you have to decide the ratio of new to return appointments, but you can keep up, don't need to work down backlog and don't have a delay. If demand exceeds capacity, you have to reduce demand or increase supply to get a balance and keep up. Then work down the backlog.

The above comments describe the overall practice. Pooling is a method to distribute work within the practice. We know that distributing work by popularity will fail due to the artificial creation of mismatch at the individual provider level. Pooling provides a mechanism to distribute the work in accordance with relative work contribution to the total effort. For example, if one surgeon contributes twice as much time to the office as another, he/she should get twice as much new patient workload. FTE, half days worked in office and relative work contribution are all terms we use to describe the amount of time worked and that amount of time worked drives the relative distribution of the work.

As I mentioned previously, I think the focus on the template is far too narrow a perspective. The template follows from the distribution of work, it does not drive it.

Here is where this gets a bit complex. The term pooling is often perceived to indicate distributing the new patient work based on relative FTE (or relative contribution) and to pool in sequence. Your surgeons are not in the office each week. They have other duties that dilute their office time and they have “time off.” So their contribution to the work effort is sporadic. Demand, on the other hand, is steady. It may show some variation but there is a predictable range. So demand varies a little and supply varies a lot. If you pool the work in sequence, that is, distribute patients to one then another and then another, even if you take into account the relative FTE status, that pooling in sequence will cause a delay since the supply is so sporadic. In a sense you have to create artificial demand variation to meet the supply variation (the surgeons are not consistently in the office). You can do this and still distribute new patient work in accordance with FTE, to relative work contribution, by pooling in sequence to the schedule not in sequence to the individual provider. This requires first and foremost that you eliminate all backlogs for all surgeons for all new patients. Then those surgeons who are scheduled three to five days from today get their new patient schedules (templates) filled from today as demand. The new patient work is distributed in a bolus, in a bundle, filling each schedule. So some surgeons may get 10 new patients this week and none for the next two weeks (they are gone) while another may get either none or five this week and five or none the next week. We reconcile for fairness and sharing by looking backwards to see whether surgeons got the right amount of new patient work, based on relative work contribution (FTE). I suspect though that the new patient work will

be distributed by relative contribution since that relative contribution is determined really by exposure and by having a schedule. The real supply is what you really could do.

If the measured demand is an average of 33, you have 50 slots each week, half are new and half return (this implies that the visit rate per patient per year is 2) then the 25 new slots won't keep up with demand. In addition, 33 is average. Half the weeks the demand is higher and half the weeks it is lower. You said you had supply in reserve and that you have surgeons who want to work more. Here is the opportunity. Add some half days (about two) and you can keep up with average. Also, if demand rises you can see this in advance. If you are filling the schedules three days in advance, get the referral and book the appointment for three days from now (no delay). Then if a demand surge takes the delay out to four or five days, add supply to recover. Just add an extra half day. Be cautious though since all new patient demand will generate a corresponding return visit or visits. So for every new you have to account for a corresponding rise in return and that must be managed later in the flow of time. Don't let the surgeons add time to see new patients and not take responsibility for the return demand that grows from the news.

This is where the template helps. The ratio of new to return on the template reflects the ratio of needed new time + needed and linked return time.

Get rid of the backlog. Then don't hold the new referrals, but book them into the open schedules. Today's demand goes to three to five days from now and tomorrow's does the same. Keep up. Book in boluses, not in individual sequence.