

# How to See More Patients Without Working More Hours

The key is to increase practice efficiency.

BY MARK TERRY

There are several ways you can interpret the question, "How can you see more patients without working more hours?" On the one hand, it seems pretty straightforward: you want to see more patients and you don't want to work more than you're working now.

But when you dig a bit deeper, this can be interpreted a little more baldly: How can you make more money without working more hours? Asking podiatrists and practice management consultants the question can provide answers that range from the practical to the more philosophical. On the practical level, much of it comes down to practice efficiency. Let's start with practical suggestions.

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## Nuts & Bolts

### *Staffing*

One key factor, says Peter Wishnie, DPM, of Family Foot & Ankle Specialists in Hillsborough, NJ, is "you have to have the right number of staff. When doctors can't see enough or more patients in enough time it is because they don't have the capacity." The standard metric is about 2.5 staff members per physician.

### *Cut Administrative Activities*

Podiatrists can get bogged down in administrative duties. Delegate what duties you can. Lynn Homisak, owner of SOS Healthcare Management Solutions, notes, "Doctors try to do the work of everybody—secretaries, ancillary staff. Until they learn to delegate, they're going to get bogged down. Chefs don't wash the dishes, pilots don't service the passengers, so

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why do doctors do things staff people should be doing?"

Larry Maurer, DPM, of Washington Foot & Ankle Sports Medicine in Kirkland, WA agrees, noting that he also uses scribes. "I have four scribes, for two doctors, who are my medical assistants. During patient hours, I don't do any work on the computer at all. I don't touch the computer. Everything I do in my exam I dictate and the scribe types."


Lynn Homisak

He notes that this also has the advantage of more facetime with the patient. "I think taking the typing out of your hands and putting it into the scribes' hands encourages you to do a more thorough history. There's no way a doctor can do as good a job if they have to type every word."

***Protocols***

Some physicians develop written protocols and scripts. Scripts, in particular, seem to generate a lot of heated discussion among physicians, who are afraid of sounding too canned or rehearsed. Homisak says, "I know a lot off doctors are against protocols because it's the McDonald's treatment, everything has to be the same, but that's not true. If you can put protocols in place, general protocols so staff have ideas of how to get the room up, get read, have the supplies ready, the instruments in place, everything they need, that can save plenty of time." But, Homisak points out, if the physician doesn't use protocols, the staff won't.

Wishnie thinks protocols simply mean you've thought about your processes and how you want your practice to run. "What happens when a patient comes into your office? How do you expedite their stay, from coming into the office, into the treatment room, out of the treatment room, and checking out? You want to re-engineer your processes and work backwards to see where any bottlenecks exist."

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***Scheduling, Part 1***

Full articles have been written on the subject of scheduling for physician offices. [See *Podiatry Management's* April/May 2014 issue, for example]. There are, broadly, three types of scheduling philosophies: traditional or block; wave or steady stream; and modified wave. Note that "willy-nilly" or "random" are not included in this breakdown.


Dr. Wishnie

Wishnie says, "Scheduling is really important. The staff knows the speed of the doctor. You can see in my office that I will be double-booked, because I have enough medical assistants. So there will be two columns, and sometimes there's nothing in the second column, which the office staff will consciously or unconsciously leave open. The second column is for anything the medical assistant can do."

That second column may also represent a physician coming in and doing something quickly like routine care. Basically, when there are two people in the same time slot, the staff need to be educated on what a productive patient is, because their job is to schedule the appointment book with productive patients. A productive patient, Wishnie says, "is someone who brings in money… new patients with heel pain, tendonitis issues, maybe discussion of surgery, those kinds of things. But the staff has to be trained on what is productive in the office and what you want to see."

***Scheduling, Part 2***

A second part of scheduling has to do with how you deal with emergency visits and what hours you set for your practice. Although podiatry probably doesn't have the number of or types of emergency visits that, for example, family physicians or dentists do, there may be more urgent cases.

