Scheduling Group Physicians for Maximum Efficiency

An electronic report from Advisory Publications

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Successful scheduling requires a concentrated effort to identify problems, create solutions and monitor daily processes. Everything in the office must focus on this critical need: increasing patient flow so all doctors will be efficient and effective and therefore maximally productive. In fact, your survival could well depend on maximizing patient flow, because the biggest issue in today’s rush-rush medical world is managing volumes well.

Learn Your ‘Patient-per-Hour’ Rate

Physician productivity is a practice’s heartbeat: Your work pace dictates your economics. An entire range of management decisions — staffing, space design and patient scheduling — is determined by doctor patterns.

That’s why it is important to measure the physician’s production level. Michael Holmes of Medical Design International uses a basic unit measure — “patients per hour” — as the tool for doing so. It’s the starting point in assessing physician style and adjusting schedules and work habits accordingly.

To determine your patient-per-hour (PPH) rate, randomly select 10 recent half-day office sessions. Total up the number of patients seen during those sessions and divide it by the “elapsed time.” This time factor is basically the number of office hours in those sessions, but adjust it for late arrival and late stay (what we call ‘overtime’) to obtain the actual elapsed time spent seeing the patients.

Arrange the data like those in the box to the right. Total the “Time Elapsed” and “Patients Seen” columns, then divide those total hours by the total patients to arrive at the average patient output. Finally, find the highest PPH rate of all the sessions and add a line noting it as the “peak” output. Set up a format like this for each physician and each non-physician practitioner (physician assistant or nurse practitioner, for example).

Though sometimes scheduling glitches can’t be foreseen nor circumvented, diligently strive to make sure that you and your work habits aren’t contributing to such problems. This report presents ways to monitor your own work style and offers a number of suggestions to help maximize and enhance the productive time you spend at the office through more effective scheduling strategies.

### Measuring Current PPH Rates

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Elapsed Per Session</th>
<th>Start</th>
<th>Stop (Hrs/fraction)</th>
<th>Patients Seen</th>
<th>Hour</th>
</tr>
</thead>
<tbody>
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<td>1</td>
<td>9:15</td>
<td>12:30</td>
<td>3.25</td>
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<td>3.69</td>
</tr>
<tr>
<td>2</td>
<td>9:18</td>
<td>12:18</td>
<td>3.00</td>
<td>15</td>
<td>5.00</td>
</tr>
<tr>
<td>3</td>
<td>8:55</td>
<td>11:55</td>
<td>3.00</td>
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<tr>
<td>4</td>
<td>9:05</td>
<td>12:45</td>
<td>3.67</td>
<td>10</td>
<td>2.72</td>
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<td>8:30</td>
<td>12:20</td>
<td>3.83</td>
<td>11</td>
<td>2.87</td>
</tr>
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<td>13</td>
<td>5.20</td>
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<td>12:55</td>
<td>3:50</td>
<td>2.92</td>
<td>14</td>
<td>4.79</td>
</tr>
<tr>
<td>8</td>
<td>1:10</td>
<td>5:10</td>
<td>4.00</td>
<td>10</td>
<td>2.50</td>
</tr>
<tr>
<td>9</td>
<td>1:05</td>
<td>4:50</td>
<td>3.75</td>
<td>18</td>
<td>4.80</td>
</tr>
<tr>
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<td>1:00</td>
<td>4:20</td>
<td>3.33</td>
<td>15</td>
<td>4.50</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
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<td></td>
<td>4.03</td>
</tr>
<tr>
<td>Peak</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.33</td>
</tr>
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</table>
crease each provider’s capacity. Doing so will ultimately enhance overall practice productivity.

**Make it an annual routine**
Repeat the calculation once a year so you can compare these “snapshots” of your productivity level. If you have different types of office sessions (perhaps solely for check-ups or post-op visits) run snapshots on these sessions as well as your regular ones. They may help you identify patterns and trends in the way you work.

In group practices, run the annual calculations separately for each member (and for each department in multispecialty groups). The per-doctor variations furnish valuable data for individualizing doctors’ appointment schedules, exam room assignments and assistant needs.

If the data show that a member is considerably slower than his partners, maybe it will help him reassess his style. Or it may lead to a much-needed discussion about staying on schedule.

