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INSIDE

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American Health Consultants® is A Medical Economics Company

The hot economy is not translating to better profits for medical groups

Study paints a gloomy picture in one state

You may have suspected it already, but now there is proof: Medical groups are failing at a record pace while health plans continue to rake in record profits. According to a study released in early September by the California Medical Association (CMA) in Sacramento, as many as 90% of physician organizations in that state are poised on the brink of bankruptcy or closure. This could affect more than 10 million patients. The study, titled *The Coming Medical Group Failure Epidemic*, was based on the CMA's own research and produced with help from research conducted by the accounting firm PricewaterhouseCoopers. According to the report:

• At least 34 medical groups or independent practice associations (IPAs) will fail or close in 1999, up from 31 last year.

• Representatives from a major health plan told California state legislators at a closed meeting that nearly 80% of medical groups with which it contracts are in serious financial trouble.

• CMA receives notices of group failures weekly, and in July 1999 a CMA survey of California Bankruptcy Court records revealed 113 medical group bankruptcies and/or closures over the last three years.

The report states that California health plans have lower premiums — an average of $135 per member per month — than other areas of the country, where the average is nearly $175. Meanwhile, plans are experiencing continued robust profits. The report notes that WellPoint saw earnings rise 19% over the year. PacificCare had an increase of 41%, and Aetna's earnings grew by 12%. Plans also continue to raise premiums. "But not enough of this increase is being dedicated to patient care," the report states. "Even with recent increases, it raises the question: How can HMOs in California receive lower than average national premiums but report higher than average earnings? They do this by shifting the burden to physician organizations, which in many cases pass the burden on to physicians themselves. These frontline providers must deliver

more care to more people while receiving very low cap rates."

PricewaterhouseCoopers noted that capitation rates have fallen from $45 per member per month in the early part of the decade to $29 currently. That's a decline of 35% when the consumer price index notes a 25.2% increase in cost of living.

Physicians often receive less than the cost of caring for patients, the report continues. For instance, pediatricians reported to the CMA that they received as little as $10 per child per month — not enough to cover the cost of legally required vaccines. California doctors also receive less for Medicaid care than the national average.

Rather than just paint a gloomy picture, the CMA report does have some recommendations. First, consolidation in the California medical market needs to end. Right now, 90% of the market is controlled by five health plans. Second, capitation rates should be actuarially based, rather than driven by what the market will bear. Third, the report says excessive administration costs should be limited.

More financial data needed

Physicians also should work to prohibit the assignment of pharmacy risk to medical groups, the report advises. Finally, health plans have to start sharing financial information with medical groups. "Health plans, as contracting partners with physicians' groups, have not been accountable to the groups for the timely provision of basic, necessary financial information," says the report. Among the most necessary: financial and utilization information on risk pools, regular reports for coordination of benefits receivables, third-party recovery receivables, pharmacy rebates, retroactive additions and deletions in enrollment, and changes in benefits. "For groups to adequately assess their financial position, this crucial information from the health plans must be provided to the groups."

The entire report is available from the CMA on-line at www.cmanet.org. ■

Claims processing goes high-tech

Practice cuts staff by using Internet service

In an era where a penny saved can be the only penny you are sure of earning, finding a way to get more money into your practice faster at a lower cost is increasingly important. One way to do that is to outsource some of your financial functions. But rather than send them to a local company, now you can send them through the Internet. One Portland, OR, pediatrics practice has done just that, saving one full-time staff position and cutting days outstanding for accounts receivable by at least a third.

According to **Katherine Whitaker**, bookkeeping supervisor at the 20-physician Children's Clinic, accounts receivable were out for 60 to 90 days a year ago. "We really wanted to find a way to increase our cash flow," she explains. She and the practice administrator felt that number needed to get down closer to 30 days in order to ensure the continued financial health of a growing practice.

They checked with their computer and software vendors, local outsourcing companies, and their peers in the Portland medical community before finding an Internet claims service, Claimsnet (www.claimsnet.com), which offered flat-fee services. "We really made the choice based on price," she says.

Over the course of the year the practice has used the service, Whitaker says the days outstanding on accounts receivable has declined steadily and is now closer to 30 days than 90. During a period where the practice grew by four physicians, Whitaker only had to hire a part-time staff person to handle the increased workload. "Without the new system, I would have had to hire at least a full-time person, and maybe one and a half people."

