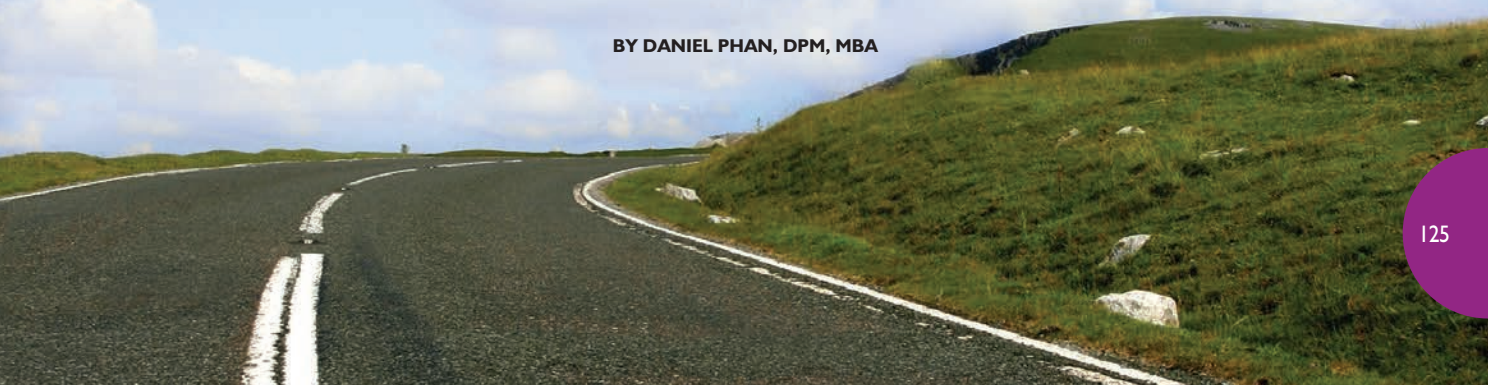
A Road Map to Practice Success

Yes, you can reduce costs, improve efficiency, and deliver quality care.

BY DANIEL PHAN, DPM, MBA



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Introduction

As we celebrate 2016, how will we remember 2015? It was quite an eventful year, full of changes. It was a year of fear and anxiety for most physicians. Some physicians embraced the changes, while others struggled to stay economically viable. To a certain extent, it transformed the organizational structure of civilized medicine. It forced some physicians to retire and others to join multi-disciplinary clinics. It encouraged the consolidation of resources within our profession.

2015's Major Changes

The Patient Protection and Affordable Care Act (PPACA) will start transitioning medicine away from the fee-for-service system and move it toward a performance-based pay system. Providers will be paid based on the quality, not quantity, of care. Healthcare providers are faced with the burden of understanding and staying in compliance with the rules and regulations in the new 2,800-page law. The Health Information Technology for Economic and Clinical Act (HITECH), enacted under the American Recovery and Reinvestment Act of 2009 (ARRA), began penalizing providers in 2015 for not attesting to meaningful use. Some older physicians debated meaningful (to continue) versus "meaningless" (as in early retirement).

On October 1, 2015, the United States implemented the use of ICD-10. It expanded the numbers of diagnostic codes from 14,000 (ICD-9) to 69,000 (ICD-10). In total, there are roughly 140,000 ICD-10 codes (including the ICD-10 PCS). It completed the trifecta of making healthcare one of the most regulated industries in the United States.

The truth is: medicine will evolve, survive, and continue to prosper.

Some critics were fearful that the new regulations would reduce autonomy, overwhelm the entire office with countless hours of extra paperwork and bureaucracy, destroy morale, and increase the overhead cost. The changes will drive some older physicians into early retirement, encourage young phy-

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sicians to seek other careers, and deter many students from becoming physicians. These critics are now faced with the daunting task of reducing costs while trying to improve the quality of care. Meanwhile, there are some providers who have embraced the change and adjusted their business strategies—it's too early to tell, of course, but thus far this group appears to be doing quite well. The truth is: medicine will evolve, survive, and continue to prosper.

Cash-flow Crisis

In the last three years, more physicians are consolidating their resources. Many small solo practitioners are joining either a multi-disciplinary group or merging into a super group. These groups are getting larger and stronger. They are the direct competitors to the smaller practitioners who are struggling to stay viable. The largest burden for the small solo practitioners is insufficient cash flow. It can be due to slow-paying medical claims (up to six months), large bloated inventories (outdated supplies), high overhead costs (rent and payrolls), low gross margins (lower reimbursements, more work hours), bad debt (claims denial, non-paying patients), and low cash reserves.