Wishnie says, "My definition of 'emergency' is if they're in pain. We try to get them in. We treat them like a customer and if they say they're in pain we try to get them in right away." Wishnie's practice will tell these patients they may have to wait twenty or thirty minutes, but they will try to get them in. He notes that this is faster than an emergency room.

**"Staff has to be trained on what is productive in the office and what you want to see."—Wishnie**

Larry Kosova, DPM of Chicago, IL agrees, saying they had recently discussed what a true emergency is in a podiatric office. "A lot of people think an emergency is an ingrown nail. I do a lot of pediatrics. Our philosophy is if a patient or parent of a patient states it's an emergency, to us it's an emergency, and we take it right away. We don't necessarily give them the eight o'clock spot, but we see them right away. We will offer them the next slot, letting them know if they come at two

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o'clock they might have to wait forty minutes. But if they come in at three o'clock, we might be able to take them right away. In our experience, our patients appreciate that."

There are ways this can backfire, of course. Homisak cautions against claiming that every time you're running late, it's because of an emergency. Just be honest. She also suggests that you "leave the last slot in your schedule free. This can be used for emergencies, catch-up time, documentation time, for patients who need to be seen by the doctor 'next week,' or new patients."

**"A lot of people think an emergency is an ingrown nail." —Kosova**


Dr. Kosova

The rule of thumb these days appears to be to see six patients per hour, with some practices pushing to eight. Kosova notes that a large medical center in the Chicago area is buying up all the practices in the western suburbs and the philosophy is very much on seeing a specific number of patients per hour. "If it's an emergency, they'd rather you went to an emergency room. They don't have time for that. If you called them with a foot fracture, it would take you two or three weeks to get in. If you call me with a foot fracture, we'll get you right in."

***Scheduling, Part 3***

Typical office hours might be nine-to-five, but that may not be the best way to go. Kosovo noted that evening hours often bring in patients who won't otherwise make an appointment. He adds, "By being more accessible and having more accessible hours, you're getting more patients. Our practice has two late nights. We're getting a completely different clientele at the different times than someone might at their nine-to-five practice."

Wishnie notes that having late afternoon hours, after three or four, often frees up teachers or other people who have a difficult time coming in during daytime hours. And Homisak mentioned a practice that had early morning hours starting at six-thirty, which often had people coming in before work or school.

**Is It Time to Look at It Differently?**

As mentioned, the rule of thumb for patients per hour is six or sometimes eight. There are clearly ways of making those numbers work reasonably well (see staffing, above), although whether it makes the physician feel like he or she is running on a treadmill remains to be seen.

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(or whether or not it makes patients feel like they're barely getting any time with their physician, who is in a rush to see the next patient.)

Maurer is blunt about it. "Nobody wants to see more patients. Everybody wants to make more money, but nobody wants to see more patients. There's no way to do it without compromise, and the compromise isn't giving patients more time. If you think about facetime hours or minutes, you only have so many to give. There's no way to see more."

Overall, he believes that in order to do what the initial topic of this article asks—How do you see more patients without working more hours?—you have to compromise on quality. "They're doing it in a bunch of different ways. People are shortening appointment times, that's an easy answer. They're taking patient emails. They're allowing telemedicine video visits. And in all of those cases, my sense is that you're giving away the ability to do an exam. And I don't feel like there's any way around it."

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Dr. Maurer

At what point do you as a physician have to ask: When is enough enough? The answers are likely to be individual. Maurer pushes back, saying, "Hey, I'm not here to maximize my income. I am here to provide a really high-quality service. I want to build that reputation and grow my business through consistently providing a high level of care. Instead of improving my volume, I've always worked at building my reputation."

Kosova also questions whether seeing more patients will really improve the bottom line—somewhat dependent on each practice's particular problems. "I don't know from a podiatry standpoint if seeing more patients per hour per day per week is really going to make you more profitable. It depends on your baseline. Sure, if you're seeing twenty and bring it up to 100. If you've been in practice a while, seeing another two per day… will that make you profitable as compared to actually having a life?" Kosova thinks cutting expenses is likely to solve more of the problems than seeing more patients will. He noted they had recently moved to a different

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location, which cut their rent by 50 percent, which was a huge change.

