



THE PRACTICE REVOLUTION

Doctors being forced to work longer hours to stem the red ink are seeking refuge in a movement that is sweeping the profession.

Re-engineering is producing impressive results
in trials across the country.

By John Zicconi

Family physician Dave Spoelhof's plight is all too common.

Working for a practice that is losing money, Dr. Spoelhof's employer recently took steps to make his office more productive. In January, the Minnesota-based HMO he works for increased his office hours, demanding he see more patients.

The 46-year-old now works harder and has less time not only to see his family but to consult with his five partners. At work a half-hour earlier every morning and an hour later every evening, he not only gets less sleep, but he often misses dinner with his family.

"When I get home, the kids are already off to activities or doing homework," Spoelhof says. "I miss dinner, which disrupts the evening. Things kind of flow from there. Communication is less."

Interaction within the office has also diminished, Spoelhof says. He and his partners are now so busy squeezing phone calls, dictation, and paperwork into their busier day that they find less time to collaborate, he says.

"We don't talk as much amongst ourselves," Spoelhof says. "The chance to pass along experiences or ask for a curb-side consultation has been reduced."

On salary, he receives no additional compensation for the increased workload.

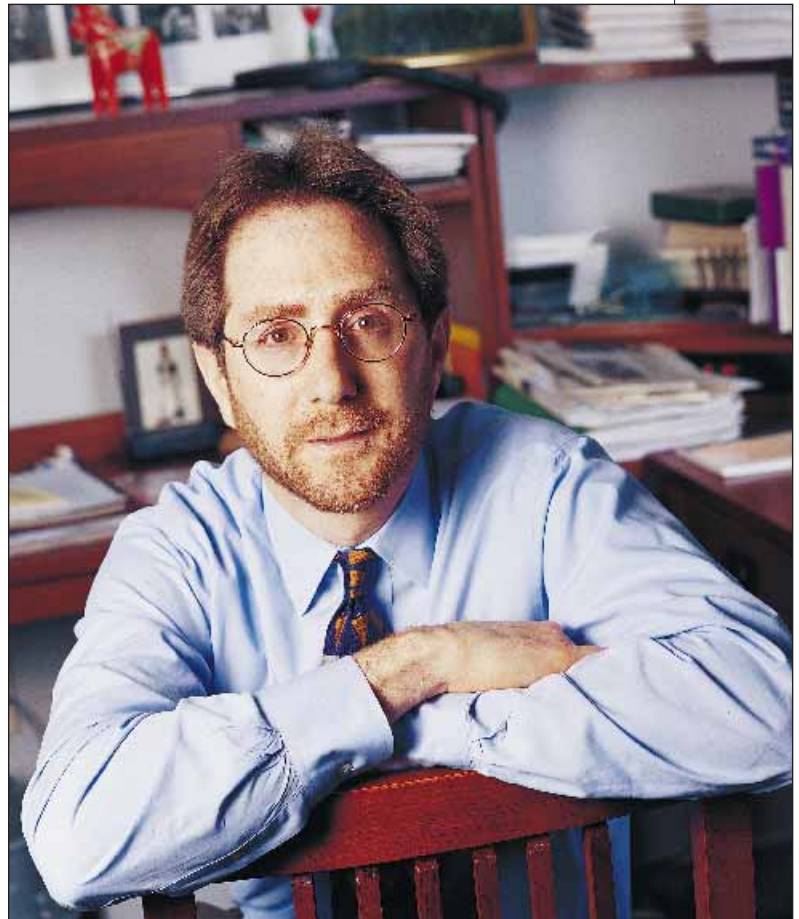
"This was pretty much handed down to us," Spoelhof says. "We'll pull together and do our part, but don't expect us to be enthusiastic. We are trying to do our best, but nobody is pleased."

Officials at First Plan, the small HMO that

employs Spoelhof, say the reason for the change is simple. The three clinics First Plan owns are losing a combined \$500,000 annually. Increasing office hours an average of five hours per week per physician is necessary to stop running red ink.