Most medical schools do not prepare students well enough to run a small business and diagnose cash-flow problems in times of crisis. Some providers will try to fix the problem with a business loan, but that's a short-term solution that does not solve the problem. It can be extremely dangerous if the practice is expanding rapidly with increasing expenses—a better alternative is a line of credit, but that also has limitations. Throwing borrowed money at the symptoms is not the smart long-term solution. The insurers will continue to negotiate for lower prices and for longer payment terms. The overhead cost will continue to increase steadily. Eventually, these small practices will go into a recurring financial tailspin. Therefore, some providers will elect to forego the stress of private practice and join a multi-specialty group or work for a hospital for a salary. Alternatively, the providers who want to stay in private practice can join a super group.

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Benefits of Supergroups

In a supergroup, the provider can retain autonomy while decreasing costs. Super groups can negotiate with insurers for more favorable rates by diluting the risks between larger numbers of physicians. It is a great way to significantly reduce payroll expenses. It can also lower the cost of healthcare benefits for the employees. Providers can save valuable time and resources by sharing a centralized electronic medical record program. The implementation cost along with the maintenance fees will be much lower. Larger super groups can even negotiate with suppliers for better prices and prevent bloated inventories (redistributing the stale inventories).

However, not all super groups are created equal. The most important consideration is the leadership and management team. Without a good leader, the group can easily fail. The mission of the successful groups will focus more on delivering consistency and improving the quality of care through the use of standardized treatment protocols.

The concept of supergroups is not new. Before becoming a world-renowned medical center, the Cleveland Clinic started as a supergroup. With all the benefits of super groups, how come they did not become popular until the last few years? The best explanation is in the diffusion of innovation theory.

Diffusion of Innovation Theory

In 1962, Professor Everett Rogers popularized the theory in his book. He used four elements (the innovation itself, communication channels, time, and a social system) to explain how, why, and at what rate a new idea spreads as it is being adopted into society. Innovation is described as the new idea or product itself. Communication channels are the networks required for the idea to grow. As for

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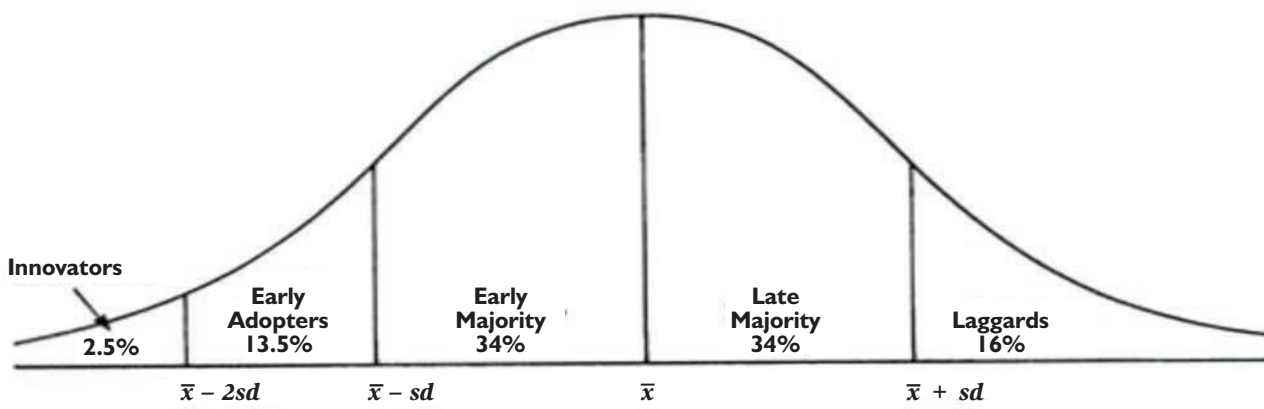

Figure 1: Diffusion of Innovation Theory *(Source: Rogers, E. (2003). Diffusion of Innovations. 5th Edition New York, NY: The Free Press.)*

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time, innovation rarely spread instantly. It requires a certain amount of time for the idea or product to catch on (Figure 1). A good example is the 3D printing industry. It was started in the 1980s, but did not catch on with the mass public until recently. Social systems are the media, political influences, and environmental factors.