The flat fee system at Claimsnet, based in

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■ Running an effective radio campaign

■ How employee jobs affect patient satisfaction

■ 10 signs of financial trouble ahead

■ Credentialing physicians could become easier

Dallas, was certainly one of the main selling points for Whitaker. The program currently has about 2,400 subscribers, says chief operating officer **Terry Lee**. It requires no software or hardware purchase. It is all done through your Internet browser and costs just $25 per month.

For that fee, practices can process unlimited commercial claims. The fee also covers each practice site, rather than a specific physician. Medicare, Medicaid, and some of the Blue Cross/Blue Shield programs cost an additional quarter per claim. "We don't get anything with them if filed electronically, so we have to charge that," explains Lee.

Statements are produced for 49 cents, including postage, return envelopes, and laser printing. "A physician practice would probably spend about a dollar on that," says Lee. Eligibility referrals are done for $30 per month.

Six standard reports provided

For another $10 per month, practices can get six standard reports:

- diagnosis and procedure code by gender;
- all patients by procedure code and geography;
- all patients by diagnosis code by geography;
- all patients by payer by diagnosis code;
- all patients by payer by procedure code;
- all patients by payer.

The next release of the Claimsnet program will include the ability to produce customized reports, too, says Lee.

The program also may cut down on denied claims because it will tell you immediately if a batch of claims contains any errors. While transmitting the clean claims to payers immediately, it will send the others back to the practice with a note on where the problem is — for instance, if the gender box wasn't filled in or if you insert the wrong payer's code.

Although this was another selling point for the program, Whitaker says she hasn't seen any decrease in denied claims from the system as yet.

In the future, Claimsnet will offer a finance option that can perform credit checks, set up leasing and credit options for practices, and perform quality checks, says Lee.

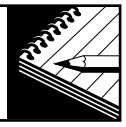
Claimsnet is the only company out there. There are other Internet services that provide these and other services. Healtheon (www.healtheon.com) is one of them. But so far, Whitaker is very happy with the Claimsnet service.

"The program is really slick," she says. "And it's more than paying for itself." ■

SOURCES

- **Terry Lee**, Chief Operating Officer, Claimsnet, Dallas. Telephone: (800) 356-1511.
- **Katherine Whitaker**, Bookkeeping Supervisor, The Children's Clinic, Portland, OR. Telephone: (503) 297-3371.

GUEST COLUMN



Education material can promote your practice

The right software makes it easier

By **Neil Baum**, MD

How would you like to increase patient satisfaction and compliance, enhance office efficiency, and reduce the risk of lawsuits all at once? If any of these sound appealing to you, you need to implement a computerized patient communication system in your practice.

Has this happened to you yet? Your patient shows up clutching an article he downloaded from the Internet and asks why you recommend a certain diagnosis or procedure instead of the latest advancement mentioned in the article. Or maybe you've been involved in a lawsuit in which the patient claims the risks of a procedure and alternative therapies weren't adequately explained.

These are easy problems to avoid with a computerized patient communication system. However, the benefits go far beyond avoidance of problems. They also include increased compliance with instructions, improved outcomes, and higher patient satisfaction. In addition, your malpractice insurer may offer a premium discount for the use of a qualified patient education product. One company, Dialog Medical (www.dialogmedical.com/insurers.htm), has a list of insurance providers that offer premium discounts for the use of patient education software.

Getting started is not as complicated as it sounds. Many companies offer software products that are easy to install and use, even for the computer novice. Computer systems are affordable as well. PCs for less than $1,000 have become a standard in the computer market, and many patient education software programs are available for under $500.

❑ **Hardware.**

To get started, you need a PC, some software, and a printer. Most patient education software programs state their system requirements, but you should be safe buying an entry-level PC. A typical entry-level configuration would include at least a 200MHz Pentium processor or equivalent, 16 megabytes of RAM (most systems currently come with 32MB), a CD-ROM drive, and a large hard disk (2 Megabytes or larger).

Laser printers work best for high-volume tasks like printing patient pamphlets because of their superior print speeds and output quality, but some physicians opt for an inkjet printer so that they can incorporate affordable color graphics in their handouts. Color laser printers are still very expensive.