"The goal is not to make money," says Kathy McNamara, the director of First Plan's clinic

Continued



Dr. Charles Kilo, a Boston-based internist, says physicians shouldn't focus on how many patients they see in a day. "Our targets should not be set on visit volume, but on how we provide really optimal care for the largest number of individuals possible in our practice," he says.

RE-ENGINEER YOUR PRACTICE

Continued

operations. "The goal is to break even." Making doctors work longer hours is one way to make additional revenue, but it is not the ideal, McNamara says. First Plan has just begun looking into ways to completely reengineer its clinics. New techniques are being developed to allow physicians to increase their panel size—in

some cases by 100 percent—without forcing them to work more than an eight-hour day.

First Plan is interested in making several changes including using nurse practitioners to help create better access, seeing patients through group visits and using the Internet to supplement care. In March, McNamara attended a conference sponsored by the Institute for Healthcare Improvement (IHI) to learn more about these

and other reengineering techniques. IHI is a nonprofit organization based in the Boston area founded in 1991 with a mission to improve health care.

HMOs must alter the way they operate if they hope to survive, McNamara says. First Plan will soon construct two new clinics at a combined cost of nearly \$5 million. The buildings, which will include conference rooms for group visits, have been designed with changes in mind, she says. "We want to be the first in our area to do these things,"

A Different Road to Redesign

The Institute for Healthcare Improvement's Idealized Design initiative may be getting national attention, but its concepts are not the only ones being used to re-engineer physician practices.

Health-care consultant Roger Coleman has been preaching modernization since 1993. He is somewhat skeptical of seeing patients in groups and using the Internet to deliver follow-up care, but he agrees working down the backlog to free up a physician's schedule is imperative.

"Open access is right on the mark," Coleman says.

Focusing on what he calls office "cycle time," Coleman teaches physicians and their staff how to limit the time patients sit in the waiting room. Aside from being granted an appointment the same day they call, patients should spend no more than 35 to 40 minutes in the office, he says.

"The average time a clinician sees a patient is only 13 min-

utes," Coleman says. "That is not a hell of a lot of time. So why does someone have to spend 60 to 90 minutes in your facility? Our answer is because we have never choreographed getting a clinician, a patient, and a medical data base in a room on time."



COLEMAN

Coleman, the founder of Coleman Associates, which is headquartered in Nashville, organizes health-care employees into teams. Each doctor is given a support staff that answers to his patients exclusively. The team includes both back and front office personnel.

Patients are taken from the waiting room to an exam room with no other stops. Team members communicate through devices like walkie-talkies. All of the patient's needs, including laboratory tests and taking financial in-

formation, are done in one room.

"The exam room becomes not the garage for the practitioner, but the office for the patient," Coleman says. "We tell people not to organize the patient around the staff, which is the way it works now as they are taken from window to window, but to organize the staff around the patient."

Coleman also preaches eliminating procedures that waste time. Many nurses weigh every patient and take their temperature when neither weight nor fever are a concern. They also ask questions the doctor is sure to repeat.

"We want to get all the debris out of the way," Coleman says. "Most of our day is clogged by work that doesn't lend any effectiveness to patient care. It only leads to crummy service. The whole idea is to squeeze that work out."

Traditional duty lines are also broken under Coleman's system.

Once the focus is on the patient and not the staff, everyone is free to "run the fast break" and take care of what the patient needs next, Coleman says.

"During one redesign test, the doctor went out in the waiting room to get the patient because he was the team member free at that moment," Coleman says. "When was the last time you ever saw a doctor in the waiting room?"

Within six months, re-engineering to this team approach decreases cycle time 25 percent and increases staff productivity 27 percent, Coleman says. This not only allows the physician to see more patients, but also makes patients happier, he says.

"There is a lot of resistance from the staff to move to these new models," Coleman says. "But the patients love it because they become the center of attention. They are startled by the level of service they get, and it's economical." ■

RE-ENGINEER YOUR PRACTICE

Continued

McNamara says. “I’ve talked to my docs and we all agree there has got to be a better way. But making changes will also give us a competitive edge. That is why we have to be first. We certainly can’t be last.”