It’s simple to set up this process as an annual routine. While some physicians may prefer not to know things that put their practice style in question, you are better off in the long run with actual data than with mere perceptions — particularly when the data will make your practice more cost-efficient and productive.

**Optimize Your Effort with a Time-and-Motion Study**

Dig further into the PPH rates by conducting a time-motion study on each doctor’s practice style. Its ultimate purpose is to identify areas where the doctor is wasting time, so s/he can make changes that maximize productivity and income.

Start by noting the start time of each identifiable doctor task. That includes chart review in the hall, entering the exam room, greeting and chatting with the patient, history review and conducting a physical exam. Time each task and chart the elapsed time as shown in the box below. Allocate each task’s elapsed time to one of three categories:

- **Doctor time** — Tasks requiring your unique knowledge and expertise, or your presence to establish effective rapport with your patient

**Time-Motion Analysis**

<table>
<thead>
<tr>
<th>TASK</th>
<th>Elapsed</th>
<th>Doctor Time</th>
<th>Delegable</th>
<th>Wasted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient work-up</td>
<td>5.25</td>
<td>5.25</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>Look for nurse</td>
<td>0.75</td>
<td>0.75</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>Doctor phone call</td>
<td>2.50</td>
<td>2.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient exam</td>
<td>7.50</td>
<td>7.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dictate chart</td>
<td>1.50</td>
<td>1.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk to lab</td>
<td>1.50</td>
<td>1.50</td>
<td>1.50</td>
<td></td>
</tr>
<tr>
<td>Look for chart</td>
<td>1.00</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk to patient in hall</td>
<td>2.50</td>
<td>2.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient exam</td>
<td>5.25</td>
<td>5.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk to x-ray</td>
<td>1.10</td>
<td>1.10</td>
<td>1.10</td>
<td></td>
</tr>
<tr>
<td>Wait for x-ray</td>
<td>2.50</td>
<td>2.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dictate chart</td>
<td>1.75</td>
<td>1.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL MINUTES</strong></td>
<td><strong>33.10</strong></td>
<td><strong>18.50</strong></td>
<td><strong>6.35</strong></td>
<td><strong>8.25</strong></td>
</tr>
<tr>
<td><strong>TOTAL HRS. (60)</strong></td>
<td><strong>0.55</strong></td>
<td><strong>0.31</strong></td>
<td><strong>0.10</strong></td>
<td><strong>0.14</strong></td>
</tr>
</tbody>
</table>

- Patients Seen | 2 |
- Actual PPH rate | **3.63** (Patients seen)/ (Elapsed time in hrs.) |
- Potential PPH rate | **6.49** (Patients seen)/ (Doctor time in hrs.) |
Scheduling Group Physicians for Maximum Efficiency

- **Delegable time** – Tasks you could delegate to support staff, based on your and similar specialists’ experience
- **Wasted time** – Needless tasks caused by inadequate communication systems, unavailable staff and/or poorly designed space

After sorting the tasks by time category, calculate the actual PPH rate by dividing the number of patients seen by the total elapsed time (in hours), and compare that to the potential PPH by dividing the number of patients seen by the total doctor time only. This potential PPH rate represents the doctor’s “natural” rate, for it includes only physician-required time. Once you finish these studies on each of your providers, take a look at how they fit into the overall office schedule.

**Spread Out Office Hours to Maximize Your Time**

Rescheduling work hours can be a bone of contention for many groups, because many individual physicians cling to personal preferences for office time. But it’s important to recognize how costly this attitude can be, particularly in a group setting. For instance, we visited a six-physician family practice concerned about its overhead. Although the office facility had 15 exam rooms, the doctors complained that it was too small. Its personnel costs, at 26% of annual gross income, were 6% higher than we expected.

The reason for these complaints soon became apparent. On Monday and Thursday mornings, all six doctors, a PA and seven medical assistants overlapped each other in using the 15 exam rooms. On Wednesday mornings and virtually every afternoon, the assistants had comparatively little to do and the doctors had more rooms than they needed. The box (top right) shows the original office schedule, reflecting the number of doctors having hours in each session.