❑ **Software.**

A variety of companies offer patient education solutions. Some are specific to medical specialties; others are more general in nature. Some products generate handouts for the patients to read and take home, while others are interactive teaching tools that require the patient to take a guided tour on the PC.

There also is a lot of information available on the Internet — much of it questionable in quality. With the affordability of patient education programs, it's not worth your time to try to write your own or to collect information from various sources on the Internet. **(For more information on some of the software options available, see box at right.)**

In most programs, you can personalize the handout materials so they appear to come directly from your practice. Many programs allow you to customize and edit the material so it meets the exact language and opinion of the physician providing the material.

Another advantage of the computerized patient education program is that it saves space. You won't need to have large filing cabinets and messy pamphlet holders. Many programs contain more than 500 different documents that are

Patient education software options

Here are some software options available to physician offices.

1. Dialog Medical, (800) 482-7963 (**www.dialogmedical.com**), offers urology Discussion, Dermatology Resource, Cardiology Resource, OB/GYN Resource. More products are due out later this year for ENT, gastroenterology, oncology, and general surgery. Probably best known for Urology Discussion (in Spanish and English), Dialog Medical's premier program is used by more than a third of all U.S. urology offices. Programs contain patient education, consent forms, patient instructions, common drug information, test and admission forms, questionnaires, authorizations, diets.
2. Lippencott-Raven, Mosby Yearbook, and WB Saunders, (800) 401-9962. This Web-based product from three well-known publishers is offered through MDConsult (**www.mdconsult.com**). In addition to a library of general patient education, MDConsult provides access to on-line reference books and practice guidelines.
3. Clinical Reference Systems, (303) 664-6485 (**www.patienteducation.com**). Generates patient education handouts on adult medical and surgical topics written in easy-to-read and easy-to-understand language.
4. Micromedex, (800) 525-9083 (**www.micromedex.com**). Information on patient conditions, including treatment, follow-up care, psychosocial issues, and continuing health concerns in English and Spanish.
5. Medifor, (800) 525-9083 (**www.medifor.com**). More than 550 primary care topics. Includes patient instructions, treatment guidelines, medications, chart documents.
6. Patient Education Institute, (319) 335-4613 (**www.patient-education.com**). Patient interactive modules cover several medical specialities across the spectrum of health care, including health promotion, disease condition, risks and benefits of surgery, and pre-op instructions. The X-Plain software presents information using text, illustrations, animations, and narration. ■

available on a few diskettes or CD-ROM.

Some programs offer educational handouts only. Others include discharge instructions, drug information, consent forms, or other types of communication. You should decide what types of communication might be valuable to you and evaluate the available options.

I suggest that you be sure that the program includes periodic updates that provide new patient education material as it becomes available. For example, a program written in 1997 and early 1998 would not have sildenafil (Viagra) information. Periodic updates will contain new drug information and patient education material on new products, procedures, and treatments.

Patient satisfaction has gone up, phone calls to the office have been reduced, and I feel better protected from a medico-legal standpoint.

Patient education programs are a real plus for your staff. The efficiency of the practice improves when staff no longer have to search the office for a pamphlet or brochure on some health-related topic. Computerized material avoids the necessity of interrupting patient care to make copies of the latest form or handout material. And most importantly, the patient education material reduces the number of questions from patients as the most frequently asked questions are answered in the handout material.

Clean and current patient education materials enhance the quality of your practice. If you hand out a sheet that has been photocopied five times and is barely legible, your patients might begin to wonder about quality in other areas of your practice. The handouts become a practice marketing tool.

I've been using my computerized communication system in my office since 1992. Since then, patient satisfaction has gone up, phone calls to the office have been reduced, and I feel better protected from a medico-legal standpoint. I'd like to hear your comments and questions about computerized patient communications systems: Send me an e-mail at neilbaum@accesscom.net.

Neil Baum, MD, is a urologist in practice in New Orleans. He is a frequent speaker and writer on the art and business of running a medical practice. ■

Network gives specialists negotiating leverage

Physicians seek greater voice in care decisions

In order to deal with the unique challenges that specialists face in today's managed care environment, a group of Boston area surgical and medical specialists have formed a physician organization to give its members a greater voice in patient care and to enable them to work more effectively with hospitals and other tertiary care providers.