Re-engineering health care

First Plan’s situation is hardly unique. Nationwide, health plans are running large deficits and searching for ways to boost

their bottom lines. Many are leaning on doctors to see more patients. But those who are just adding time to a physician’s schedule without looking to redesign the entire way office care is administered are likely doomed to failure, says Dr. Charles Kilo, a Boston-based internist who works with IHI.

“Everybody out there is focusing on visits, but that doesn’t mean it’s the right thing to do,”

Kilo says. “The key industry measure of throughput today is visit volume—how many people you see on a daily basis. That is an outdated mode of thinking. A more appropriate mode is thinking about how many patients or customers we care for in total, our panel size.

“Our targets should not be set on visit volume, but on how we provide really optimal care for the largest number of individuals possible in our practice. Most panel sizes range from 1,500 to 2,500. We are looking to double that while providing better customer service and higher quality care at the same time,” Kilo says.

In the second year of a three-year initiative titled the Idealized Design of Clinical Office Practices (IDCOP), IHI has reengineered 42 health clinics including some associated with Vanderbilt University, Harvard, and the Mayo Clinic. The institute has yet to produce publishable results, but early anecdotal evidence has many in the industry calling the work revolutionary.

IDCOP techniques not only allow physicians to double their panel size but also eliminate the scheduling backlogs that force patients to wait months for routine procedures like physicals and pap smears. Using a combination of group visits and follow-up methods other than office visits, IDCOP doctors are reporting greater professional satisfaction, but with drastic increases in both patient satisfaction and clinical outcomes as well.

Clinics are also reporting a reduction in health-care costs.

When patients have better access to their doctor, they are both healthier and use lower-cost segments of their network. Emergency-room visits and hospitalization drop, as does the need to see specialists. Patients are also happier, so they are less likely to doctor shop or change their health plan.

In Colorado, a Kaiser Permanente clinic specializing in geriatrics recently completed a study that saved nearly \$600 per patient annually just by offering group visits to high-utilizing patients. Those seen in groups not only required less care, but were 2.5 times less likely to leave Kaiser than the control group.

“Kaiser Permanente wouldn’t even let me



Dr. John Scott led a study in Colorado that saved nearly \$600 per patient annually for a Kaiser Permanente clinic specializing in geriatrics. The program, now mandatory in most regions, offers group visits to high-utilizing patients. During the 90-minute sessions, Scott is able to see about 20 patients.

RE-ENGINEER YOUR PRACTICE

Continued

talk about this until we proved it was economically feasible," says Dr. John Scott, an internist who led the Colorado study. "Now it's mandatory in most of our regions."

See patients sooner

The single most important aspect of office redesign is working down the scheduling backlog to open space so patients can be seen immediately. Not only does this make the physician more flexible so he can increase his panel size, but it keeps patients both healthier and happier because they can be seen right away.

Eliminating the backlog also reduces work for the office staff. People in line consume resources. They call back more often and tend to come in more frequently. Sometimes they don't show, so staff must make phone calls or mail post cards as reminders. And patients asked to wait can get sicker, ending up in the high-cost emergency room.

Re-engineering advocates say making patients wait has no health-care advantage, it is just convenient for the doctor. But what most physicians fail to realize is the wait actually works against them. Although they believe people in line equates to financial stability, all it really does is tie their hands, they say.

"We believe pushing demand out to the future protects us," says Mark Murray, a California-based family practitioner working with IDCOP. "Doctors think the way I can protect myself today is to make you convince me or my nurse how sick you are. If you are really sick, I will see you. If you are not so sick, I'm going to push you out to the wait time."

"But that triage component of dividing people into urgent and routine really is a waste. There is no value added to the doctor. I'm still going to see you three months from now, so making you wait hasn't added any value. All

that triage is really a waste of time and resources."

If the long wait is to see a specialist, the patient's primary-care doctor often runs up an unnecessary bill before the patient can be seen, Murray says.