The medical assistants, all loyal and excellent workers, were full-time employees. Each one followed his/her “own” doctor and the extra RN handled special needs. Despite its good qualities, the practice could have saved two full salaries and benefits — more than $70,000 per year — by changing its schedule.

**An even schedule reduces costs**

The box (bottom right) presents a revised schedule that makes the 15 exam rooms adequate and saves $70,000 per year in personnel costs. This schedule has the same total number of office sessions, but only Monday morning finds five doctors on hand. The practice still can make available three extra exam rooms per physician, often being able to spill over to a fourth and fifth if needed. In fact, there’s enough space to easily add a seventh doctor.

<table>
<thead>
<tr>
<th>Original Physician Schedule</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Tuesday</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Wednesday</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Thursday</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Friday</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Saturday</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revised Physician Schedule</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Tuesday</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Wednesday</td>
<td>3</td>
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<td>Thursday</td>
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<td>Friday</td>
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<td>0</td>
</tr>
<tr>
<td>Saturday</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Personnel cost savings result because now five medical assistants (instead of seven) can easily handle the week’s schedule. At least one of them (generally the RN) remains available where needed at all times except Monday mornings. And there are still three weekly sessions when one or two assistants can be assigned to evening duty.

The important point to remember is this: a key goal of your office schedule includes spreading demand for office space and staff throughout the week. This means avoiding the common flaw of scheduling too many doctors on Monday mornings, too few on Wednesdays and frequently none at all on Friday afternoons. These flaws place inconsistent demands on space and personnel, pushing expense levels up to meet the peak demands with little flexibility to cut down during low-volume periods.

There’s no business rationale for physicians insisting on certain office hours. Tradition should not trump profits. And in fact, doctors typically find work less stressful when the office is not jammed with too many physicians, too many patients and too few exam rooms. Even hospital rounds can be balanced between morning and afternoon to permit balanced office usage.

Average out your group’s schedule so nearly the same number of doctors is on hand at any given time. Your office staff, including receptionists, technicians and nurses, will be more effective — and less stressed — while you save money on space and personnel costs.

Make your scheduling system work for you

As we’ve discussed, your office’s patient patterns probably vary according to the day of the week and from doctor to doctor. If an office is open five days a week, it’s doubtful that all five days actually have the same practice characteristics. Being willing to change to reflect real-life activities (rather than enforcing an unrealistic pattern on patients and physicians) is critical to staying on schedule and making the most of your time.

For example, Mondays might have many “work-ins,” so that more slots should be kept available to accommodate them. Tuesdays might be partly blocked out for surgery, or for long in-office physical examinations, or whatever. Perhaps the doctor wants to bunch many check-ups or brief post-op visits on Wednesday mornings. Be sure your scheduling program (or appointment book pages) can be customized to these variations.

Given the likely schedule variations in your office, it makes little sense to lay out all the appointment screens or pages in the same way. Scheduling is handled more efficiently and with fewer mistakes if each day’s slots are actually designed to fit that day’s preferred working pattern.

Reflect your style

In a three-doctor group practice, we doubt that each doctor handles his/her office hours the same way. Dr. A might see six patients per hour effectively, while Dr. B might prefer 15-minute visits. Or Dr. C might prefer to intersperse his new patient visits, while Drs. A and B want new patients appointed consecutively. Acknowledge that Dr. A doesn’t necessarily practice exactly like Dr. B — so their schedules shouldn’t be the same, just to fit a preconceived notion of the “perfect” or “usual” system.

Design separate pages or screens fitting each doctor’s preferred work patterns. We agree with adapting appointment schedules to fit the practice’s actual features. It is neither efficient nor effective to fit the doctors to the appointment book or default software template. Since good software packages offer flexibility, and appointment book pages can be designed and printed inexpensively to one’s own specifications, begin your scheduling system overhaul by customizing individual physician pages or screens.
Define Your Group’s ‘Workdays’ and ‘Workweeks’

Six physicians in an extremely busy cardiology practice were pleased with their professional accomplishments — and their high incomes. They were a major regional hospital’s key cardiologists, receiving most of the difficult referrals and admissions, dominating the cath lab schedule, directing the non-invasive lab and assuming new responsibilities as new diagnostic modalities appeared.