Specialty Care, LLC, based in Scituate, MA, is made up of more than 80 surgical and medical specialists who are on staff at six hospitals in communities on Boston's south shore. Members are specialists in four areas: cardiothoracic surgery, general and vascular surgery, orthopedic surgery, and gastroenterology.

"We're doing a lot more networking and working harder in ways we are not accustomed to, but we're getting good at it," says **Robert Driscoll**, MD, a general and vascular surgeon who is president of Specialty Care.

A leverage booster

The organization has brought together specialists who previously didn't know each other but who realized the benefits of joining together in today's health care environment. "We were surprised to find that many of us across different hospitals in our region were having the same problems with managed care organizations and primary care groups," Driscoll says.

The organization is the state's first surgical/medical specialty care organization. The physicians in Specialty Care say having an organization will strengthen their position in the managed care market and give them greater leverage in the process of making decisions about patient care.

"Patients are looking for us, the specialists, to assume a more active and upfront role in the management of patient care. There is genuine concern and anxiety about the direction that managed care is taking. Patients are concerned that nonphysicians or employees of managed care organizations are making decisions about their care," Driscoll says.

The organization expects to be able to negotiate risk contracts with other physician networks

and health care organizations as well as save money on malpractice insurance rates and other expenses by purchasing as a group. The organization is structured so members share information on best practices and communicate regularly with the patients' primary care physicians.

"Very smart and experienced specialists are talking about the best way to manage care. There is real value added for the patients as well as for the HMOs because they know what to expect and they don't always have the resources or the expertise to manage diseases," he says.

Improving care by sharing information

One benefit of the organization is that it brings together groups of specialists who can share information and come up with the best practice models, Driscoll says.

"We can discuss how we can best manage patients with a certain disease and share information on the best techniques and the newest innovations that will allow us to get the patients through our offices quickly and efficiently, to the operating room, through the operating experience, and to educate them," he says.

The specialists share their experiences on techniques that have worked well for them. "There is a comprehensive series of things that need to be done on the patient's behalf. One member might do one thing particularly well and share the information with the others," he adds.

The specialists also sit down and review cases weekly with the primary care physicians at each hospital where they practice. "It has opened the lines of communications," Driscoll says. "We talk regularly rather than having to wait several days for a referral letter to be generated."

The face-to-face contact benefits both the physicians and the patients, he says.

"The primary care physicians can tell me directly what the patient needs. It gives me a better understanding of which patients have more critical problems, and I am able to see the patients with more acute needs more quickly," he says.

Having a comprehensive discussion with the primary care physicians helps the specialists establish patterns of treatment and makes it easier to treat the next group of patients, he adds.

"We discuss patients who are going to have surgery, those who have had surgery. We talk about how they are doing, their expected length of stay, and how we might improve them with therapy or alternative care, such as discharging them to transitional care or home with a visiting nurse service," Driscoll says.

The specialists intend to pool their knowledge and experience to develop their own best practices and critical pathways. Each of the hospitals where the specialists practice have critical pathways and patient outcomes plans, but the specialists want to write their own.

"The best practices change on an ever-present basis. We want to make sure that we are able to introduce innovations that are better for patients, such as minimally invasive technique," he says.

For instance, some innovations, such as laparoscopic surgery, are better for the patients but raise eyebrows with insurers because initially they seem more expensive, he adds.

"We want to look at our experience and be able to freely discuss those operations with our patients and with the insurance companies," he says. ■

When a full waiting room means business is bad

Better scheduling means happier patients

If your office typically has patients who sit in the waiting room for more than a few minutes or has a backlog of patients waiting for an appointment, act now to alleviate the problem before you lose your patients to a more efficient provider or you lose your contract with a health plan that emphasizes access to care.

When patients fill out patient satisfaction surveys, they often complain of waiting too long for appointments and spending too much time in the physician's waiting room.

For instance, in a recent survey conducted by *Consumer Reports* magazine, one-fourth of readers responded that their primary care provider "typically kept me waiting too long."[1]

"All over the world, and specifically in this country, patients tell us a very consistent story about what they want from their health care providers," says **Mark Murray**, MD, MPA, of Murray, Tantau and Associates, a Sacramento, CA-based consulting firm that deals with health care efficiency and scheduling issues. Murray has worked as an independent consultant and on projects with the Boston-based Institute for Healthcare Improvement.

