

“Breathing Room” and an Overview of the IdealMedicalPractices.org “Curriculum”

You Want To Do This But Wonder Where You Will Find the Time

Creating Breathing Room

With each participating cohort our appreciation of "breathing room" grows. Practices/physicians able to create breathing room are more likely to test new ideas/approaches/tools and make real and lasting change. To help find some breathing room, we put together some ideas we've come across in our work as well as one IMP's post.



It is very difficult to test new ways of working, new tools, etc when you're working at the limits of endurance every day. To try anything new it is essential to have a little bit of breathing room, to be able to step aside and review new things, try something that may take a bit of effort but promises to lead to an improved outcome.

Busy practices have tried a number of strategies and we list a few here as options you might want to try as you search for your own breathing room. These are strategies used by many practices. Some may not appeal to you or may not be within your control, others may have negative consequences that limit their effectiveness in your practice. If nothing in the list below appeals and you still lack the breathing room necessary, post an appeal to the group for help as we know from extensive experience that no breathing room is a strong predictor of frustration and failure.

Strategies Used by Others

Temporarily stop accepting new patients.

While you may still be short of your ultimate goal, a temporary new patient stoppage can give you a good deal of breathing room. You don't have to go through a formal closing of the practice to new patients with the insurance companies (unless you find it appropriate) ^ this is a temporary measure. "We are not accepting new patients at the moment, please call back in the future if you are still looking."

Extending re-visit interval

Busy clinicians ask some patients to come back for future office visits. From published studies we know that the interval has more to do with habit than medical evidence. We know from those studies that it is safe to extend the interval for many patients. By asking some patients to come back in 3 months instead of 2, a busy clinician can open up enough of the schedule to find breathing room.

Here is a post from Lynn Ho MD in Providence RI (a solo no-staff example):

"Here's a solo - solo list of the things that got changed in the past 3 months, that really seemed to help me LOTS, not really in any ranking order:

- 1) NEVER answer the phone, pretty much ALWAYS let the machine take a message. I was letting the phone interrupt me before- takes some training to just let it ring, but the payoff is big. Also, be meaner about having patients come in- less phone medicine and more face to face medicine makes me feel less put upon.*
- 2) Try to avoid calling any results, TRY to email all the results possible, a close second leaving messages on an answering machine, paper the 3rd most useful method (but takes longer); leaving a message on a machine is also fine, but you can't predict when you call if someone is going to be home or not! The worst of all is being stuck on the phone for 'by the way' questions from a patient.*
- 3) Electronic billing is great! Much faster and easier than paper (may save me 2-4 hours per week upfront) but more importantly, on the downstream side, doesn't allow those smarmy insurances to get away without paying because you didn't catch them before 6 months expires- provides proof of submission date. I Almost like billing now. Why didn't I do this before?*
- 4) Hired a poster/biller to argue with the insurance companies, 5-6 hours every 1-2 weeks. Thank goodness and worth every penny, for the peace of mind alone.*
- 5) Instant Medical History- really a time saver, documents and does it well, often more completely than I would have done, patient does the work, made all my paper rating scales obsolete. I REALLY appreciate it by the ends of the days when I sometimes would get way overwhelmed and feel late, even though I wasn't, and essentially not document anything in a complicated note, then (groan) have a complicated note to finish after the visit. (this is NOT happening any more!) Gives me a great start on the note, reminds me of details/problems that I did ask about but forgot completely about and would never have documented in my past methods, doesn't get tired by the end of the day like I do. Now without even a guilty start, I am easily billing just about all 99214s. Audit me!*

For \$50 a month, much cheaper than a medical assistant and has one hell of a medical background. I'd highly recommend it.

6) Other helpful things-

1) more patients are using appointment quest and making their appointments online, it's a matter of training but means lots less time on the phone for me;

2) new patient volume is tightly controlled and ratcheted down, less abstracting of old records has to happen, also the 'more mature' patient population is requiring less training and effort;

3) my technology has stopped jerking me around, for the moment- haven't had a major issue in almost 3 months, just have to keep my fingers crossed, really don't want to add any more technology pieces now or ever (but I suppose I'll have to as time goes on);

4) paperless office and workflow it generates really contribute to efficiency in general.