And yet, despite their relatively young ages, these physicians were already beginning to burn out. Each work day was a hectic race from the office to hospital rounds, to cath or echo lab, to office, to an emergency, back to the office, to a new consult, to the EKG reading room, back for some hospital rounds. Most workdays stretched to 8, 9 and even 10 p.m. Relations between these six partners, who had always trusted and respected each other, grew tense.

We see this scenario a surprising number of times these days as small specialty practices grow into so-called premier groups. As your burgeoning “premier group” practice imposes hectic and exhausting daily work burdens on your physician-members, you may be forced to reallocate your patient care duties.

While many groups see the ultimate solution as adding enough physicians to reduce the per-doctor workload, things often seem to get worse each time another doctor comes on board.

While nothing short of many extra physicians can totally solve the problems, one other approach helps make the partners’ lives more bearable: Define each “workday” and “workweek” so each doctor’s set of duties is carefully limited. The goal, though rarely satisfied in full, is to have each physician stay in one location and in as few activities as possible each day and each week.

Rotating ‘shifts’

Take the cardiology group as an example. If they practice in just one hospital and one office, they could adopt a rotating six-week work schedule like this:

- **Doctor One** — #1 in the hospital (rounds, admissions, consults, discharges and emergencies)
- **Doctor Two** — #1 in the cath lab
- **Doctor Three** — #2 in the hospital and #2 in the cath lab (back-up for each, covering both as able)
- **Doctor Four** — Office practice all week
- **Doctor Five** — Non-invasive lab
- **Doctor Six** — Off (vacation, professional meetings or else back-up where needed)

This schedule is obviously an ideal, and it almost certainly cannot work as drafted. Perhaps Doctor Four should have three days (six sessions) in the office and other sessions in the non-invasive lab. Perhaps s/he should also be responsible for the EKG readings. Modifications will surely become necessary as some members are not invasive, some have special non-invasive responsibility and others have newer high-tech expertise. And the many “schedule busters,” like hospital committee meetings and teaching obligations, will foul things up still more.

Even with these variations, though, defining the partners’ daily and weekly work schedules can help simplify their burdens. By staying put each day — to the extent possible — a member will be less hassled. S/he even has the prospect of getting home for dinner more often as the need to run back to the hospital or office and cover still another problem at day’s end is reduced.

The big trade-off

Converting to this type of work schedule presents one major problem of medical practice philosophy. It forces the partners to abandon — either partly or wholly — a favored “my patient” style. Doctors cannot, for instance, follow “their own” style. Doctors cannot, for instance, follow “their own” style.
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tients’ office visits if their office hours are bunched into one week out of six.

Premier groups often are inexorably pushed away from a “my patient” attitude anyway. Members typically resist the shift, but we often find that it has occurred even before we make our suggestions. Our scheduling concept becomes more acceptable as harried members recognize the inevitable inroads on individual patient responsibility.

Reassess relationships
You may be able to define your schedules and still keep a satisfactory doctor-to-patient relationship. Some groups strictly define their duties in the hospital but provide each doctor with one office session per week — above and beyond Doctor Four’s weekly office assignment. While patients will accept group coverage when hospitalized, the schedule recognizes that patients should have a basic office rapport with a “personal” physician.

If you identify with our cardiology group example — which fits other medical subspecialties as well as general medicine, ob-gyn and at least the trauma-related surgical specialties — redefining the work schedules may be worth your while. Just going through the exercise may reveal a number of efficiencies you can incorporate in your practice, whether or not you carry the schedules to their logical extreme.

Such an effort may help you and your partners set goals for continued improvement in your work patterns. The only alternative may be personal burnout and group disintegration.

Keep Focus on Physician to Maximize Productivity

Though staff efficiency helps you maximize your per hour patient rate, don’t over-emphasize staff movement. Minimize physician — not staff — movement and hence maximize the physician/patient encounter rate. For example, a tight exam room arrangement that allows the physician to move just a short distance from door to door maximizes productivity.

Beware of anything drawing the physician away from his/her production area. Sometimes the physician’s private office stands adjacent to the exam area. But unless s/he uses it regularly for direct patient contact, it only provides an easy distraction from productive work. See if the physician can remain in the exam area while dictating notes, talking on the phone or reviewing records (including films and reports).