He says the things patients value most are:

• the opportunity to choose their primary care doctor;

• a chance to get an appointment at the time they choose;

• a good experience in the physician's office. This means a short waiting time and a good relationship with their provider.

If a physician office is crowded all the time, the problem should be addressed, says **Randolph D. Smoak Jr.,** MD, president-elect of the American Medical Association.

"The office should run on time. It's a problem that should be addressed, whether it's because of scheduling or because the physician is always late getting back from the Rotary Club," he adds.

Value patients' time

Smoak cautions his fellow physicians to remember that a patient's time is valuable, just as a physician's time is valuable.

"Some patients have to lose time at work to make an office visit, or they may have a ride only at one certain time. There are many reasons why it is important to them to be seen on time," he says.

"You can improve patient satisfaction by decreasing patient waiting time. At the same time, you also increase productivity so that patients can get in to see the physician sooner for non-urgent care," says **Julie Elmore Jones**, MBA, MHA, a consultant with Atlanta-based Gates, Moore, and Co.

In the managed care environment, an increase in productivity is a major goal for most practices, and providers should take steps to achieve efficiency, Jones points out.

The problem could be scheduling, poor use of staff time, or not enough personnel. **(For a list of potential causes of patient backlogs, see story at right.)**

Whatever the cause, the adage "a stitch in time saves nine" could apply to solving the problems of patient waits. If you get behind this week, the problem could snowball so you'll be even more behind in the future. If it does get worse, you could lose patients, who will choose another provider who doesn't make them wait, or you could lose a contract with a health plan that puts a high premium on access to care.

Doug Hough, PhD, a partner with Arista Associates in Fairfax, VA, provides this scenario that illustrates the snowball effect of patient waiting time:

The physicians get behind, and patients have to wait for their appointments. Eventually, the patients start coming in late because they know they'll have to wait when they get there. Then, the physician office overbooks to compensate for the late patients. "And if everybody shows up at once, they're in big trouble," Hough says.

Or, if you have problems with an appointment backlog, the problems will only get worse unless you take steps to solve it, adds Murray.

When a patient calls a primary care physician whose schedule is completely booked, the staff may refer the patient to an urgent care center, Murray says.

Many times, the patient wants to be seen again by his or her own doctor after the urgent care visit. This increases the cost of treatment and causes a lot of dissatisfaction, he notes.

"When patients have to be referred to an urgent care center because the schedule is backlogged, this means practices have failed to develop a system that ensures that patients see their own doctor when they are ill," Murray says. "The result is additional cost to the patient or the insurer and ill will toward the physician."

Reference

1. Rating the HMOs. *Consumer Reports* 1999; 64:23-28. ■

Six common causes for office backlogs

If your office has a constant backlog of patients waiting for appointments and waiting to see the doctors once they arrive, here are some potential problem spots:

1. **Appointment scheduling.**

Some practices schedule in 20-minute time slots regardless of why patients are coming in, and despite the fact that some physicians work less quickly than others. This can cause backlogs and idle time for physicians, says **Julie Elmore Jones**, MBA, MHA, a consultant with Gates, Moore and Co. in Atlanta.

2. **Inappropriate staffing.**

Where the staffing problem lies is unique for each practice, Jones says. It may be that there are too many people in checkout and not enough lab technicians to handle the volume

CPT codes can help solve scheduling woes

Study helps determine 'ideal patient hour'

If you look at how your patients are distributed according to CPT codes, you can determine your "ideal patient hour" and come up with an efficient way to schedule them, declares **Doug Hough**, PhD, a partner in Arista Associates in Fairfax, VA.

An analysis of your CPT codes can point out the types of patients each physician in your practice is seeing and help you come up with a schedule that makes the best use of each individual physician's time, he adds. You can determine how many patients each physician is seeing for limited visits vs. extended or comprehensive visits, and the number of new and established patient visits.

"If you look at the distribution, you can construct what your ideal patient hour is so that if you're seeing a lot of patients for extended office visits, you can schedule fewer patients," he adds.

