LONG VIEW
THRIVE BY DESIGN

The New Physician Adviser

Part 2 of 2 | An Enhanced Operating Model

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Doing More with Same or Less

Key Learnings

- **The legacy physician adviser (PA) model based on part-time clinical rotation is ill-suited to today's throughput and reimbursement pressures.** Beyond resetting the basic qualifications, health systems must build enhanced, team-based operating structures with clear accountability and availability across the entire patient journey.
- **An enhanced solution is not about better individuals, but a better operating model.** When physician advisers are embedded in daily rounds, denial huddles, and command-center meetings, they can materially improve patient care, reduce denials, decompress ED's, and unlock inpatient bed capacity without adding new FTEs.
- **What sets the new model apart is shared accountability.** By assigning joint ownership of key performance metrics across clinical, operational, and financial teams, the PA becomes a unifying force, aligning stakeholders who once operated in silos.

Introduction

In Part 1 of this article series, we described the need for a revised set of foundational qualifications for the PA role. Those qualifications intend a "reset" of the foundation and will work for many health systems. However, large health systems in competitive markets and complex payer portfolios will likely require an "enhanced" model. In this article, we share what an enhanced operating model is, beyond simply hiring a new person with the enhanced qualifications. The enhanced model's key benefit is better clinical and financial outcomes with the same or even fewer FTE's.

What are Limitations Today, and what Should the Future Look Like?

Part 1 of the article showed the limitations of the model used today. We recreate the same list of limitations below and expound on what the future state operating model could look like via some examples.

Table 1. Future State Physician-Adviser Examples

Limitation	Description	Future Model	Future State Example
Advisor not available when care team needs input	Rotational PAs are on site only a few hours per week, so many status questions wait until the next review cycle.	A dedicated 0.8–1.0 FTE PA (or coverage team) participates in daily multidisciplinary rounds, midday denial huddles, and late-day chart follow-up.	The advisor joins the 7:30 a.m. capacity huddle, walks ACE unit rounds by 8:00, and is on call for peer-to-peer requests within 30 minutes, covering the full census in real time.

Limitation	Description	Future Model	Future State Example
Thin mastery of payer criteria	InterQual and MCG updates arrive quarterly, yet rotational advisors rarely train on every release.	Annual competency testing on InterQual, MCG, MA policy, and state rules are conducted; PA library of quick-reference guides refreshed every quarter.	The PA team completes a 20-question InterQual update quiz each quarter; failure triggers one-hour remediation. Results feed an internal "policy readiness" dashboard visible to clinical leadership.
No live data to spot hot cases	Without dashboards or AI scoring, advisors review charts alphabetically rather than by risk or timing.	AI-driven dashboard stratifies census by clinical need, SDOH, denial risk, LOS variance, and discharge barriers; PAs tackle red-flag cases first each morning.	At 6:00 a.m. the system flags top high-risk cases; the PA clears status errors before rounds and launches same-day peer-to-peers, preventing $25 k in likely denials.
Limited peer-to-peer bandwidth	Payers allow a 24- to 48-hour window for peer-to-peer calls, but a part-time advisor may be off site when the call request arrives.	Dedicated group of "on-demand" PA peers exists with a shared calendar; two-hour maximum response time; backup PA covers absences.	A payer requests a call at 1:00 p.m.; the on-duty PA accepts the slot at 1:15 p.m. and overturns the denial by 1:45, preserving $9 k in DRG revenue.
Cannot escalate discharge barriers in real time	Rotational advisors rarely attend discharge huddles, so clinical or social obstacles linger.	PA co-leads a 15-minute daily discharge-barrier board with case management; items unresolved >24 hours escalate to the command center.	A missing rehab order is identified and signed within two hours; the patient transfers to SNF the same afternoon, freeing the bed for a surgical admit.
Disconnected from command-center flow	Bed control often makes capacity decisions without clinical context from a PA.	PA sits in—or virtually joins—the capacity command center; provides real-time clinical context for bed moves, ICU downsizes, and transfers.	When ICU census spikes, the PA approves two step-downs after reviewing criteria, opening critical-care beds within 30 minutes and avoiding a diversion.
Little influence on post-acute placement	Advisors unfamiliar with SNF and home-health criteria focus only on inpatient status.	PA trained in SNF swing-bed and home-health rules; collaborates with post-acute network to match patients to the first safe discharge option.	PA flags a CHF patient for home-health with tele-monitoring, facilitating discharge one day earlier and saving $650 in variable cost while preserving quality metrics.

