Streamlining Workflow In the Practice Pays Off

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PHILADELPHIA — Office-based physicians who maximize efficiency can see more patients per day without any loss of quality—in fact, smoother workflow can actually boost patient satisfaction, Dr. Mary S. Applegate said at the annual meeting of the American College of Physicians.

Improved efficiency can have "huge financial implications." By saving 2 minutes per patient, physicians can see two more patients daily. At $50 per patient, this amounts to $10,000 more per year. Alternatively, doctors can choose to work a shorter day, going home about 45 minutes earlier instead of seeing those two extra patients, added Dr. Applegate, a family physician in a small group practice in rural Ohio.

One pressing reason to improve efficiency is the anticipated effect of pay for performance and other mandated initiatives. Physicians already have too much to do, and they need to find ways to protect their sanity if their workload actually escalates, she said. "In the end, we all don't want to become psych patients!"

In the past year, Dr. Applegate and her colleagues—two other physicians and two nurse practitioners—looked critically at workflow and practice design to identify these strategies for enhancing time management:

► **Delegate all "nondoctoring" tasks.** Physicians should not spend their time on simple activities such as taking blood pressure, administering vaccinations, handling prescription refills, and filling out forms. Midlevel providers—nurse practitioners and physician assistants—can do a lot of these tasks. Designate a "queen of forms," typically a nurse, who can fill in codes and dates; the physician may only need to sign. Save your time for diagnostic dilemmas and treatment failures, Dr. Applegate suggested.

► **Give staff clear instructions on handling common situations.** Flowcharts work well and can empower paraprofessionals to manage various problems and tasks without consulting physicians.

► **Cross-train your staff.** Avoid situations where only one person knows how to do a certain task; when that person is out, workflow is disrupted. Staff members may be happier with more variety once they are comfortable with the new responsibilities, but "the transition sometimes can be difficult," she noted. To ease the transition, offer incentives to staff members willing to learn new things.

► **Avoid routine phone calls.** Although you may need to return calls to other physicians personally, a staff member can call patients back on routine matters. If bad news needs to be communicated to a patient, this should be done in person.

► **Organize work space logically.** Look at how the exam rooms, equipment, and inner offices are arranged and consider whether simple changes could streamline tasks that physicians and staff perform repeatedly. Simply moving a patient scale, or buying an extra one, might save snippets of time that can really add up. All exam rooms should be stocked with the same supplies and should be set up identically if possible, Dr. Applegate said.

► **Listen to your patients.** The patient interview will actually go faster if you do not interrupt. Patients talk for only about 60 seconds if they are not interrupted, she said. The patient feels heard, and clearer communications can lead to greater patient satisfaction. Make eye contact, sit down with the patient, and briefly touch the patient reassuringly or shake hands.

Flowcharts work well and can empower the paraprofessionals in the practice to manage various problems and tasks without having to consult the physicians.

► **Avoid batching of unpleasant or difficult tasks.** Putting off work until later in the day when you're probably tired—and have forgotten some details about a patient encounter—can become "an unhealthy addiction," she said. One task that physicians often batch is writing notes in patient charts. The inefficiencies can add up when errors are made and patients are dissatisfied with their care down the line.

► **Work in real time and get the job done.** This is the opposite of batching: Stay focused and complete the entire patient encounter before that patient leaves. It is fine to look up information and even dictate in the exam room with the patient present. When some tasks unavoidably accumulate, set a rule that you will stop at regular intervals (for example, every two to four patients) to catch up before taking the next patient.

► **Be a team player.** Huddle with your staff for a few minutes every morning and afternoon to set a game plan and take control of the day before it controls you. This can help prevent glitches that would eat up valuable time. "Empower the staff to help you stay on time," Dr. Applegate said.

► **Take care of yourself.** Balance work demands against personal time to avoid burnout. Physicians who neglect their needs for downtime and recreation are less productive and efficient. In extreme cases, this can lead to financial losses and even bankruptcy, she said.

► **Embrace and use new technology.** Use the available tools for billing, coding, and communications. Electronic medical records are not perfect and the transition can be painful—"It's like 3 months of pure hell"—but they are becoming a necessity. The need to log lab results for pay for performance is "the single best argument for an EMR," Dr. Applegate added.