It almost goes without saying, but we’ll say it again anyway: Time is money. And doctor time equals the most money. In order to see as many patients as possible in a clinical session, place a high priority on making the doctor’s work area as compact and efficient as possible. Mass-production industries bring work to stationary laborers with a conveyor belt. In the same way — without the conveyor belt! — bring work to the doctor; not the other way around.

Creating a productive physician office space
In the exam room where much of the action takes place, organize cabinets, furniture and equipment to minimize steps. Plan the room so the doctor can pivot between exam table, instruments, view box and chart (paper or electronic).

On the other hand, make sure the room is large enough to accommodate you, your assistant, the patient and whoever typically accompanies him/her in your practice. Provide for patient privacy by “reverse-hanging” the door: Make sure it sweeps in, toward the room’s center. That way, you can’t see the patient when you first open the door, allowing you to ask if s/he’s ready.

Having established an ideal exam room, make them all identical and group them into “exam modules” designed to provide workspace for each physician. Again, minimize walking. Bring the needed rooms — including dictation and consultation areas —
into a tight grouping so you can move quickly from exam to exam.

**Determining your need for more examination space**

Not much costs you more than a lack of exam rooms. For an office-based practice, having an extra room that permits one physician or physician assistant to see one additional patient per hour can easily add over $50,000 revenue per year. (This assumes you collect an average of just $50 per visit, including charges for related services, in six scheduled hours four days a week and 46 weeks a year. Specialists with surgery or other larger fee procedures will typically gross still more from seeing more patients.)

Yet incurring the cost of expanding your space — or even moving to larger quarters — is daunting enough to cause most doctors and groups to make do until clearly convinced. Try taking these steps first:

1. **Verify that all rooms are always filled.** It’s a lot less expensive to use existing space fully than to redesign the office or move. Don’t rely solely on anecdotes about wasted space; stroll down the hallway and see for yourself. Observe the number of rooms occupied and empty at random times several times a day over several weeks. You may be surprised to see a pattern of chronically empty rooms. Find out why they are unfilled and see if you can make use of the space.

2. **Compare actual and ideal exam room usage.**
   
   First calculate how many patients per hour your rooms actually accommodate; divide the number of patients seen in a session by the number of session hours and then divide that result by the number of exam rooms in use. If, for instance, one physician sees 24 patients in three rooms over a span of four hours, the actual room usage measurement is 2.0.

   The **ideal** usage rate is harder to determine. Review your normal patient visit patterns and estimate how long, on average, to devote a room to each patient. Don’t forget time to undress, be seen by a nurse or assistant, perhaps go to lab or x-ray, and redress, as well as time to exit the room, have it cleaned up and receive the next patient. The ideal average will be 15 minutes in many specialties, though some will average as little as seven or eight minutes — especially if patients need not undress.

   The ideal rate also varies with physician patterns and use of assistants. A slower doctor or one with a more complex staff work-up process will, of course, use rooms at a lesser rate. Anyway, if your rooms should turn over every 15 minutes, your ideal exam room usage rate is 4.0.

   Comparing the ideal and actual rates gives a utilization ratio. In the above example, that rate is 50% — 2.0 actual to 4.0 ideal — which is not very good. Put another way, each room accommodates two patients per hour but ideally should be used for four visits. Your rooms are being used at only half their capacity. Be aware that your actual and ideal rates, thus your utilization ratio, may vary by the day, physician on duty or even hour. This may call for applying the math to different segments for a full appraisal of room usage.

   An 80% utilization ratio indicates good, comfortable use of space. If you come in under 75%, you probably have unused capacity.

3. **Decide ways to use unused room capacity.**
   
   Assuming the calculation shows you can do better with your existing space, study your patterns and determine how to improve office efficiency. Knowing how many patients you should be able to schedule for each hour, what can you do to make that possible?

   Are there certain hours, physician shifts or days when too many patients are scheduled for the space to accommodate? Perhaps you can schedule certain patient groups for different hours, opening the rooms up for faster use in other hours. And if, as in some offices, patients clog exam rooms because x-ray backs up, consider setting up a sub-waiting area with a separate dressing room(s).