"As people wait, their family doctors write more prescriptions and orders more unnecessary and useless tests," he says. "When you have somebody waiting three months to see the orthopaedic doctor you have primary-care docs ordering MRIs just to keep people happy. If they could see the orthopod right away, these tests would not occur."

To open access, a physician must treat patients outside the office-visit model. If the doctors' daily schedules are going to be left open for the sick, alternative methods must be used to meet routine needs.

Phone calls, e-mail, and either nurse practitioners (NP) or physician assistants (PA) must be used to provide follow-up care to the working well. A patient suffering from seasonal allergies does not need an office visit. Once the physician has a relationship with this kind of patient, prescriptions can be filled after a short phone call or by trading e-mail.

An NP or PA who consults regularly with the doctor can care for chronically ill patients on a regimen.

Buffalo internist Allyn Norman maintains a panel of nearly 6,000 patients. He employs a nurse practitioner, 1.25 registered nurses, a medical office assistant, two secretaries, and a half-time accounts receivable person. He pushes his medical support team to its limits, and makes good use of the telephone and fax machine.

"We have an expansive use of RNs to do things at a level that are within their scope of practice but pushes them to the maximum of what they can do, but always with direct physician supervision," Norman says. "Say a person

comes in with hypertension. I will do whatever laboratory evaluation is necessary and will commit the patient to some therapeutic regimen.

"Then, as a general rule, I'll have the patient followed by the RNs who have protocols for modifying therapy within certain boundaries without [the patient] having to come back to me. So by the time I see the patient again in a month or three months, basically they are controlled."

Norman has both hypertensive and diabetic patients self-monitor blood pressure or blood sugar and fax or e-mail daily counts to his office. His staff monitors the numbers, and he gets back to the patient via phone with therapy modifications.

"I'll accept the information by e-mail, but I will usually get back to them by voice so we can interact after that," he says. "A lot of people prefer this. They can deal with it at their own convenience."

This approach is also profitable. Keeping well people out of the office or by caring for them in ways other than doctor visits allows the physician to see patients with higher acuity and higher reimbursements.

"When I look at the medical economics journals, I'm in the top one percent of what internal medicine potentially can earn, and at the level of what a lot of the surgical subspecialists are," Norman says.

System replaces chaos

Doctors entrenched in the old office model often believe working down their backlog and opening access will create chaos, Kilo says. They are afraid to leave 70 percent of their day unscheduled because patients either would flood through the door or no one at all would show. Neither of these things will occur

RE-ENGINEER YOUR PRACTICE

Continued

as long as the doctor's panel size is appropriate, he says.

"It actually boils down to science," Dr. Kilo says. "Demand is satiable. If you study demand in your population you can predict it. Your demand for care on a daily basis, whether it be e-mail care or visit care, is directly related to the size of your panel.

"Once you understand your demand, it's a relative Bell-shaped curve. On some days you're a little over your estimate, and some days you're a little under. But that degree of variation is actually less than what practices are currently experiencing. Why? Because doctors have all kind of no-shows and cancellations, or they are trying to double and triple book because sick people call. The current system is a true system of chaos. What we need to do is really understand the science behind the management of systems."

Group visits are another way to manage demand. Some doctors have running groups that meet monthly, while others hold weekly, drop-in sessions for those requiring immediate care. In both cases, the groups are filled with similar-type patients—relatively stable, chronically ill people who need routine follow-up care.

In Colorado, Dr. Scott holds monthly sessions with set groups of geriatric patients and their spouses. All have at least five major medical problems and are on an average of nine medications. Groups work well for these patients because everyone's needs are similar, he says.

Instead of spending 15 minutes twice a month with each patient, Scott spends at least 90 minutes once per month with a group of about 20. These people form strong bonds and actually get more attention in the group than they would during individual office visits, he says.

In the group, time is set aside for

patients to share personal experiences as well as for the medical team to educate patients on a variety of topics like medications, nutrition, and exercise. During a preplanned snack break, the doctor and a nurse seek one-on-one conversations and take care of normal visit issues like refilling prescriptions and taking blood pressure. A fifteen-minute question-and-answer session ends every group visit, but another hour is reserved for individual appointments as needed.

