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BACKGROUND
As a not-for-profit, academic health system, Mayo Clinic cares for over 1.3 million patients from all 50 states and nearly 140 countries each year. In addition to a strategic focus on providing integrated multi-specialty care to patients with serious and complex illness; Mayo Clinic also provides community care in more than 60 rural communities in Iowa, Wisconsin, and Minnesota through the Mayo Clinic Health System.

Mayo Clinic is not immune to the national pressures of workforce demographics, providing affordable healthcare, and regulatory changes. Mayo Clinic had two otorhinolaryngology positions within rural communities that had been unfilled for over three years despite significant recruitment efforts. The dearth of surgeons practicing, or willing to practice, in rural areas can negatively impact patient access to care, as well as adversely affect local rural economies. The National Center for Rural Health Works estimates that an average rural general surgeon generates $2.0 million of direct revenue and 19 jobs, with a community impact of $2.66 million and 26 jobs.

Mayo Clinic implemented an innovative surgeon staffing model, thereby helping drive the Triple Aim – improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities.

OBJECTIVE
• Fill surgeon vacancies in the community practices.
• Increase Department of Surgery retention through career development and job satisfaction.
• Increase specialty surgical service line offerings in the community practices.
• Provide general surgery services in alignment with facility and resource availability.

METHODS
The Department of Surgery at Mayo Clinic addressed these pressures by hiring surgeons to the destination location, Rochester, MN, and allocating surgeon time between the main campus and rural communities. The majority of the surgeon’s time is spent in the community practice. This allows patients to receive care in their communities and support community hospitals while providing surgeons the ability to maintain their specialty skills in an academic center.

Planning methods included defining current state of the Southeast Minnesota General Surgery Practice, including collecting data on provider satisfaction, open positions, existing capabilities, and available performance metrics (e.g. volume and types of cases, payer mix, patient demographics, patient satisfaction, quality, etc.). A future state was outlined which assessed strengths/weaknesses, defining roles, catchment area, role of education (resident/fellowship training), and recommendations for service delivery.

Implementation methods include:
• Implementing a Mayo Clinic recruitment strategy vs site based recruitment strategy, including using a single recruiter for Department of Surgery at all locations.
• Adopting joint appointment model (80% community based and 20% complex care practices), resulting in four placements.
• Regional Morbidity and Mortality Conferences to help integrating the practices. The opportunity to review cases creates common understandings of practice patterns and decision-making along with building relationships.

RESULTS
• 100% retention of joint appointment model between the Destination Practice and the Community Practice (+2 years).
• Eliminated the use of Locums in the Department of Surgery-Division of General Surgery/Mayo Clinic Health System.
• Mayo Clinic Health System at Mankato Minnesota, Otorhinolaryngology: Two positions were open for 3+ years. After implementation, offers were extended within 4 months.
• Maintenance of complex surgical skills
• Increase access to specialty care
• Lower patient transfers to main campus
• Lower surgeon turnover
• Reduced time to hire
• Surgeons have association with an academic center

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