



Patient Flow and Cycle Time in the Podiatric Medical Practice

Removing bottlenecks leads to increasing efficiency.

BY MARK TERRY

It comes down to efficiency. And although they are related, patient flow and cycle time are two slightly different things.

John Guiliana, DPM, executive vice president of NEMO Health, says, “Cycle time is the amount of time in minutes that a patient spends in the office. The cycle begins at the time of arrival and ends when the patient leaves the office. The flow, the process of patient flow, dictates your cycle time.”

Patient flow is how the patients move through your practice. Improving patient flow includes how quickly, efficiently and effectively your practice meets patient care demand by moving patients through the office.

The Biggest Bottlenecks

Bottlenecks can occur anywhere throughout the practice, and, of course, emergencies can throw an entire day’s schedule out of whack. Individual practices may have unique bottlenecks based on how their staff behaves (or is trained), or unique aspects of the patient population.

Jane Andersen, DPM, with InStride Chapel Hill Foot & Ankle in Chapel Hill, North Carolina, says, “I think the biggest barrier for us now is getting everything entered in the medical record system. Now that everything is computerized and everything we have to enter, my staff is ideally going to enter in all the medical his-

tory, their allergies, and all of those things, but they’re not as good at it as they should be. I think our biggest limitation in flow is getting our staff up to speed.”

Some of that is unique to Andersen’s practice, because, partly due to their joining a supergroup, they have had three different electronic medical record systems in three to four years. “Every time they get a little easier and a little harder. It makes our lives easier as physicians if we can have as much entered in there as possible, but what that does for our staff is it kind of slows them down. Because if the patient is ready to be seen and they don’t have everything entered, do they give me the opportunity to see the patient

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Dr. Guiliana



Dr. Andersen

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or do they keep the paperwork for five minutes and enter data? That’s something we’re trying to work out.”

Annette Joyce, DPM, Program Chair of Derm Foot and with 360Care in Pawleys Island, South Carolina, admits things are different for her now. She was in private podiatric practice for 20 years, but is now semi-retired, working for 360Care, essentially a nursing home company. “It’s interesting how they do things,” she says. “They really schedule tightly. I have to see 40 to 50 patients per day. They put 40 patients on your schedule. But in a facility environment you’re seeing a patient every 10 minutes, but you don’t have to do any paperwork, so it’s much more efficient.”



Dr. Joyce

But she notes that in her previous practice, they had every technological advantage. The biggest bottleneck was actually caused by something of a screen-

Sample Cycle Time for X-Minute Office Visit

STEP	TIME (MINUTES)
Wait at Check-in	
Complete Check-in	
Wait in Waiting Room	
Move to Exam Room	
Wait for Physician	
Interaction with Physician	
Move to Checkout	

ing or triage situation. “I think the biggest challenge is not knowing how long it will take when a patient makes their appointment, what their real complaint is. If you have a really good interviewer on the phone, if the person has a lot to say and a complicated history, we flag them and give them a little more time. But if it’s a new patient, you don’t know.”

For much of her private practice history, new patients were given a 30-minute appointment. For a routine patient, typically 15 minutes. “For instance,” Joyce

“Everybody should be using patient eligibility software and most electronic health records have it integrated.”—Guiliana

says, “if a patient calls and says they have heel pain, to us that maybe means 15 minutes; it’s not trauma or surgical. But if the patient has a complicated heel problem medically, it could be a 30-minute appointment.” But toward the end of her practice, as reimbursement pressures kicked in, the new-patient appointment shifted more towards 15 minutes.

Guiliana notes, “Bottlenecks typically occur at the front desk for patients who haven’t filled out their registration information. Problems occur at the front desk if practices aren’t utilizing technology for things like patient eligibility. Everybody should be using patient eligibility software and most electronic health records systems have it integrated.”

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Analyzing Patient Flow and Cycle Time

Some consultants suggest you go through the practice as if you were a patient, timing each step of the way—how long you waited in the waiting room, how long you were triaged by staff in the examining room, how long you waited until the physician turned up, then after-exam waiting times, to front desk and exit. For many physicians, practice management software can provide much of that data.

Guiliana distinguishes between value-added time (VAT) and non-value-added time (NVAT). “VAT is time spent with the physician or other members of the care

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team, versus NVAT, where the patient is sitting there idle either in the reception room or the treatment room.” Taking a benchmark of decreasing the office visit cycle time to 30 to 35 minutes, you want a ratio of about 1.5 times the VAT to NVAT. In other words, Guiliana says, “1.5 times the actual time spent with the clinician, the doctor, 1.5 times the actual time spent with the provider.”

To determine what’s going on in the practice in terms of flow and cycle time, Guiliana recommends taking a sample of 15 patients, both onsite and remotely over a period of time. “I suggest the physician or the officer manager takes a random sample of a minimum of 15 patients per week and do it on the same day and time each week for four consecutive weeks,” Guiliana says.

He also points out that there are some excellent online templates for patient flow. An example is fairly simple as shown on page 66.

Guiliana says, “You’re measuring each component of that office visit: the time filling out documents and forms, the time just sitting there waiting in the reception room, the time with the physician, with the medical assistant, time checking out. Each is measured in minutes.”

Appointment patterns can also reveal a lot of information. Are there certain types of patients (or specific patients?) who use up more time? Are there certain types of exams that require more time? What are your busiest days? What are your slowest days?

