
Answers to Your Questions on Solo, Idealized Practice

How does a solo doc with no support staff manage his referrals, order his supplies and give immunizations? Gordon Moore, MD, answers those questions and more.

Office-based practice is getting a major makeover in many parts of the country in response to growing concerns about the quality of care and service in the current health care system. Remaking the medical practice is no small task, but Gordon Moore, MD, a family physician in Rochester, N.Y., has found what seems to be a successful, albeit unorthodox, solution. By applying the Institute for Healthcare Improvement's four themes of ideal practice (access, interaction, reliability and vitality), Moore has crafted a lean, low-volume, low-cost solo practice. He handles all clinical and practice management tasks himself without any support staff in his 150-square-foot office. Because his overhead is remarkably low, he does not have to rush masses of patients through his practice in order to be profitable, which has resulted in high patient (and personal) satisfaction and excellent clinical outcomes.

Moore detailed his solo, idealized practice in *FPM* in the February 2002 issue [page 29] and the March 2002 issue [page 25]. In response, *FPM* received an unprecedented number of letters, e-mails, phone calls and faxes containing hundreds of reader questions and comments. *FPM* pulled the most commonly asked questions from the pile and posed them to Moore. His responses follow, along with a sampling of readers' reactions to his articles.

While solo, no-staff practice is intriguing, what would happen if all family physicians abandoned the existing

system? Would family practice be reduced to a niche market that only a small population could access, or could we provide good care for the nation with panels of 1,350 patients?

Moore: The system as it exists is incapable of achieving the results we need and should be abandoned. We should no longer tolerate the ubiquitous waits and delays, the shocking inefficiencies that lead to incredible human suffering or the 13 percent of gross domestic product being expended on health care.

If every family physician chose to practice all alone, we would have a significant physician shortage. The ideal practice model does not rest on any specific configuration of a care team. It rests on the concepts of continuous flow, access and the intelligent use of systems. These fundamental concepts may be applied to care teams of any size and accommodate a wide range of panel sizes.

My practice demonstrates the real-time utility of the concepts. I have chosen at this time to use a "care team of one" strategy to achieve simultaneous breakthroughs in access, interaction, reliability and vitality. Adding another person to my care team (clerical or clinical) would immediately expand the practice's capacity, thereby allowing the team to care for a wider population.

The "care team of one" strategy is not the end in and of itself. It is but one path taken to achieve the pressing needs of improved access, interaction, reliability and vitality. ►

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Gordon Moore, MD, has crafted a solo, idealized practice built on four themes: unfettered access, personal patient interaction, clinical reliability and practice vitality.



Ideal practice does not rest on any specific configuration of a care team but on concepts such as continuous flow, access and the intelligent use of systems.



Moore's budgeted expenses are remarkably low, averaging just \$1,600 per month.



His practice arrangement has enabled him to avoid certain practice expenses (such as staff salaries) and reduce others (such as malpractice premiums).

Your budget, outlined in the March 2002 article, allots \$100 per month for "insurance," which seems too low to include malpractice insurance. How are you paying for this?

Moore: The budget is a simplification but does have a placeholder for "insurances" that includes business insurance as well as malpractice. The graph of expense and income (on page 27 in the March issue) is an accurate representation of my checkbook accounting method. As I see the checks go out the door each month, as shown on the expense graph, I see reality, no fabrication.

My medical malpractice costs are low as I do not do obstetrics and am able to purchase insurance at a discounted rate through the University of Rochester's Medical Center Insurance Corp. I am affiliated with the university through my part-time administrative position with Strong Health, an academic health system in Rochester, N.Y.

As time goes on, I expect my monthly average of \$1,600 in expenses will change a bit. Eventually the \$338 monthly expense of the start-up loan will be gone, and the occasional big-ticket items and full medical malpractice premiums will come along. Still, my monthly expenses will stay quite close to \$1,600. If my expenses were closer to \$2,000, or even \$2,250, the point would be the same: A low-volume, low-overhead

practice is radically different from the typical office and allows the physician to create breakthroughs in access, interaction and reliability.

How have you been able to streamline the time-consuming process of scheduling patients, verifying their insurance, collecting co-payments and making referrals so that you can simultaneously see patients?