Avoiding Unintended Consequences

1: Closing to new patients is much more complex than most clinicians expect.

James is finding that the clarity of rules drives the success. If the clinician is ambiguous, the staff struggle with the message and some potential patients hear that as an opening to pound until they get in the door.

The weakest link in the "closed to new" chain is usually the doc. Turning patients away, especially family members of existing patients, especially if they are twisting our arms, is difficult. Remember that taking on too many patients results in a great deal of dysfunction, leading to degraded patient experience and outcomes. When pushed to the wall, I resort to: "I really cannot take you on as a patients. If I take on too many patients it has a negative impact on how well I can treat all of my patients. That's the way I used to practice and I can no longer practice in that manner. I'm very sorry."

2: How we temporarily close to new patients can lead to unintended consequences

The desire to pull back temporarily raises the concern that when we open again we won't be able to attract the needed patient volume. "Call back in X." is a typical response, but can have negative consequences. James is seeing a growing volume of repeat call-backs (leading to dissatisfaction for the potential patients as well as tension for James). Satisfaction in the "potential" pool is dropping and James is answering more phone calls each month for people who are not even in his practice.

Booking "new" out in the future is not anathema in the world of advanced access. It is the one category where future booking may in fact be reasonable, but will result in a percent no-show that may not be acceptable. Keep up the advanced access for existing patients, but I recommend rather than "call me in X time to check if I have openings" consider a "portals of entry" approach.

Scenario: New patient demand for the practice exceeds your new patient supply.

Strategy: Push all new demand out to the future.

Unintended consequence: increase phone volume "can you take me yet?"

Strategy: Completely close to new.

Unintended consequence: not enough new patient volume to keep up with attrition.

Strategy: Close most portals of entry, but keep enough open to match attrition and maintain a full practice

Unintended consequence: be careful how you choose portals so you don't end up with the reality or perception of a cherry-picking doc. How test: Try closing as many portals as you can, recognizing that you can never get your existing patients to stop asking, then consider how often and forcibly you reject requests from folks you know well.

3: Right panel size. The only true answer is "the panel size that results in net work (including variation) that does not exceed your capacity."

The Curriculum

The IMP Curriculum is a highly pre-tested format of materials, communications, and practice experiences. It has been designed for all sizes of general medical and many specialty practices. The attached Table summarizes the way it works.

Over time, IMPs will have the opportunity to be certified for special programs such as Pay-for-Performance , NCQA accreditation, etc. Patient-reported performance measures are increasing recognized to be critical for certification. The benchmarks indicate the high levels of performance already attained by previous IMPs against which all new IMPs would be expected to measure their own performance....and set even better benchmarks!

If you have questions on any aspects of your IMP work, contact:

- gmoore@idealhealthnetwork.com for general information
- [Deborah J. Johnson@Dartmouth.edu](mailto:Deborah.J.Johnson@Dartmouth.edu) or John.H.Wasson@Dartmouth.edu for questions about web function and individual feedback of results
- jzettek@idealhealthnetwork.com for questions about health coaches

Are You Becoming an Ideal Medical Practice?

