A Better Way To Practice

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By Bonnie Darves [2]

Results from a study on improving practice efficiency

Greg Long, MD, says positive change is possible in today's healthcare environment.

The proof is in his practice's nearly 30 percent reduction in daily patient visits — along with a $12,000 jump in the monthly operating margin of ThedaCare, a 90-physician integrated delivery system in Wisconsin, where Long is medical director. Making some key changes in the patient-flow process has also translated into a more manageable workweek for Long. With the scheduling bottlenecks largely cleared and office efficiency ramped up significantly, he finds he no longer spends hours at the end of the day catching up on paperwork and phone calls. "I'm keeping up on dictation, documentation, and coding. So when the end of the day rolls around the majority of things are done," he says, adding that while his practice life is "still hectic and packed, it's a different kind of busy."

Thanks to more efficient, targeted use of staff and improved communication using technology, patients in Long's practice no longer have to wait — either for appointments or in the waiting room. As a result, they're visibly more satisfied, and that is reducing stress on everyone else. "When the patient feels more satisfied, and the whole interaction the patient has with the system is positive, the doctor feels better and the staff feels better," he says.

Long's experience is not unique. Practices of all sizes and in all corners of the country are finding that, by making some fundamental changes to office operations, they are reaping the rewards of greater efficiency and career satisfaction. Incoming results from a three-year-old initiative by the Institute for Healthcare Improvement (IHI) on the way care is delivered at the practice level indicate that embracing change and encouraging innovation are not only possible but, ultimately, profitable. The practices interviewed in the following article have all seen their bottom lines stabilize or improve as patient and staff satisfaction rise, the quality of care increases, and — wonder of wonders — inefficiencies decline. If they can do it, why can't you?

Starting over

It may sound simple, but to change the way care is delivered in most physician practices requires a whole new mindset. "If we want to rid the current system of its defects, we have to start with a clean slate," says Charles Kilo, MD, a fellow of the Institute for Healthcare Improvement (IHI), a Boston-based nonprofit organization whose mission, as its name suggests, is to improve the quality of healthcare. The group heads up initiatives that find ways, for example, to improve clinical outcomes, broaden access, and lower costs.

The IHI's formula for problem-solving is simple: Rather than try to fix problems as they happen, look at the big picture, then break it down into several smaller elements to be worked on as parts of the whole. It's the same method many educators suggest for completing large or multipart projects. It works. And it's the guiding principle behind the IHI's Idealized Design of Clinical Office Practices (IDCOP), which seeks to re-engineer the way care is delivered in the most common ambulatory setting — the doctor's office.

The successes that these evolving practices are enjoying shouldn't come as a surprise. The reality is, many of the IDCOP ideas aren't new: streamlining patients' movement through a visit by better use of staff and space; using technology to manage processes and patient data; getting rid of schedule backlogs by making office visits more productive and fewer in number; and delegating to staff more effectively, freeing up physicians to focus on the work that requires their expertise. But when practices try to implement change in a system with well-known constraints, like limited time with patients and capitated payments, it's tough to make progress. "So much of what we have seen has not been a failure of the concept, but more a failure of the culture to implement the concept," Kilo says.
Under the aegis of IDCOP, however, ThedaCare and about three dozen other practices — ranging from solo-practitioner sites to 200-physician clinics — are implementing the concept, and producing impressive results. Participating practices, which pay approximately $25,000 per year over three years to access IHI's expertise and assistance, are encouraged to embrace the IDCOP model's four key themes — access, interaction, reliability, vitality — in a manner that best meets the needs of the patients they serve, while tapping the knowledge and experience of their staff members. That may sound like Customer Service 101, but as most practices know too well, the "system" (and all of its flaws) often gets in the way — and staff feel powerless to change it.

**Try something different**

Scott Decker, quality manager for ThedaCare, remembers the first day he and several physicians and staff members were introduced to the IDCOP concept. Forty-five minutes into the presentation, Decker recalls, he saw the two physicians' eyes light up. "They knew what they were operating was 'broken,' and couldn't be fixed as it was," says Decker. "They knew there was no guarantee, but they were willing to try something different."