   The lack or misuse of staff can clobber exam room usage, too. So see if adding another clinical assistant
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(or re-deploying existing ones) can help you move patients through the rooms faster. Remember, the cost of another staffer may be small potatoes if that person helps increase physician productivity.

Following this approach, you may find that you don’t need more exam rooms at all. That’s wonderful, for it is generally better to improve your clinical office patterns than simply throw money at the problem by expanding or moving to a new office.

And what if you learn that your existing space is indeed effective and you could still handle more patients? Then, it’s time to deal directly with the space problem. Consider redesigning your present space, taking on adjacent space or flat-out moving to larger quarters. The economics of physician productivity will probably justify the cost.

Consider ‘Sophisticated Volume Planning’

Many kinds of physicians face the problem of scheduling for a wide variety of patient visits. Perhaps you go by basic 15-minute slots, giving some identified visits two or three slots, but more visits than you’d like probably run either too long or too short. Is there a way to schedule your patients more realistically?

Working for a large institution’s gastroenterology department, consultants Debi Croes and Jayne Oliva approached that question by performing what they call “sophisticated volume planning.” The process applies just as well to smaller GI groups — and other specialists.

Categories of care

Start by dividing your patients by the type of care they require. For the GI group, Croes and Oliva identified these three categories of care:

- Chronic, which involves an underlying, multiple disease state monitored over time
- Complex, involving multiple diagnoses and problems that may take a tremendous amount of resources in a condensed time period
- Episodic, simply requiring short-term intervention

List your patients by category and keep track of the office visits by patient type. Then determine how much time each type of visit normally requires. Have your physicians determine those needs, for they know their time involvement. Allocate the groups into six basic categories — splitting each category of care into “new” and “return,” as shown above.

The next step

Making this analysis enables you to develop a more realistic appointment book or computer template. Then go on to a second step of “pre-visit planning” for each category of care. It essentially sets up protocols for handling appointments, with the process depending on the category.

Under the protocols, a complex patient requires a nurse’s prior telephone assessment to decide how much time to set in the schedule. The nurse also tentatively determines the plan of care and what interventions and non-physician resources will likely be required. Based on these determinations the nurse then sets the visit length for scheduling purposes. When the visit occurs, the chances are good that it will run close to how that nurse determined it.

### Sample Categories of Care Mix

<table>
<thead>
<tr>
<th>Percent of Total</th>
<th>Phys. Time Alloc.</th>
<th>Patients/Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic new</td>
<td>12%</td>
<td>60</td>
</tr>
<tr>
<td>Chronic return</td>
<td>26%</td>
<td>30</td>
</tr>
<tr>
<td>Complex new</td>
<td>16%</td>
<td>60</td>
</tr>
<tr>
<td>Complex return</td>
<td>28%</td>
<td>45</td>
</tr>
<tr>
<td>Episodic new</td>
<td>3%</td>
<td>45</td>
</tr>
<tr>
<td>Episodic return</td>
<td>16%</td>
<td>20</td>
</tr>
<tr>
<td><strong>Average patients/hour</strong></td>
<td></td>
<td>1.69*</td>
</tr>
</tbody>
</table>

*Weighted avg. calculated from mix and physician time estimate.
Scheduling Group Physicians for Maximum Efficiency

For an episodic patient, a triage nurse takes the call and determines the visit’s urgency. S/he can thus identify the scheduling needs, develop a tentative care plan and make sure the needed resources (lab, x-ray, dietetic) are ready. A chronic patient’s routine visit needs less pre-planning. Most can simply be scheduled and any preparations for interim or next-visit care are handled at checkout.

Multiple advantages
Taking time up front to plan your volume process can save many times the cost and effort if it makes your office — and its physicians — move smoothly thereafter. This two-step process — categorizing care and planning visits — leads to a number of benefits not usually found in general routine scheduling:

- Accurately anticipates the patients’ needs and visit schedule
- Correctly allocates time and support staff to visits
- Optimally uses the office facility and its exam rooms
- Properly supports your physician(s) with the tools and resources needed for each visit
- Adopts realistic patient service guarantees and communicates them to your patients

