

Best practices for the Independent RHC:

Independent RHC's are very different from their Hospital based counterparts. Some common differences can especially be seen in staffing, or lack there of when a provider or other staff member is out. There is not the option many times of pulling one provider from one location to cover the next. What about if the provider gets sick and it's a one provider clinic? Does the clinic close for the day? Many independent RHC's are owned by the sole provider who is also tasked with seeing patients. How can the owner/provider generate enough revenue to pay employees, themselves, make a profit, and actually grow their business? These are common questions an independent RHC may face on a daily basis. Two best practices to help combat this are discussed in this presentation.

DIVERSIFY/ADD SERVICES/SPLIT STAFFING MODEL:

- The independent practitioner does not have to “be in this alone.” At the same time, they do not have to bring on a second full time provider to ensure that they can have time off or a vacation if they ever want one.
- While typically an independent RHC can not offer some of the big salaries and packages (401K, health insurance) that a hospital based clinic may be able to support, what they can offer is a unique/flexible staffing model that their counterparts normally cannot.
- **We use a split staffing model at our practice. 3 FNP's make up one FT position. The advantages here are vast.**
 - **They have set days so there is still continuity in pt care and scheduling but they are able to swap freely as long as it is in enough time to schedule pts accordingly.**
 - **We use a slot policy for malpractice for them. Cost is exactly same as if covering one FTE FNP. Three share the one slot and are fully covered as long as the total hours does not exceed what a regular sole FNP coverage would be.**
 - **While some providers need and are seeking full time hours, others find it VERY challenging to find practices that will let them work part time and flexible hours. This is a win/win for the practice that can not incur another full time provider. It's an attractive draw to help hire/keep a provider whose desire for family/work balance etc. is higher than perhaps their hourly salary.**
 - **It helps ensure that your clinic would not close perhaps if a provider was out sick, more resources to pull from.**
 - **It allows patients some additional options of providers if perhaps they have a better rapport with one provider over the other vs them going to another practice if you're a sole practice.**
 - **It allows the independent owner/provider a resource familiar with their clinic time off when needed.**

- **Cons:** As with anything in life there are always some hurdles to overcome. Scheduling is a bit more time sensitive. When swaps occur ensuring the front desk is notified so pts are scheduled on the right provider. Patients understanding which provider is there when. However, the pros certainly outweigh the cons especially for the independent practice with this model.
- **Bottom line,** we have found that our ability to be open to a split staffing FNP model vs the standard 40 hour a week model has given us a unique advantage in attracting qualified providers.

DIVERSIFY/ADD SERVICES:

Yes! The independent practice can do this!! It brings in another revenue source. It adds services vs making your pts go else where for those services. We offer womens health services two days a week and mental health services two days a week in addition to primary care daily. 1099 the specialty providers but it provides broad spectrum of care while allowing the primary care crew to focus on their specialty and not being tasked with addressing at times complex womens health and especially mental health issues, all the while under one roof so exceptional full scope care for the patient. *Mental health best practices.

- **USE PMP's. Critical. Helps verify as well as address perhaps controlled substances pt may not be mentioning and confirms date of distribution. These are pulled the day before appts during chart prep and have been invaluable for the providers.**
- **Rapid drug screen on site at time of visit. We have found many independent RHC's send out all UDS and must then have pt come back to get script, or left providers scratching their heads as to next move if their was some concern if pt was taking something they had not admitted to. It also helps discover/confirm if a pt is not taking their medication.**
- **Costs. Benefit far outweighs cost. While the RHC can not "bill" for this rapid UDS we have found a company in which we pay less that 3.75 cents per cup. It has helped tremendously with assisting provider decision making at that time, as well as benefit to the patient on returning to clinic. It also helps establish that any pt on a controlled substance learns early on, that is our practice model.**
- **The gold standard for MH care is medication (when needed) and counseling. We have a team approach and incorporated an LCSW (same reimbursement) and a MHNP. ****The MHNP has her own collaborative so this is a non-issue with perhaps the medical md collaborative who does not feel comfortable with the MH side. They co care for all pts and it allows us to assess the commitment of the pt when they only want a medication vs the best practice treatment plan of meds and therapy.**