In the months before his clinics became prototype sites for IDCOP in 1998, Decker recalls, morale had hit rock bottom. "Some of the staff members were ready to walk. They were working until 7:30 at night, and still couldn't catch up." So the group started by embracing the IDCOP principle that nonphysician personnel are capable of performing a number of tasks typically handled by physicians — history taking, certain patient exams, and procedures such as Pap tests, for example.

"This is a very touchy topic for physicians, but too often, you realize that physicians are doing a lot of work that other people could very competently do" with appropriate supervision, Kilo says. The concept has become a happy reality at ThedaCare.

"Now, they're loving their jobs," says Decker, "and the doctors are seeing about 25 patients a day instead of 35."

As each new innovation or process change takes hold, clinic staff members come up with new ideas for improvements, making the redesign a staff-led, dynamic process.

"We coined the phrase that 'it's our job to slay the sacred cows,' and embraced the idea of figuring out what we can do differently right now," Decker says. "Three years later these clinics continue to challenge the sacred cows."

As word of the clinics' successes and improved working conditions gets around, staff working in other parts of the system are seeking spots there, according to Kathryn Correia, senior vice president of physician services.

"I get a lot of requests from people who want to work in our division because they've heard about this," she says. "It's what I call the 'wow factor.' One of the most important things about redesign is that the real meat is the behind-the-scenes improvements."

**'How we do business'**

Other practices are realizing similar successes, albeit with different focuses on the four IDCOP themes. For Luther Midelfort Mayo Health System, a Rochester, N.Y.-based behavioral health clinic, a key to its redesign was the IDCOP principle of population-based care — namely, improved management of patients with depression, who account for 40 percent of its patient panel.

Its new Depression Care Track involves a more structured patient intake process and brings nonphysician personnel into symptom reporting and history taking. It also makes extensive use of "problem knowledge couplers" — a data-driven, evidence-based system of using symptoms, patient history, and patient data entry to devise more standardized care.

Approximately 25 percent of patients with depression participate in group therapy sessions, which have brought treatment response rates above national benchmarks. In addition, the advanced-access scheduling system, now two years in operation, ensures that most patients are seen within 24 hours of requesting service; patient education and empowerment are intrinsic elements of their care. The group also began combining the medical and psychotherapy treatment aspects into a single visit, where feasible, ultimately reducing the number of patient visits without compromising revenues.

"Patients were very positive about it, and highly endorse the process," says Robert Peck, MD. The Depression Track program's success garnered Luther Midelfort an award from the American Group Management Association, and Peck, as part of IDCOP's train-the-trainer methodology, is consulting with other regional practices looking to implement the IDCOP principles.

In changing its system, Luther Midelfort got even more out of the bargain than expected. Efficiencies gained by using nonphysician personnel and patients themselves in information gathering and patient tracking, for example, contributed to a reduced need for transcription services and
streamlined use of front-office and nursing resources - eventually, through attrition, reducing the number of full-time equivalent (FTE) personnel by 6.5.

The redesign process taught Peck two important lessons: "For one, I never fully realized how many people were involved in supporting my practice. And I also know that if you want to make substantial gains in improving the care of patients and populations, you have to work in a new way. You can't make the old system do more."

Peck is quick to point out that championing change isn't always easy. "Some people love change, but we're a minority. It was hard because I would hear ideas and immediately see the possibilities - but the challenge is how to get your colleagues to see those possibilities and move forward," Peck recalls. For now, he says, IDCOP has become a "part of how we do business."

**Independent thinkers**

Outside the circle of IDCOP study sites, other forward-thinking physicians have been moving ahead with self-styled initiatives based on some of the same concepts. Charles Burger's primary-care practice in Bangor, Maine, has been integrating technology (electronic medical records and exam-room terminals, computerized decision support, and recently, e-mail), advancing the use of nonclinical personnel, and substantially involving patients in their own treatment decisions for about a decade. Putting those principles to work has enabled the practice, which is affiliated with Eastern Maine Healthcare, to care for an active patient panel of 5,000 — a number that just wouldn't have been feasible under the "old system," Burger says.