A New Operating Model for Physician Adviserships

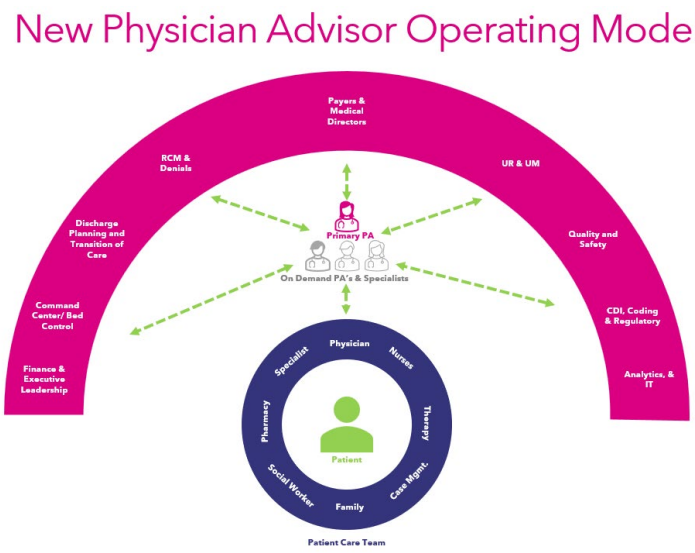
The enhanced operating model of physician advisership will not be defined by a single individual, but by group of stakeholders within an operating model or system (hence the term "physician advisership" vs. "physician adviser"). In this model, a primary PA plays the role of "quarterback" and works with multiple specialists, nurses, case managers, and administrative leads to ensure care decisions are sound, timely, and aligned with institutional goals. The new model is based on the Donabedian principle of focusing on creating the correct "structure" such that heroic interventions by individuals is not the norm. Rather a durable operating structure comprised of a PA team is what creates routine, consistent, high-quality outcomes.

The PA team engages across the entire patient journey. The primary PA coordinates across the team of "on demand" PA's (backup PA's, specialists etc.) each with a defined schedule (e.g., neurologists A covers on-demand calls for Mon-Wed and B covers Th-Fri to work with the primary PA), an agreement to respond within certain timeframe set by a service level agreement (e.g., return call within 2 hours of contact from primary PA) and joint metrics owned by each role. All stakeholders are appropriately

trained in UR principles, payer contract nuances and state regulatory nuances related to prior authorization. Additionally, this team is trained in the appropriate technology stack and AI tools to be able to discern any technology and AI driven analysis. In this way, these stakeholders are not merely "humans in the loop", rather they are drivers of the process. They are designing, refining and overseeing the algorithmic processes (e.g., review all charts using AI for certain conditions, flag high risk ones based on evidence-based medicine and policy, then conduct full human review).

In addition to this core PA team, a broader team of adjacent stakeholders sits "above" the PA team interacting with them as necessary. For example, the PA team might work with the denial team to find that a core reason for denials is related to inpatient vs. observation criteria. The PA team can discover that these criteria are not fully adhered to using standards such as MCG or InterQual and take on changing the dashboards and processes to ensure proper adherence.

Below is a diagram of the new enhanced operating model along with essential responsibilities of the PA team followed by the essential responsibilities of the overall PA team.



PA Team Essential Responsibilities

- **ED decompression support** — Monitor live boarding queues and trigger early inpatient status reviews, aiming to keep boarding time below two hours per admitted patient.

- **Concurrent review and level-of-care determinations** — Provide clinical judgment on medical necessity, align status to criteria, and collaborate with case managers.

- **Peer-to-peer communication** — Clarify clinical rationale with attending physicians and payers to keep care on track. Engage appropriate specialties early and often to avoid downstream delays or write offs.

- **Discharge planning and transition of care** — Identify barriers early and coordinate safe, timely movement to the next setting. As an example, Banner Health cut skilled-nursing facility length of stay by 1.4 days after embedding a full-time physician adviser in weekly discharge calls.

- **Denial management and appeals** — Review payer denials, craft medical necessity arguments, and lead appeal efforts. Ensure familiarity by the whole PA team of the individual payer contracts via a shared "contract repository" with key terms highlighted and commented upon in a forum-like fashion. This can serve as an ongoing internal library of tips and tricks for the entire PA team and possibly even the patient care team. With the addition

of Large Language Models, this can become an easy repository for others to query and troubleshoot.

- **Education and training** — Teach medical staff, case managers, and revenue teams the latest utilization and regulatory requirements. Use the contract repository to continue to share best practices and internal tips and tricks with the broader, adjacent team.
- **Policy and protocol development** — Write and update health system guidelines to match evidence and payer rules.
- **Collaboration with case management** — Partner daily to optimize patient flow and resource use. This is one of the crucial items where the interpersonal skill of the primary PA is of utmost importance to bring about productive collaboration across the case management and discharge teams.
- **Data analysis and performance improvement** — Interpret utilization trends and target high-impact opportunities.
- **Algorithm and process improvement** — Design (or select a vendor platform for) the algorithms used to review inpatient charts, flag them for review by primary PA (with possible recommendation to engage specialist), oversee the process and algorithm, improve the process/algorithm for improvement (e.g., cover more cases at deeper levels of chart review driven by clinical experts, augmented by AI, where AI serves as a second pair of eyes).
- **Real-time capacity coordination** — Attend the health system's command-center huddle, prioritize bed moves in concert with bed control, and escalate barriers to the surge team during peak demand.