| “Curriculum” | Major Components | Benchmarks | Recommended Tools | | | | | | | | | | | | |
|--------------------------------|---|--|---|----------|-------------|-------------------|--|--------------------------|---------------|-----|---------------|------------|-----|---------------|--|
| Getting Started-Breathing Room | √ Baseline Surveys | Completion of: 1) Staff, Overhead, and NCQA surveys 2) HowsYourHealth.org for at least 20 patients | Overview from IdealMedicalHome.org; Register; Read “General Announcements” on IdealMedicalPractices.org | | | | | | | | | | | | |
| Patient at the Center | √ “The Pyramid” and Patient Experience √ Segmentation and Resource Planning √ Problem-Solving and Confidence Building | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Measure</th> <th style="text-align: center;">Minimum*</th> <th style="text-align: center;">Top Quarter</th> </tr> </thead> <tbody> <tr> <td>Perfect Care</td> <td style="text-align: center;">50%</td> <td style="text-align: center;">60% or better</td> </tr> <tr> <td>Communication</td> <td style="text-align: center;">50%</td> <td style="text-align: center;">60% or better</td> </tr> <tr> <td>Confidence</td> <td style="text-align: center;">50%</td> <td style="text-align: center;">60% or better</td> </tr> </tbody> </table> | Measure | Minimum* | Top Quarter | Perfect Care | 50% | 60% or better | Communication | 50% | 60% or better | Confidence | 50% | 60% or better | <i>Module One:</i> CARE Vital Signs; Visit Planner; HowsYourHealth.org with Posters, standard letters, and handouts; Resource Planning; Problem-Solving Module and Phone Support; “Campaign for Confidence”; Group Visits. Podcast: Patient at the Center. |
| Measure | Minimum* | Top Quarter | | | | | | | | | | | | | |
| Perfect Care | 50% | 60% or better | | | | | | | | | | | | | |
| Communication | 50% | 60% or better | | | | | | | | | | | | | |
| Confidence | 50% | 60% or better | | | | | | | | | | | | | |
| Access and Efficiency | √ Overhead Awareness √ Access √ Patient Time Wasted | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Measure</th> <th style="text-align: center;">Minimum*</th> <th style="text-align: center;">Top Quarter</th> </tr> </thead> <tbody> <tr> <td>Overhead Estimate</td> <td style="text-align: center;">Suggestion to keep below 50% of revenue not counting MD, NP or PA salaries</td> <td style="text-align: center;">An even lower percentage</td> </tr> <tr> <td>Access</td> <td style="text-align: center;">60%</td> <td style="text-align: center;">70% or better</td> </tr> <tr> <td>No Waste</td> <td style="text-align: center;">80%</td> <td style="text-align: center;">90% or better</td> </tr> </tbody> </table> | Measure | Minimum* | Top Quarter | Overhead Estimate | Suggestion to keep below 50% of revenue not counting MD, NP or PA salaries | An even lower percentage | Access | 60% | 70% or better | No Waste | 80% | 90% or better | <i>Module Two:</i> Know Your Processes; 10 Points of Advanced Access; Advanced Access FAQs. Podcast: Access and Efficiency |
| Measure | Minimum* | Top Quarter | | | | | | | | | | | | | |
| Overhead Estimate | Suggestion to keep below 50% of revenue not counting MD, NP or PA salaries | An even lower percentage | | | | | | | | | | | | | |
| Access | 60% | 70% or better | | | | | | | | | | | | | |
| No Waste | 80% | 90% or better | | | | | | | | | | | | | |

| Defragmentation | ✓ Determinants of Practice Style ✓ Specialty Referral and Value | Completion of Standard Patient Scenarios | | | <i>Module Three:</i> Managing Standard Problems; Specialty Referral/Consult Form and Follow-up; Patient Personal Health Record | | | | | | |
|------------------------------|--|--|-----------------|--------------------|--|----------|-------------|--------------|----------------|-----------------|---|
| | | Measure | Minimum* | Top Quarter | | | | | | | |
| | | Continuity | 90% | 95% or better | | | | | | | |
| | | One in Charge | 85% | 90% or better | | | | | | | |
| Equity | ✓ Gap in Benchmarks by Financial Status after adjusting for illness burden | <table border="1"> <thead> <tr> <th>Measure</th> <th>Minimum*</th> <th>Top Quarter</th> </tr> </thead> <tbody> <tr> <td>Any of Above</td> <td>20% difference</td> <td>10 % difference</td> </tr> </tbody> </table> | | | Measure | Minimum* | Top Quarter | Any of Above | 20% difference | 10 % difference | <i>Module Four:</i> To be addressed. |
| | | Measure | Minimum* | Top Quarter | | | | | | | |
| Any of Above | 20% difference | 10 % difference | | | | | | | | | |
| | | | | | | | | | | | |
| Other Technologies and Tools | ✓ Electronic Tools ✓ Paper Tools ✓ Other References | | | | <i>Appendix for Technologies and Tools Offered But Not Used by Everyone</i> Podcast: Technologies | | | | | | |

* The IMP minimum benchmarks are generally 10% in absolute terms better than the top quartile of performance for a comparable national sample.