"If you're going to use technology right, you have to change the way you work, designing processes very carefully and saying, 'OK, we're going to train people to do this reliably,'" says Burger, who is a longtime advocate of computerized support in diagnosis and treatment.

"All of our training is very performance-based. Once people can do [a task], we let them do it. We tend not to pay too much attention to degrees and titles," says Burger, whose staff includes two nurse practitioners, one registered nurse (RN), and two medical assistants. Burger explains that the practice's specially trained medical assistants and the RN handle most of the work associated with physicals and wellness visits.

Telephone triaging and assessment are used in lieu of office visits whenever possible, with telephone follow-up built into the process. And when patients are seen in the office for initial visits or follow-up care, they are asked to input some of their own information, while medical assistants gather the rest.

By the time he enters the exam room, Burger says, "most of the work is done, and all I have to do is sit down with the patient and say, 'Here are your symptoms and here is your data. Let's think about these things together.'" He contrasts this with the typical office visit, in which the physician spends two-thirds of his time gathering information and one-third analyzing it.

"That's just not very efficient," says Burger.

For Burger, the payoffs in efficiency are just as gratifying as the staff satisfaction and relationships that have developed over the years.

"We have exceptionally low turnover because if you were to ask the staff about their work, they have a strong sense that they own the practice," Burger says. "They really function as a self-managed team, and the electronic tools simply give them a greater ability to contribute."

**Moving forward**

Now that the theories of IDCOP have taken root, Kilo is moving on, translating his philosophies into a new practice model that he hopes will become nationally recognized. Last spring he and Steve Gordon, MD, created GreenField Health System, which is based on high-functioning "care teams" and supported by technological "knowledge management systems." Patients have multiple points of entry to the practices, including e-mail and group visits, and "patient coordinators" ensure patients receive the care and follow-up they need.

At inTandem, the prototype GreenField practice that opened in Portland, Ore., last June, convenience and customer service are palpable - starting with the presence of the greeter who escorts the arriving patient immediately to an exam or conference room (there is no traditional waiting room). Patients pay a $350 annual fee to join, which helps the primary-care practice defray the cost of providing services payers currently don't reimburse, such as e-mail for matters that don't require a one-on-one visit.

Elizabeth Muckler, MD, who joined inTandem in September after completing her internal medicine
residency at UC San Francisco, says the practice embodies everything she was looking for in a practice opportunity, without the baggage she expected to find. "When I looked at other practices they were all very traditional. My perspective is that the traditional structure's constraints and access difficulties make it impossible, time-wise, to give the kind of care that I want to give to my patients," she says.

Muckler cites a recent situation in which a female patient exhibited signs of depression but wasn't ready to consider medication. But when the patient coordinator made the follow-up call a week later, she sensed that the patient's symptoms were worsening and that she wanted to pursue treatment. "I jumped in then, and worked with [the patient] to make a plan for treatment. Under the traditional system, that might not have happened until the patient came in for a follow-up visit," Muckler points out.

"What drew me here is that I knew I'd have more time to see patients," she adds, "because the patient coordinators would be doing the kind of things I would have done alone in another clinic."

**Lasting legacy**

Kilo hopes that, as word of participants' successes gets around, more practices will jump on the IDCOP bandwagon. Even if that is slow in coming, the body of knowledge that is being gathered is nothing short of "spectacular," says Kilo.

Over the coming years, a new Robert Wood Johnson Foundation (RWJF) initiative called "Pursuing Perfection: Raising the Bar for Health Care Performance" will take the IDCOP concepts a step further. The $20.9 million undertaking, which evolved following an RWJF survey in which 80 percent of responding providers said the healthcare system needed fundamental changes, will fund its 12 grantee organizations — systems and physician practices — to create and implement plans that foster the needed improvements. Preliminary results will be published this spring.

"I think we can say with confidence that this is indeed hard work, and that people have put a lot of time and effort into making innovations," says Pat Rutherford, IHI vice president and director of IDCOP. "But once implemented, the yields for patients, providers, and staff are substantial."

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