Key Metrics to Own

Below is a set of sample metrics along with sample ownership of those metrics to reimagine the new role and new operating model for physician adviserships.

Patient Journey Segment	Sample Metrics	Why It Matters	Sample Ownership
ED to Admission	- ED boarding hours per admitted patient - Left Without Being Seen (LWBS) rate	Shows how quickly inpatient beds are made available for incoming patients (ED throughput).	Command Center/Bed Control → Primary Physician Adviser (Bed management team coordinates admissions; Physician Adviser assists by expediting clinical status decisions to reduce ED wait times).
Admission/Early Stay	- Observation rate - Observation-to-inpatient conversion rate	Confirms correct status at the front door and prevents revenue loss.	Primary Physician Adviser → UR/UM Team (Physician Adviser leads accurate admission status determinations; UR nurses support by initial screening and criteria checks).
Inpatient Period	- Length of stay (LOS) Observed/Expected (O/E) LOS index	Measures efficiency of care progression and bed utilization.	Primary Physician Adviser → Patient Care Team (Physician Adviser flags delays and coordinates flow; bedside care team executes timely care and discharge plans).
Throughout Stay	- Denial rate - Appeal success rate - Reduction of OP tests as an IP	- Tracks real-time payer alignment and strength of documentation.	Primary Physician Adviser → RCM Team (Physician Adviser intervenes with concurrent reviews and peer-to-peer calls to prevent denials; RCM denial

Patient Journey Segment	Sample Metrics	Why It Matters	Sample Ownership
		- Reduces delays in schedules and average cost per IP case. Physicians who understand the method of DRG payment and the average services included in those payments, reduce unnecessary or OP reimbursable expenses.	management team handles appeals and claims, consulting specialist physicians as needed for complex cases).
Discharge Planning	- Discharge before noon percentage (DBN)	Gauges timeliness of discharge tasks that unlock capacity (next-day bed availability).	Discharge Planning Team → Primary Physician Adviser (Case managers/social workers drive discharge logistics; Physician Adviser helps remove medical barriers and expedite disposition in difficult cases).
Post-Discharge	- 30-day readmission rate - HCAHPS "Care Transition" score	Indicates quality of transition planning, follow-up, and patient experience/education.	Quality & Safety Dept. → Medical Leadership (Quality leaders monitor readmissions and patient experience; Medical Leadership (e.g. CMO) champions clinical initiatives across departments to improve transitions of care and follow-up).
Cross-Cutting Experience	- Physician satisfaction - Case manager satisfaction	Signals how well the advisor supports clinical teams (staff experience).	Primary Physician Adviser → Medical Leadership (Physician Adviser cultivates collaborative relationships with physicians and case managers; Medical Leadership oversees and addresses systemic issues affecting provider satisfaction).
Financial Impact	- Cost savings or cost avoidance (e.g. denial prevention ROI)	Quantifies bottom-line benefit of accurate status and successful appeals.	Finance Leadership → RCM Team (CFO/finance leaders track financial outcomes of throughput and denial management; RCM team provides data on recovered revenue and ensures financial metrics are met).
Regulatory Compliance	- On-time utilization reviews - Documentation alignment to CMS rules	Reduces audit exposure and protects reimbursement.	UR/UM Team → CDI/Coding Team (UR nurses ensure timely review of cases per regulations; CDI/Coding specialists ensure documentation meets CMS criteria to withstand audits).

The Long View

Redefining the physician adviser starts with refining foundational qualifications. For larger health systems this expands into a sustainable, robust operating model. Health systems that move beyond person-dependent fixes and adopt team-based operating models have shown shorter LOS and fewer denials in early adopters. Such long-term focused health systems will be better positioned to manage

rising demand, shrinking margins, tight and transient labor markets. In the long view, the physician adviser team serves not just as a clinical and financial steward, but as a command-center catalyst that orchestrates flow across every unit and unlocks capacity every day.

About the Authors

Tammy Gavin is a seasoned health system executive with 30+ years of experience navigating transformation elbow-to-elbow with front line clinical staff or leading from the front. She has a unique ability to develop and execute a vision and strategy that improves revenue generation and achieves operational efficiency while being a champion of the patient and maintaining strong business alliances among the medical staff, clinical staff and administration. She has proven results of changing culture and impacting outcomes across several health systems. For any questions, contact tgavin@longgame.com.

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