In a multi-physician practice, doing this separately for each physician and graphing the results can be illuminating. It can move your patient flow along if you set aside certain days or certain blocks of time for new patients, for example.

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Staffing and Triage

Being aware of where the problems are in patient flow and cycle time is a first step. Knowing what to do about problems can be tougher. As

examination process, taking notes so the physician can focus on the patient. This obviously has some effect on staffing requirements.

Although it's a little basic, take a look at how your medical practice is designed. Exam rooms, for example,

It's possible, even likely, that some of these interruptions can be scheduled—responding to phone calls from pharmacists and referrals, for example. Creating blocks of time each day in your schedule specifically set aside for “busy work,” or at least, things not directly related to patient care. Setting time aside for “business work,” such as dealing with billing issues and practice-related business issues, can go a long ways toward making your practice more efficient.

“Our electronic health records are sophisticated enough to tell us how long the patients have been waiting.”—Joyce

suggested above, if the front desk is a common bottleneck, working to train staff on the appropriate questions to ask patients in order to determine the best appointment time length will likely solve problems down the road. Using appropriate technology and automation is also a great idea.

Joyce notes, “Our electronic health records are sophisticated enough to tell us how long the patients have been waiting—whether they're checked in or on a computer, that starts a clock, so you actually know how long they waited and you can track it. We see where are pitfalls are, where our gaps are.”

But appropriate staffing and use of staff can also work to create more efficient patient flow. Andersen says that can be a tricky issue, because her practice has always run lean, with three doctors who are not quite full-time and four full-time employees. “Most people's offices have more and that might increase their workflow and efficiency. So far, that's one of our barriers. We're hoping to improve our workflow with the new CareCloud EHR (that came on via joining the supergroup) and that it won't put extra demands on staff. If it isn't the ticket, then we'll have to increase our staffing; otherwise we'll spend all of our time entering in the data or having to do it at the end of the day, and that's really, really annoying.”

Typically, the staffing metric is 2.5 staff members per physician, although that can depend somewhat on whether you're doing billing in-house or using a billing company. Also, some podiatrists depend on scribes, who follow them through the

should be as identical to each other as possible, with everything in the same location. Each room should be appropriately supplied so time is not wasted looking for what is needed or even having to leave the room looking for supplies. Dealing with emergencies or just plain running behind, no matter what, can completely mess up a schedule and irritate patients.

Everyone interviewed for this article said it was important to explain to patients that, depending on the sit-

Priorities

Guiliana emphasizes, “Everybody thinks the only goal here is to reduce cycle time, but it's not. Reducing cycle time is a secondary objective. The goal is to maximize the time the patient spends with the value-added entities, the physician, the medical assistant, because it's all about quality care. What we're trying to reduce is the non-value-added patient care.”

In fact, each person interviewed for this article was asked, particularly in light of the trend in healthcare of do-more-do-more-do-more, “Was it

“My priorities are to provide good patient care; that's the number one thing. So if someone needs something and I have to do it and it's going to put me behind, I do it. Because they need it.”—Andersen

uation, the doctor is dealing with an emergency or running behind, and to please be patient. If there's an issue, offer to reschedule.

Interruptions and Non-Visit-Related Care

Some people also track interruptions. This is related to tracking flow, but very specifically tracking interruptions. The physician can make an “interruption list”, writing down things that require them to leave the exam room, or more broadly, any interruption, whether it's to answer the phone from a physician, a patient, an insurance company, a staffer, etc. Finding patterns can lead to solutions.

possible to be too efficient?”

Andersen says, with more than a little bit of humor, “I'm not sure I'm capable of that with this patient population.” By that, she says, “I'm in a little bubble. Chapel Hill, NC has the highest number of people with a doctoral degree in any town in the country. It's an extremely well-educated population here. There is no cutting corners or hyper-efficiency here. The average person in Chapel Hill is a professor or a doctor and they know a lot about their problems and have a lot of questions about etiology and practice plans, so I probably have longer sessions because of this very demanding patient population.

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They're very nice, but they require a bit more attention." However, she emphasizes, "My priorities are to provide good patient care; that's the number one thing. So if someone needs something and I have to do it and it's going to put me behind, I do it. Because they need it."

Joyce agrees, saying, "I never, ever want to diminish the value of quality care in my practice and what that means, even if it takes two hours instead of 15 minutes." She does think a physician can be too efficient by "treating the computer." By that, she means, relying too

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heavily on the computer in the exam room, paying more attention to entering information into the computer than into treating the patient. "It does make the practice more efficient, because your note is 80% finished; some physicians find it valuable, but I think it detracts from the patient-physician relationship if you don't have time to look the patient in the eye, have a physical connection, shake their hand, touch their foot."

Guiliana said, "Well, the answer is yes, unless you change the question to be, 'Can you be too efficacious?' The answer for that would be no. What we strive for is efficacy, not efficiency."

On the other hand, a little improvement in efficiency—in patient flow and cycle time—if done in a way that is smoothing over rough spots or eliminating unnecessary inefficiencies, can lead to more quality time with the patient, and potentially more revenue in your practice.

Guiliana points out, "In most offices, if the provider adds just one more patient per day, because they've optimized their cycle time, that's going to equate to \$20,000 to \$40,000 per year, most of which, by the way, is profit because the fixed costs are already paid for. Imagine if you saw five more patients per day." **PM**



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