‘Specialty Days’ Can Increase Patient Volume

It’s an unofficial trend: specialties setting aside an afternoon or a day for specific patient routine visits, such as ob days for ob/gyn practices, lipid clinics at cardiology practices or post-surgery days for general surgeons or orthopedic groups. By grouping similar procedures or diagnoses together, you can speed up your schedule and possibly see 10 percent more patients per week. Studies indicate that with some advance planning, one ob/gyn can see six to eight ob patients in an hour without any extra stress on staff or patients. And patients like specialty days, for several reasons:

- **Camaraderie.** When all the patients in the reception area are pregnant, for example, they naturally develop camaraderie, trading stories and bonding. And if they must wait, the opportunity to chat together helps, making them less likely to keep checking their watches and grimacing at the receptionist.

- **Speed.** From a working patient’s perspective, specialty days can be a lifesaver. It can be very annoying to wait half an hour for a 5-minute post-op check-up, especially when these checks come regularly.

- **Educational sessions.** Specialty days present a wonderful opportunity for showing videos and conducting educational sessions about a particular condition or procedure.

Preparation is key
But in order to make specialty days a success, first do your homework. The same thing that makes such days desirable can turn them into nightmares if you and your staff don’t know what to expect: a large number of patients, all demanding quick service.

Consider these issues for your specialty:

1. **Nurses and exam rooms.** You’ll need staff and space specifically allocated for specialty days. The nurses must keep patients moving. If you can’t cope with the load, it will stress your system to its breaking point.

2. **Avoid a clinic set-up.** If you have an assembly-line atmosphere, perhaps a line outside the bathrooms to give urine samples or waiting for the ultrasound room, the entire project will fail. Make sure to keep the tone of the specialty day the same as that of your regular hours. Individualized care comes first.
3. **Scheduling.** Even if you see six patients in an hour, avoid scheduling them at 10-minute intervals. A 1:10 p.m. appointment feels odd to patients. Instead, schedule three people to come in at 1 p.m., and have the next three set for 1:15 p.m., moving everyone smoothly and continuously through the appropriate tests such as blood-pressure or weight-checks.

4. **Sidetrack sick patients.** Inevitably, a complicated patient will need an appointment on a specialty day. Schedule him/her to see a different physician — not the one handling routine specialty visits.

Unfortunately, not all checks are routine. You may find a problem causing the visit to take longer than five minutes. What do you do then to keep the flow moving? Either see the problem patient later in the day or reschedule for another day. Those options won’t work if a serious problem exists, but try to use them whenever possible. They may not happen that often since patients with possible true emergencies will likely call and make separate appointments anyway.

**Highest appropriate level of care**

One major advantage of specialty days is the greater control you gain over both the care and the cost of high-risk patients. While an ob-specialty day would likely want to avoid high-risk pregnancies, in other specialties the patients who benefit most from care management services usually are those who can’t withstand or won’t improve from more invasive procedures.

These patients are typically frail, elderly and in need of regular medical attention — but not necessarily of constant physician services. As your practice accumulates more such patients, fitting in numerous brief, routine visits creates a bottleneck and cuts into physician productivity.

Consider, for example, that a nurse practitioner or registered nurse with appropriate training can daily provide 30, 40 or more anticoagulant and/or lipid panel screenings plus patient education sessions with only a single cardiologist’s oversight. By establishing a “lab” site — just one or two properly equipped exam rooms — and scheduling clinic visits separately, you control the flow of traffic and minimize doctor interruptions. Just as important, of course, are the solid medical and corollary psychological gains you’ll be providing for some of your most time-consuming but needy patients.

A mix of patients normalizes the flow and works fine for many groups. But if you can use these ideas to make it work, scheduling separate specialty days may help you increase patient volume — and profits. Physicians can schedule and use their time most productively, without having to fit in short simple visits or juggle multiple daily interruptions. Those seemingly small time savings add up to big bucks and better patient care.

### Rules of Thumb for Optimizing Physician Time

Each of the following 12 steps may save a few seconds of doctor time, but they happen hundreds of times during a single office session. If all those instances add up to seeing just one extra patient per physician per hour, you can produce $50,000 or more of extra revenue or handle an equivalently greater managed care volume.

1. **Always prepare another patient to be seen.** A waiting physician means too much unacceptable expense. If you come out of an exam room and another patient isn’t ready for you, tell your manager to solve this problem — ASAP.