For instance, if 80% of your patients are CPT codes 99213, 99214, and 99215 (intermediate, extended, and comprehensive) and only 20% are minimal and brief visits, you should schedule five patients in an hour, expecting that three will take 15 minutes and the other two seven and a half minutes each, Hough says.

Hough suggests analyzing the visits scheduled in a typical month, not the busiest or the slowest month. "A good practice ought to be looking at the distribution of CPT codes for billing purposes, anyway,"

Your analysis should include a separate analysis for each physician in the practice. "Each physician has a different patient load and different requirements, and each physician takes a different amount of time depending on his or her practice style," he says.

For instance, a CPT 99213 should be a 15-minute visit, but some physicians take 20 minutes while some take 10 minutes, Hough says. "Younger physicians typically haven't been broken of the habit they learned as a resident: It takes half an hour per patient. But established practitioners have different practice styles, and their schedules should reflect it." ■

of laboratory procedures. Or it could be that physicians can't complete their examinations in a timely manner because there aren't enough medical assistants.

"They're flipping on the light, and no one is there to assist them. Instead of having everything they need, the physicians have to go and get it themselves," Jones says.

3. **Inefficient handling of medical records.**
Sometimes the patient gets to the exam room long before the medical record. This leaves the physicians standing around with nothing to do. "It's extraordinarily wasteful and expensive and upsetting for the physicians," Jones says.

4. **Double- and triple-booking.**
Booking several patients for one appointment time may seem like a good solution, but if all patients show up at the same time, you get even further behind.

5. **Delayed test results.**
These may be caused by a backup in the on-site lab or communications problems with the off-site lab.

6. **Inefficient use of physicians' time.**
Some delays occur when a physician has to spend time on patient care issues that don't need a physician's attention, according to **Doug Hough**, PhD, partner at Arista Associates in Fairfax, VA. ■

Easing patient backlog takes work and ingenuity

Here are some solutions to consider

It's possible to eliminate a patient backlog, but it takes work, experts say.

"It takes everybody in the whole practice to work together and look at how they can treat the greatest number of patients most efficiently," says **Tom Aug** of Development Partners, a Cincinnati-based firm that specializes in patient satisfaction improvement for physician group practices.

Here are some suggestions for improving patient flow that Aug and other consultants have put into practice:

Keep it simple when scheduling appointments

Too many variations can worsen your backlog

The existence of multiple appointment types and corresponding appointment times has impeded access to care, says **Mark Murray**, MD, MPA, a consultant with Murray, Tantau and Associates in Sacramento, CA.

"As physicians, we have created categories of appointment types in a vain attempt to control demand. What we ultimately do is increase waiting time. We create a lot of variation and increase waiting time in a vain attempt to control demand," he says.

"Wave scheduling" may be the solution to some office backlogs, says **Doug Hough**, PhD, a partner at Arista Associates in Fairfax, VA. If a physician typically sees five patients in an hour, the classic way to schedule is to set one appointment on the hour, the next at 10 minutes after the hour, and so on.

Instead, Hough has found it effective in some practices to schedule patients in waves. This means scheduling three patients on the hour and two on the half-hour. "Many times, patients won't show up on time. This way, the first one that gets there gets in immediately," Hough says.

He adds that wave scheduling often helps physicians use their time more efficiently so they are behind less often. One potential drawback is that if all patients show up at the same time, one of them has to sit in the waiting room for 20 minutes.

However, that's not likely to become a problem, Hough adds, "because most of the time patients don't show up exactly on time." ■

• **Spread out your complicated appointments.** For instance, don't schedule back-to-back physicals or other procedures that take physicians a long time. In scheduling, medical offices need to set some time aside for extended office visits as well as the limited visits. **(To learn how to tell how many of each kind of visit to expect, see box, p. 128.)**

• **Add examination rooms.** Have enough examination rooms so people don't have to wait long for an open spot. If the wait is going to be 20 minutes, have patients wait for 10 minutes in the waiting room and 10 minutes in the examination room, Hough suggests.

"Psychologically, it tells them they're moving along. It may require additional expense to have more examination rooms, but in terms of patient satisfaction, it goes a long way," he adds.

• **Standardize the examination rooms.** This enables each room to be used for flexible purposes and ensures that staff know where all items are located, suggests **Mark Murray**, MD, MPA, with Murray, Tantau and Associates, a health care consulting firm in Sacramento, CA, specializing in efficiency measures for physicians and hospitals.