Professor Rogers divided the adopters into five groups (in chronological time): the innovators (2.5%), early adopters (13.5%), early majority (34%), late majority (34%), and laggards (16%). Professor Rogers further explained that the innovation must reach a point of critical mass (enough adopters for the idea to be self-sustaining) to survive. The early adopters are the major orthopedics and podiatric groups that saw the economic potential of consolidating resources, expertise, and academic knowledge.

The passage of the PPACA created a favorable social system for the super groups to flourish. The changing political environment encouraged other forward thinking providers to join the established super groups as the early majority. At this point, the product has captured nearly 50% of the market share. Eventually, the paradigm shift will be completed with the late majority (the skeptics) and laggard groups (the anti-change group).

Lean Principle

Both smaller providers and larger groups can benefit from identifying the strengths and weaknesses of their practices. To lower costs, the provider must strive to reduce inefficiency in the workflow process. This can be accomplished by using the Lean principle, which has been a popular Japanese manufacturing principle used by Toyota for years. Essentially, it is a systematic method used to identify the value and eliminate waste in a manufacturing process. In medicine, workflow inefficiency can hinder work productivity, create a negative working atmosphere, and prolong the wait time for patients. It can also lead to poorer quality control, bad customer service, and higher burnout rates for the physicians. The Lean principle is comprised of five steps: Define Value, Map Value Stream, Create Flow, Establish Pull, and Seek Perfection (Figure 2).

Value

Value is something that the patient wants and is willing to pay for. It is not dependent on the best materials, the newest technology, or the most beautiful office. The most valuable resource and the core of your business is the staff. Author Zig Ziglar once said, "You don't build a business, you build people, then people build the business." In a Modern Survey (fall of 2014), it is reported that only 16% of employees are

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fully engaged in their jobs. The employees are the direct extension of the physician. They understand the patients better than anyone. They can help define the value by speaking directly to the patients to see how the practice can grow and improve. By empowering the staff in the decision-making process, it will create a sense of pride in the workplace and increase productivity.

Value Stream

The value stream is any process that will add additional value to the practice. It can be as simple as embracing a new technology to increase productivity. In addition, resources such as marketing, branding, and public relations can help build your practice. In-office product dispensing is a great way to increase revenue while providing extra care and convenience to patients. Educational brochures (treatment instructions and guidelines) are great marketing tools that will help patients understand their illness and encourage them to be more compliant.

Flow

Flow can be defined as how a process moves from point A to point Z. In a perfect world, the most efficient flow is a straight line with no detours (waste). It allows a product to move through the processes quickly without sacrificing quality. Flow can be determined by following the patient through a complete visit.

The process starts when the patient checks in with the receptionist. Check for any waste. Is the receptionist overburdened by other work? How long does it take for the patient to fill out the forms? Is the patient comfortable in the waiting room? In order to become more efficient with limited resources, other industries have turned to consumer-focused plans such as self check-in (airport, movies, hotels), online banking (mobile deposits), online reservations (restaurants, hotels), self-assembling furniture (IKEA), and advanced online purchases (retailers). It empowers the consumers to be part of the process while freeing up the resources to increase workplace productivity.

Some medical offices are encouraging their patients to fill out the necessary forms online prior to their scheduled visit. Other places are using self-serving tablets for data entry and registration. In modern practices, patients can often schedule and reschedule their appointments online. This added convenience can reduce the no-show rates. Some practices even allow patients to interact with the physicians through a secured network. Patients can request medical reports and refills through the same portal.