2. **Things always go to the doctor; the doctor doesn’t go to things.** Even in an exam room, placing the sink across the room from the exam table causes hundreds of delays per day — at the cost of accumulated physician time. The same is true of medical supplies, instruments, light switches, call buttons and charts. Put everything within the doctor’s reach.
3. **Give staff written instructions.** Don’t rely on verbal instructions for a lab test, an x-ray or another procedure. Develop a check-off sheet. Then signal for the nurse or assistant to handle it and move on to your next patient. If you know you’ll need an x-ray or a lab test on the patient’s next visit, dictate (or write) it into the chart. Train staff to handle the requirement before you enter the exam room on the next visit. It saves you at least one trip into that room and the attendant time loss. By establishing written protocols, your nurse or assistant can carry on without specific direction — meaning that the physician can handle an exam on just one trip into the room instead of two.

4. **Emphasize doctor time.** Look at the value of the doctor’s time you free up, not at the cost of staff time needed to do so. Doctors often work very hard sacrificing incredible amounts of productive time to be sure their $18-an-hour nurse doesn’t have a minute of downtime. That doesn’t make much sense when it’s most cost-effective to optimize your time, not your staff’s. As an example, we can cite one orthopedic practice that declined to hire a “cast tech” to save a $30,000 salary — even though the physician time in casting could have been used to produce $125,000 more income!

5. **Keep techs busy.** Once you fill your exam rooms and your assistants or technicians do the initial work-up, don’t allow them to tell you they “can’t do anymore patients until the doctor comes in.” For instance, take the two patients most recently worked up and put them back in the waiting room. Then move two more patients into those empty exam rooms for the pre-doctor work-up. Keep the techs busy and the patients moving through the system.

6. **Isolate the doctor’s exam area.** Get the physician working in only one part of the office, removed as far as possible from distractions, patients and families entering or leaving the exam area, other physicians, and non-clinical assistants passing through. Each interruption takes a little bit away from the doctor’s productive time. The sum of a day’s interruptions drains your energy as well. Distractions just aren’t worth going home more tired than need be.

7. **Limit piggybacked visits.** Don’t allow families to schedule three or more members for one blanket time. While that may sound good for both you and the patients, if they cancel, they leave a huge hole in your schedule. Stick to a maximum of two family members at a time.

8. **Shift patient loads.** If one physician is behind, ask his/her patients if they’d like to see another doctor. New York practice administrator Don Stemmer often confronts this challenge, as many of his group’s patients wish to be treated by what he calls the practice’s “prestige” physicians. When these doctors’ schedules back up, front desk staffers offer patients the choice of seeing another partner at or near their already-appointed time. This same strategy works well when a physician calls in sick, too. When that happens, be sure someone calls his/her scheduled patients and describes the situation right away. Give them the option of seeing another doctor or an extender, or of rescheduling. (But be aware that one physician may not be able to fill in for another if they’re not both signed up for the same health plans. Each plan is different in terms of credentialing mid-level providers, too — and you can’t bill with another physician’s number. To solve this problem, make sure you have a complete list of all the plans, showing which providers are credentialed by which plans. Stay on top of this, because plans select and de-select providers frequently.)

9. **Rework afternoon appointments.** Similarly, if you find yourself becoming overwhelmed early, call your afternoon patients and offer them a different doctor, a later time-slot or, if
their conditions aren’t critical, first choice on another day. Patients will appreciate being given an option to an extended — often incalculable — wait.

10. Do a visit time study. Stamp the intake sheet with the time the patient actually arrives. The patient who says that he showed up two hours ago may be misleading you; the time stamp defines precisely when he came in. Track when the patient is called in from the waiting room, when the doctor actually sees him and when he leaves. You can identify (and work to rectify) any lags.

11. Define equipment bottlenecks. Keep the patient moving through the system, even if it means rearranging some routines. In an ophthalmology office, for example, can you complete something else while your patient waits for a visual field exam? Or if the auto-refractor is tied up, can you use the manual refractor?

12. Eliminate documentation delays. Keep scribes moving with the doctor, or implement a fully integrated digital system to prevent slowing him/her down to document patient conversation and clinical observations.