**Accessibility**

A hot topic in terms of seeing more patients is texting and emailing with patients. It can be something of a minefield in terms of productivity, HIPAA, and billing, but many patients really want that kind of accessibility. Wishnie points out that texting can be problematic. "Some physicians might try to respond to texts, but they can't. Some offices have to text a doctor or the office about appointments or medications and those offices have a dedicated person who handles that. But there's so much miscommunication when you do that, and you have to stay HIPAA-compliant and all those texts and emails have to be coded properly so you're not violating any HIPAA rules. I personally don't think it's a great idea."

Kosova is an admitted tech-lover and his practice uses different texting applications. Supposedly, Gmail is encrypted end-to-end, and he will use texts or Gmail to discuss quick questions with other care providers about common patients. "That's part of my management of those patients. To say you need to get HIPAA-compliant texting platforms is okay, but I do give out my number to surgery patients and to specific others."

For example, a big part of Kosova's sports-medicine practice caters to dancers, professional or otherwise, and one person who has his number owns a local dance company. "They have my number and will text when they feel they need to. What I usually do is let them know I'll call them right back and have a conversation with them. I try not to text back and forth about medical care. That's the way I get out of the HIPAA issue, but those platforms are definitely becoming more available."

The big risk here, of course, is the patient that's looking for free medical advice rather than coming in for an exam. Kosova also believes the so-called Millennials (generally defined as those born between 1981 and 1997) lean more heavily on mobile technology and are interested in using these types of technology, both as young physicians and as patients.

**The 80/20 Factor**

Most everyone knows the 80/20 rule, or more formally, the Pareto Principle. It's usually described as: 80 percent of your income comes from 20 percent of your business. (Pareto originally was describing that 80 percent of Italian land was owned by 20 percent of the population, and he stated that back in 1896.) There are plenty of ways to apply it to business—and just about everything else—but it may also apply more broadly to a podiatric practice. And although it doesn't directly apply to money (in this case), it may eventually have a big impact.

What types of patients do you prefer to see? Sports medicine? Pediatric? Elderly? Diabetic? Kosova says, "When you start out, you see everyone because you're building. But then you get to a point where you say, I want to see these kinds of patients because it brings me more joy, and my experience of being a doctor is more pleasurable. And if that comes across to the patient, like refers like. I think it's true. In the end, I'd like to see types of patients I want to see versus types of patients I don't want to see."

It's a point Wishnie agrees with. "You need to know which type of patients represent those 20 percent and those take precedence. You spend most of your time marketing to those patients and seeing those patients. If you like children or you like sports care, that's where you get most of your patients from. The rest is helping you and it helps pay some bills, but if you analyze it, you have to have a reason to schedule, not just randomly put people all over the place."

He's also quick to point out that "priority" is something of a relative thing. Priority patients are patients in pain, he says, but, "you don't want to stack up 10 routine care patients in a row unless that's your preference, which is fine."

There are plenty of good ways to make your practice more efficient by using delegation, good training, and savvy scheduling. But as Maurer emphasizes, "Every day there's a new rule or regulation and you have to have someone on the phone to manage that and there's no way around it. The overhead's going up, our reimbursements are going down, so there's a big push to see more patients and do more. And I know I'm basically saying, make less money. There's no way around it. If you increase your speed, you're going to decrease your patients' care, increase mistakes, increase misunderstanding, and increase the number of misdiagnoses."

**"If you increase your speed, you're going to decrease your patients' care, increase mistakes, increase misunderstanding, and increase the number of misdiagnoses."—Maurer**

Efficiency isn't necessarily the opposite of good patient care and can, in fact, often make for better patient care. It's knowing when to say when and deciding on priorities that make or break a practice in terms of doing more, more, more. **PM**

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