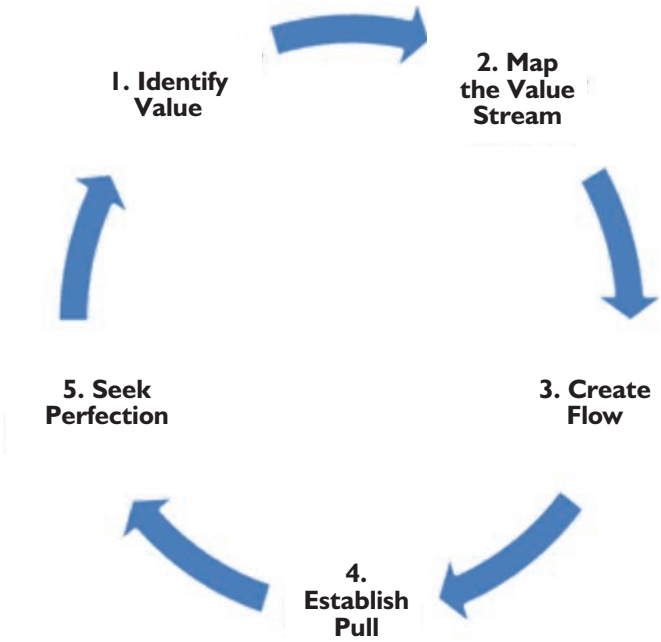

Figure 2: Lean Principle *(Source: www.lean.org)*

In a perfect world with no waiting room, the medical assistant will bring the patient into the examining room and the doctor can immediately talk to the patient. In real life, the physicians need the medical assistant to expedite the process by taking a quick HPI of the condition, updating the medical records, obtaining the pertinent x-rays, and setting up the proper supplies (instruments, brochures, instruction sheets, value products) for each patient. This will eliminate waste such as physicians scrambling to find supplies or looking for a patient's chart. After the physician is done with the patient, the office assistant will reschedule the patient for a follow-up visit, take the time to explain the brochures/instructions, and assist the patient with new products.

When the patient proceeds to the discharging station, the office assistant will clean the room and prepare for the next patient. The discharge specialist will review the account with the patient and handle any payments or reimbursements. In this work example, the physician can increase productivity by empowering the assistants to carry out specific roles as part of a healthcare team. In an ideal setting, the entire visit should take under 20 minutes (Figure 3)

Pull

In Supply Chain Management (SCM), supply chain models are set up in either the push type or the pull type. The push type (make to stock) is when the items are not produced based on demands. Overproduction can lead to bloated inventories (similar to books in a bookstore). The pull type (make to order) is a system where an item is only produced when there is a demand. The Lean principle requires the provider to examine the pull (demand) for each product to control the level of inventory.

Seeking Perfection

The last process is seeking perfection. Providers should establish baseline data to measure the average time per visit (check-in to discharge). By eliminating the waste, it should lower the work burden for the staff and expedite each office visit for the patient. With repetitive training and preparation, the practice will improve over time.

Benefits of Treatment Protocols

Earlier, we mentioned that our goal is to reduce cost while improving the quality of care. We discussed

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the different ways to reduce cost by consolidating resources (joining a multi-disciplinary group or super groups) and eliminating waste through the Lean principle. How do you improve the quality of care? An effective tool is the development of treatment protocols and guidelines.

When we speak about treatment protocols, most of us think of the larger super group or multi-specialty clinics. A common misconception is that smaller solo practices do not need treatment protocols. In reality, treatment protocols are useful for all physicians (including residents, attending physicians, solo practitioners, and large super groups). An effective treatment protocol will improve the quality of care and maintain consistency. In smaller practices, the protocol will serve as a reference or checklist for the busy solo practitioner. It prevents careless mistakes. In larger groups, protocols are used to established consistency regardless of where or by whom the patients are treated. In addition, protocols empower the patients to be part of the process. Patients are more compliant when they understand the required steps to recovery. Good effective protocols are constantly updated to prevent physicians from practicing outdated medicine. Treatment protocols that show consistency and quality outcomes can be great negotiation tools against the insurers. The providers can argue for better rates for consistency, better outcomes, and reduction in associated risks.

Figure 3: Flow Diagram (Office Visit)

Developing Treatment Protocols

When developing treatment protocols, it is important to verify the validity of the treatment option through evidence-based medicine. Protocols should be derived from recognized peer-reviewed sources. A good protocol includes measurable metrics against accepted benchmarks. Protocols should be easy to read and understand. Protocols should be practical

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and reproducible. Most importantly, protocols must be constantly updated and reviewed by the advisory board.

As a society, we are living in a litigation-oriented world. Protocols can be dangerous if not used correctly. Some people will argue that protocols should be able to hold up in a court of law (if necessary). In reality, protocols are not intended to be clinical laws. They are merely an effective reference that can improve efficiency and outcome. They are not intended to take away the autonomy of the physician. They encourage physicians to share their experiences and make changes to the protocols as necessary.

Summary

Due to the shifting changes in healthcare policies and demands, physicians are forced to adapt to survive. The goal is to stay economically viable. It will require physicians to work together to navigate the new terrains. In addition to being in compliance with new rules and regulations, physicians must work to control their cost while improving quality. One solution is for physicians to consolidate resources by joining multi-disciplinary groups or large super groups. Smaller solo practices can still survive and prosper by exercising caution with cash flow and following proven successful business models. Both large and small practices can benefit by using the Lean principle to eliminate unnecessary waste. Treatment protocols can be used as valuable references. It can provide consistency and improve the quality of care. Laws can change; medicine can evolve, survive, and prosper. **PM**

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