"During the group, about three or four will tell you they need to see you afterwards, and you tell three or four they need to stay," Dr. Scott says. "You leave an hour for afterwards, but it's an incredibly efficient hour because you have taken care of all the social and emotional stuff in the group. These people have already been with you for 90 minutes so they just want to get their business done and get out of there."

Drop-in groups work similarly. Physicians set aside 90 minutes for a particular type of patient—diabetes, Parkinson's, stroke, hypertension—and people attend one of three ways: They can drop in, physicians can schedule them after a one-on-one encounter, or a scheduler can call patients the doctor would like to see.

"Roughly speaking, groups leverage a primary-care physician's time 300 percent and a specialist's time 400 percent," says Edward Noffsinger, a retired health psychologist who consults with doctors interested in drop-in groups. Group visits "are not meant to replace individual visits, but rather to work in conjunction with judicious use of individual visits. They are best looked at as an extended medical appointment.

"Patients who are the worried well, people who have extensive psychosocial

needs, and those who are depressed, angry or distrustful of their health care do very well in groups."

Early results impressive

Most reengineering efforts are still in their early stages. Scott, who has been conducting group visits for nine years, has published data supporting his claims of increased physician satisfaction, improved medical results and cost savings. But proof these other measures will have the same results is still some time away.

The IHI is keeping data on its 42 ID-COP locations, but the initiative is still a year and a half from completion. This lack of hard evidence, however, is not deterring health plans from mimicking its protocols.

Dennis Horrigan is the vice president of managed care and development for Independent Health, a non-profit HMO serving 400,000 members in upstate New York. Two of his 2,800 doctors, including Dr. Norman, are part of IDCOP. Horrigan is so impressed with what he has already seen he is taking steps to re-engineer 15 more offices on his own.

Our doctors "have done some good work in their practices, but when you see the work of the Mayo Clinic, Vanderbilt, and some of the other big sites you realize this concept is just sweeping across the U.S. medical system," Horrigan says. "When I left the IHI conference (in March), the American academies of pediatrics, family physicians, and neurologists were all coming in to talk about how to take this stuff and bring it into their specialty societies."

Physicians working for a capitated HMO have an advantage because they can institute group visits and other cost-saving methods without worrying about reimbursement. Doctors beholden to third-party payers are in for a rougher ride.

Blue Cross/ Blue Shield Medical Di-

RE-ENGINEER YOUR PRACTICE

Continued

rector Dr. Doug Hiza is a proponent of reengineering and alternative care methods. He believes they can lead to better outcomes and cost savings. But convincing the “bean counters” at the Blues and other insurance companies is not going to be easy, he says.

“What terrifies my chief financial officer or the people in charge of contracting most is a new way to spend money,” Hiza says. “If you open the window to pay for things like telephone calls or group visits, how do you monitor fraud and abuse?”

“Medical directors look at these things and say they look like interesting and valuable ways to provide patient care. We think this is intriguing. But it needs a better developed business plan and proof of content. If by seeing 20 people in a group visit you can save five ER visits and one hospitalization, that would more than pay for that kind of thing. And that is the kind of balance we need. We need to be able to look at the experiences—and it’s all statistical—that show costs will at least remain the same.”

Re-engineering advocates realize this and say they are up to the task.

“The key to whatever we do has got to be data driven,” Scott says. “It’s got to be provable to the health-care organizations so they will adopt it. It has to be provable to the payers so they will want us to do it. And the patients have to believe it is a better way of doing what we always used to do.

“Once big systems and universities that are beyond moral reproach start publishing that you can get better results, start making doctors happier, and you can make it more affordable medicine by doing these new things—that is what will change the world. That is when the bureaucrats will start taking notice.” ■

John Zicconi covers politics and government for the Stowe Reporter. He was the recipient of the New England Press Association's 1999 award for general news reporting.