• **Consider hiring midlevel providers.** Hough suggests that practices consider hiring a physician assistant or nurse practitioner to handle some of the routine patient care. "Some people say they can't afford the additional expense, but I can demonstrate that within a reasonably busy physician practice, a nurse practitioner will earn her keep two- to threefold," Hough says.

• **Track the waiting time for every patient, every day.** Just tracking the waiting times so staff can see them may be a way to alleviate some holdups, Aug says.

He suggests having a space at the top of the encounter form that tracks the time the patient arrives, when the patient is called into the examination room, when the patient is seen by the physician, and when the patient checks out. "If the physician looks at the form before they see the patient, they can apologize for the delays and be aware that they are running behind," Aug adds. Sometimes, if other staff notice the delays, they'll make an effort to improve the patient flow, he says.

• **Consider extending your hours.** Look at how your practice as a whole can be available to patients for more hours in the week, Aug suggests. "Physicians should look at their patient population to see how they can create a schedule that will benefit the [biggest] number of patients," he adds.

For instance, physicians in the office could rotate working late on certain days to see more patients, Aug suggests.

• **Schedule additional appointments for patients with multiple problems.** If a patient

makes an appointment to take care of one problem and then mentions three or four other problems to the medical assistant, that visit can disrupt the entire day's schedule, Aug points out. He suggests that the medical assistants ask the patients to make another appointment for their less-urgent complaints. "It doesn't sound patient-friendly, but it can disrupt things for the rest of the patients if one person is allowed to monopolize the staff's time."

He suggests that the medical assistant tell the patient: "These problems require a lot of time to deal with, and we're on a tight schedule today. We can schedule another appointment so you can get the attention you need."

• **Synchronize your systems.** Take steps to make sure the patient, the provider, and the paperwork all start at the same time, Murray suggests.

• **Reduce the need for unnecessary visits.** "The key linkage to eliminating unnecessary visits is between the doctor and the patient. There are a lot of strategies you can put into place," Murray adds. Some suggestions include increased telephone triage and doing more with each visit to decrease the total number of visits.

• **Work longer hours to catch up on your current backlogs.** "This takes work. Basically, physicians have to work more for a short period of time to get the backlog eliminated," Murray says.

"Our mantra is, 'Do today's work today.' What we see in most organizations is that they're doing last month's work today," Murray adds. ■

Analyze patient flow to solve scheduling woes

Methods help you identify the bottlenecks

A patient flow analysis can track the experiences of both patients and providers and give an overview of what is happening during clinic hours, says **Julie Elmore Jones**, MBA, MHA, a consultant with Gates, Moore & Co., an Atlanta-based health care consulting firm.

The process can give you internal management information such as staff mix and utilization, an analysis of your appointment scheduling methods, and problem areas or glitches in the way patients move through the system.

"It's a relatively easy thing to do, and it gives you a wealth of great information," Jones says.

Here's how a patient flow analysis works:

Each staff member who comes in contact with patients fills out a personnel registration form that includes his or her job and an assigned code number. Staff members log in when they begin seeing patients and log out when they take a break. This tracks each staff member's actual time on the job.

A patient registration form is attached to the medical chart and follows the patient through the visit. Every time staff who work in the practice come in contact with the patient, even if it's for 10 seconds, they enter their code and log in the time their face-to-face contact starts and ends. For instance, if the medical assistant calls a patient in, takes the history, weighs the patient, and sends the patient to the lab, the assistant logs his or her time in and time out with the patient.

The person who is the primary caregiver for the patient, in most cases the physician, initials the form, records the time in and time out, and includes the reason for the visit.

Once the study is complete, Jones checks the data for accuracy, then enters them in a computer program that analyzes the schedule and pinpoints bottlenecks.

"Often, practice managers and administrators already have a sense of what the problem is. When you get statistical tables and graphical representations of where the problems are occurring, you see not only what is happening to the patients but what is happening to the physician," Jones says.

The studies give you the tools to determine where the bottlenecks are occurring and how to eliminate them.

For instance, if it appears the well-patient visits are taking too long, you could find that there is a backup in the lab or that the examinations were not scheduled appropriately for the physician who was doing them that day.

