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THE INFORMED PATIENT

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## Cutting Waits at the Doctor's Office

**New Programs Reorganize Practices to Be More Efficient; Applying 'Queuing Theory'**  
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The dysfunctional doctor's office is getting a makeover.

A growing number of programs around the country are helping doctors redesign their offices to wring more profit out of their practices and fix problems that have long frustrated patients: weeks-long delays to get appointments, hours in the waiting room, too-brief visits with the doctor, and the near impossibility of getting the physician on the phone. While the goal is to improve care, the programs also aim to avert a looming shortage of primary-care doctors who are frustrated with low pay, long hours and rising overhead costs.

The new programs borrow lessons from other industries to help doctors work more efficiently, especially those in solo and small group practices who account for the majority of outpatient office visits. One approach employs calculations used by airlines, hotels and restaurants to predict demand: The idea is that doctors can cut patient waits much the way restaurant chains seat diners and turn over tables efficiently. Others involve relatively simple changes, such as leaving afternoon appointments open for urgent visits, or having patients fill out paperwork ahead of time online.



SuperStock

Doctors' offices are seeking to improve

efficiency, boost profits and cut waits.

Managed-care giant Kaiser Permanente is launching a program to help 12,000 doctors that contract with its health plan increase their efficiency with a new electronic-medical-records system. Portland, Ore., physician Chuck Kilo, whose GreenField Health Systems helps restructure medical practices, and is assisting with the program, says that too many doctors' appointments take up valuable office time with follow-up that could be accomplished with phone calls and email.

Other models involve more-radical change, such as one called "Ideal Micro Practice" that sharply reduces or even eliminates support staff. With this blueprint, doctors rely on electronic health records and practice-management software to quickly dispense with administrative tasks. And they may run their offices solo, greeting patients personally as they come in the door.

"The office practice hasn't changed much in 50 years," says John Wasson, a Dartmouth Medical School professor and practice redesign expert who is helping to launch a national program to expand the Micro Practice concept. "This is a disruptive innovation that can lead to increased quality and reduced costs."

Such redesigns face significant challenges -- including getting doctors to change age-old ways of practicing medicine and interrupt their busy schedules to retrain staff. Even if doctors spend more quality time, that might mean seeing fewer patients, and the unintended consequence may be to exacerbate the shortage of primary-care doctors, warns the American College of Physicians.

Even a pioneer of the Ideal Micro Practice, family physician L. Gordon Moore of Rochester, N.Y., admits his program "challenges every assumption about medical practice" -- and won't work for everyone.

It is also hard for doctors to invest in expensive new technology when they are already faced with high overhead. But less-expensive electronic-medical-records systems are becoming more readily available, as is help in using them. The federal Center for Medicare and Medicaid Services is funding a program using contractors known as Quality Improvement Organizations to help 4,000 practices adopt electronic patient records.

Much of the information to help doctors redesign practices is available free. Dr. Moore offers a Web site, [idealmicropractice.org](http://idealmicropractice.org)<sup>1</sup>, which shows how a practice with minimal or no support staff can cut operating expenses to the bone, increase the time doctors spend with each patient, and offer same-day access for urgent needs.

While the number of patients doctors can see is usually relatively low, his own experience suggests that by averaging just 12 patient visits a day, a doctor can earn 130% of the salary earned in a large practice seeing 25 to 30 patients a day. Drs. Moore and Wasson are working with about 40 doctors who are using the Micro Practice ideas, and

collaborating with business and health-quality-improvement groups to set up state programs.

For patients, the idea of better access to doctors is a welcome change. Mary Lou Lunt, a 47-year-old artist and marketing consultant who has a husband with diabetes and a teenager with cerebral palsy, switched to Dr. Moore's practice after becoming frustrated with her family's physician, whose office waits were sometimes an hour and a half, with only five minutes for actual appointment. When she or her daughter or husband calls with the need for an urgent visit, "I always make sure we are showered and dressed because when we call, I know we can see him right away," Ms. Lunt says.

Other programs avoid the drastic approach of eliminating staff, aiming to instead help staff manage patient flow more efficiently. The American Academy of Family Physicians is helping practices change their management strategies through a program called TransforMED, while the American College of Physicians, the largest medical specialty group, is sponsoring about 50 small to medium-size practices in a pilot that borrows from a program to help companies better design, produce, market and deliver their products.

Among the ideas it is adapting for medical offices is smoothing "inbound logistics" -- such as making sure the front desk has medical records on hand when a patient arrives -- and "outbound logistics," which include making sure patients get any test results available after the visit.

"Everyone recognizes it is critical for American medicine to solve these problems, and figure out what is making small and medium-sized practices struggle financially," says Michael Barr, director of the ACP's Center for Practice Innovation. Dr. Barr says the number of medical students and residents choosing to go into office practice has declined sharply in the past few years, as residents flock to more-lucrative specialties. Last year, more than 12% of third-year internal medicine residents were training as hospitalists -- doctors who care for patients only in the hospital -- up from zero in 1998.

ACP is pushing for dramatic changes in the way primary-care doctors are reimbursed by Medicare and private insurers, including financial incentives for using electronic records.

**More than 4,000 medical professionals have attended practice-redesign summits held by the nonprofit Institute for Healthcare Improvement, which works with Drs. Moore, Kilo and Wasson and offers free information in its IHL.org<sup>2</sup> Web site.**

Among other things, its programs show doctors how to predict supply and demand much like airlines or hotels do, adopting such tools as "queuing theory" used by restaurant chains to minimize customer waiting time. "Open access" programs help doctors calculate the demand for appointments using formulas based on the number of patients in their practice and an average no-show rate.

That differs from current practice, where doctors may book appointments three months in advance, leading to a big logjam in the office and no time for urgent cases. Dr. Wasson says the most efficient way to offer same-day appointments is to leave 60% to 70% of

slots open all day, because in a typical medical practice 30% to 40% of patients will want a set future appointment while the remainder will need urgent care or be happy to call on a day most convenient for them.

James Brady, a Newport News, Va., internist who left a group practice about three years ago to hang out his own shingle, adopted the Micro Practice model, working with just one nurse. Dr. Brady often answers his own phone, offers same-day appointments, makes the occasional house call, and uses email for many follow-up issues. His Web site, [thevillagedr.com](http://thevillagedr.com)<sup>3</sup>, offers patients forms they can print out and complete before they arrive.

Woodland Park, Colo., internist Michelle Eads says she decided to try the Micro Practice model after tiring of her job in a large office practice group, "where it was the typical hamster wheel -- 15 minutes with a patient and then kick them out the door as fast as you can."

Doctors adopting the micro practice model say they can't always manage their time perfectly -- during flu season for example. And some have had to accept lower incomes, at least in the start-up phase. "My income is much lower than if I took a job running a mill and seeing people twice as fast," says Jean Antonucci, who opened a "micro" practice in Farmington, Maine, after 19 years in larger practices. "But I'm happy, and my patients are happy."