The most important take-home message is to avoid batching difficult tasks, she emphasized. Get it done in real time. "It really does work!" ■

POLICY & PRACTICE

Uninsured Get Inefficient Care

The uninsured not only face a "downward spiral" in health, they also experience inefficiencies in care, a report from the Commonwealth Fund found. Uninsured persons are more likely to go without the care or screening tests that could prevent serious health problems, are less likely to have a regular doctor (41% vs. 86% of insured adults), and are more likely to face fragmented care. "Nearly one-quarter (23%) of adults who are currently uninsured or had a time uninsured reported that test results of records were not available at the time of a doctor's appointment, compared with 15% of insured adults. Nearly one-fifth (19%) of uninsured adults had duplicate tests ordered, compared with 10% of insured adults," the study said. Researchers found that an "alarmingly high proportion (59%) of adults" with chronic illnesses such as diabetes and asthma who were uninsured for a time in the past year went without their medications because they couldn't afford them. The findings are from the Commonwealth Fund Biennial Health Insurance Survey, a nationally representative sample of 4,350 U.S. adults aged 19 years and older, conducted via phone August 2005-January 2006. This analysis focuses on the population aged 19-64.

Glaucoma Screening

Hispanic Americans aged 65 years and older are now eligible for glaucoma screening under Medicare. Medicare will pay for glaucoma screening exams provided by (or under the direct supervision of) an ophthalmologist or optometrist who is legally authorized to perform the services under state law. At least 11 months must have passed since the last covered screening. In 2002, Medicare began covering glaucoma screening for patients with diabetes, those with family history of glaucoma, and for African American beneficiaries aged 50 years and older—all of whom are considered to be at high risk for the disease.

FDA Eyes Phase IV

The Food and Drug Administration has hired a contractor to conduct a thorough evaluation of the postmarketing study process for collecting information about drugs, devices, and biologics, the agency said in a statement. Such phase IV studies help to further define a product's safety, efficiency, or optimal use, the agency said. "Greater internal consistency across the medical centers at FDA for requiring, requesting, facilitating, and reviewing postmarketing study commitments" is the goal. Booz Allen Hamilton was awarded the contract last month, and is expected to take about a year to finish, according to the FDA.

Part D Cash Flow Woes

Administrative improvements in Medicare Part D have not eased cash flow pains for independent pharmacists, a survey found. The National Community Pharmacists Association surveyed 5,000 of its members; one-third said the Part D cash flow crisis may threaten the viability of their businesses. During the program's initial days, pharmacists nationwide dispensed millions of dollars in emergency prescriptions when eligibility could not be verified, and claims could not be processed due to problems with plan databases. Even now, payment procedures for low-income seniors eligible for both Medicare and Medicaid have "drastically slowed payment schedules," the NCPA said. Under Medicaid, pharmacists were reimbursed weekly; under Medicare Part D, prescription drug plans issue reimbursement checks generally only once every 4 weeks and prescription claims filing may delay payment by additional weeks. Some 525 independent pharmacies (10.5%) responded to the faxed survey.

Prescribing Scooters, Wheelchairs

Prescribing power wheelchairs and scooters for patients should be easier under a new Medicare rule. The final rule, published in the Federal Register, requires a face-to-face evaluation, but also extends the time allowed to submit the prescription and other paperwork to the supplier from 30 days to 45. Also, a requirement that a specialist physician such as an orthopedic surgeon or rheumatologist assess the patient's ability to operate the equipment has been removed. An additional payment has been provided via an add-on CPT code to recognize the additional work and resources required to document the patient's need for a power device. A beneficiary being discharged from the hospital does not need to have a separate face-to-face exam. If a physician has an established treatment relationship with a patient, a face-to-face exam is not required, but documentation of need based on previous visits must be provided, according to the rule.

Tobacco Settlement Funds Waning

States will likely receive $400 million less tobacco settlement funds in fiscal year 2006 than in 2005, a Governmental Accountability Office study has found. GAO said the decline occurred because states have been selling bonds based on expected revenue from tobacco companies. States are "selling proceeds for pennies on the dollar," and will have less to spend on health care, said Eric Lindblom, director for policy research at the Campaign for Tobacco-Free Kids. Tobacco settlement money was supposed to be spent on public health, especially to prevent smoking and treat its effects, he said, adding that when states have million of dollars coming in from tobacco companies, it is easier for health advocates to push for spending on smoking-related health matters. A recent paper from the campaign said that California and Massachusetts were saving as much as $3 in smoking-related healthcare costs for every dollar spent on tobacco prevention when their programs were adequately funded. This is the last such report the GAO is set to perform under current federal law.

—Nancy Nickell