"Some physicians work more quickly than others. Some practices schedule 20-minute appointments regardless of who is doing them. The patient flow analysis can point out these problems and help you schedule for maximum efficiency," Jones says.

While you can do a patient flow analysis

If they have to wait, tell them why

Honesty will pay off in happier patients

Sometimes, no matter how hard you try, patients are going to be faced with a lengthy wait to see a physician. When this happens, keeping patients informed and giving them the opportunity to reschedule can go a long way toward keeping them happy, the experts say.

When patients get to the office, they should be told how much time they can expect to wait before seeing the physician and the reason for the delay, says **Doug Hough**, PhD, a partner with Arista Associates in Fairfax, VA. Like airlines, physician office personnel are getting a bad reputation for lying about how long the delay will be, he says.

In today's market, a physician's business integrity is almost as important as his or her professional integrity, he says. This means that every staff member should be honest about the length of the delay and the reason for it, Hough adds.

Physicians and their staff should keep in mind that patients often have to lose time at work to see a doctor; patients may be depending on someone else for transportation; or they may have an appointment at another doctor's office.

"It seems simple for the receptionist to inform the patient who is waiting if the doctor is running late. Keeping the patients informed and giving them an opportunity to reschedule is good office management and good public relations with the patients," adds **Randolph D. Smoak Jr.**, MD, president-elect of the American Medical Association.

Hough's clients have reported that patients are usually understanding if they are told the doctor has had an emergency.

"If they are informed, their psychological clock doesn't start ticking until the physician is back in the office," he adds.

Hough recalls a physician client who came up with an amazingly simple way to keep his patients happy while they were waiting to be seen.

The office was set up so that when the physician went from one examination room to another, he passed by the waiting room, made eye contact with the patients there, and told them he'd be with them soon.

"One of the things that drives patients crazy is when they have no idea whether the physician is even there. They think he's on the phone or out to lunch. If they can see that the doctor is there and working hard, their frustration level goes down," he says. ■

yourself, Jones recommends using a consultant or external advisor to give a fresh perspective to the problems and issues in your practice. "Much of the survey deals with observations and interviews with the physicians and key staff. Often, people who work every day in a practice have difficulty seeing that things could be done differently. It's the same with all of us," she says.

If you decide to conduct the analysis in-house, choose the practice manager or someone else who does not normally come in contact with the patients, Jones advises. "If you come in contact with patients, you are part of the study. You can't be in the study and implement it."

The purpose of a patient flow analysis is to see what happens under normal circumstances. If one person is removed from the normal process, you can't get a good sense of what is happening, she adds. ■

Practice accreditation: The next big thing

NCQA says it will make your life easier

Although it's still about a year away, the National Committee for Quality Assurance (NCQA) in Washington, DC, is planning a new accreditation program for physician practices. According to communications manager **Brian Schilling**, the NCQA is still trying to find funding from several grant sources. "That makes it premature to discuss what the program will look like or when it will come out," he says. "But we do think it's important, and we do want to do this."

The committee already has a basic preferred provider organization accreditation program. A

SOURCES

- **Brian Schilling**, Communications Manager, National Committee for Quality Assurance, Washington, DC. Telephone: (202) 955-3500.

full set of standards for it is due out in July 2000. Once that has been completed, says Schilling, the NCQA would like to start getting a physician organization accreditation program under way.

While some practices may view such a program as just one more administrative hoop they'll have to jump through, Schilling says it should lessen the number of quality assurance programs you'll have to contend with. "This is a recognized name in quality assurance that could be a marketing tool for a practice," he says. "And it is a way to streamline what you now have to do for every plan you work with. This could take the place of many or all of the individual accreditation programs you have to go through. That could result in substantial savings for both health plans and for physician organizations."

The physician practices that are part of the NCQA advisory board like the idea, and Schilling says it may be very attractive in markets where physician organizations contract directly with employers, such as California.

Although there are no specifics yet on what kinds of requirements the new accreditation program will have — and a pilot program hasn't even been discussed — Schilling says any program likely will have a lot of the same "characteristics and flavor" of other NCQA accreditation programs. "Some of the standards may be identical to those we use for our MCO accreditation," he says. "But this is still under development." ■

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