Moore: The answer is both simple and complex: by assiduously focusing on process. I use the concepts embedded in the phrase "continuous flow." The moment something comes up, I do everything I can to bring that piece of work to completion. For instance, when a call comes in for a referral, I pull up the patient's demographic information on my computer, cut and paste the member ID number into a fax cover page, click on the insurer's referral fax number, type "Mr. John Doe needs three visits with Dr. Jekyl for halitosis as of today. Thanks, Gordon Moore," and click "send."

I do this while on the phone with the patient and then tell the patient that I have done it and that the specialist can get the referral number directly from the insurer or, if the patient wants it, he or she can call the HMO. I do not have to take any notes, and I do not have to think about it again. Eventually, I will get the form from the

insurer with the referral information and I will scan it into my system. (As a sidenote: I fail to see the value in any of this work and believe the entire "gatekeeper" concept is bankrupt. It adds considerably to the expense of every doctor's office and often drives unnecessary office visits.)

I apply this kind of process streamlining to everything I can. In the aforementioned example, I don't have to pull the chart, I don't get a second (or third) call from the patient asking whether the referral has been made, and I don't get a call from the specialist's office. Carrying a task to completion at the very moment it arises allows for a significant reduction in rework. These concepts

Not for the practice-management challenged

To the Editor:

I've been using a model of practice similar to Dr. Moore's since December 2000, and I love it. My practice receives mixed reviews from the medical community and surprises patients who call the office for the first time. They are stunned to talk directly to the doctor and to be offered an appointment the same day.

I would caution, however, that this model is not for every doctor. For it to work, the doctor must be fully able and willing to do the billing – from coding to software to evaluating accounts receivable to negotiating insurance contracts – all things traditionally delegated to support staff.

This model is viable, offering important improvements over the faceless, cattle-call style of medicine. We have allowed the practice of medicine to be dictated to us for far too long. We can choose a more humane and effective manner of practice.

*Sheila Hellman, DO
Jonesboro, Ark.*

are elucidated in the work of James Womak et al in *The Machine That Changed the World* and *Lean Thinking*. See www.lean.org.

What kind of process do you use for billing that allows you to accomplish it in “less than one hour per week”?

Moore: Billing simplicity is based in part on good systems that allow me to use intelligent searching and pull-down lists for ICD-

per day, the billing workload is lighter.

Could a family physician adopt your style of practice and still do obstetrics or procedures, such as flexible sigmoidoscopy?

Moore: Yes. Any practice can create a match of capacity to demand and, therefore, deliver on the promises of access, interaction, reliability and vitality. It starts with understanding the nature of your capacity and demand.

Work can be sustained in the long term only if there is an equilibrium between the work (demand) and my ability to accomplish that work (capacity). As Mark Murray, MD, says so well in the work of advanced-access scheduling [see “Same-Day Appointments: Exploding the Access Paradigm,” *FPM*, September 2000, page 45], we must create a balance between capacity and demand. When creating an ideal office practice, we must assess the true nature of our capacity: How many hours per week are you willing to work?

On the other side of the equation, we do all we can to figure out the true nature of the demand. Demand will be driven by the number of people calling you

their doctor, their illness burden, their historic utilization rates, your scope of practice and other thresholds to care driven by co-pays, office hours, location, etc. You may or may not be in a position to alter any of these variables. If you are the only doctor in a small community, you may be obliged by contract or moral obligation to assume care for the majority of the community. You may be obliged to offer phlebotomy, EKGs, treadmill testing, laceration repair, ob ultrasound, etc. Everything you take on in scope of practice, procedures, population size, etc., will bring more work. Once that burden of work exceeds your individual capacity, you must increase the size of the team caring for that population. At that point you would have the option to

Carrying a task to completion at the very moment it arises allows for a significant reduction in rework.

9 and CPT coding and that remember the diagnoses from one visit to another. I have these capabilities in the Alteer computer system that I use. The second major piece is my low-cost, low-volume office. Because my overhead is low, I don't have to see as many patients per day to be profitable. And because I don't have to see as many patients

Principles to put into practice

To the Editor:

I enjoyed reading about the adventures of Dr. Moore. As a solo family doctor who started a solo practice twice, once fresh out of residency and then again after a few years of teaching in a family practice residency program, I think more doctors would go into solo practice if they had some practical guidelines. Before other physicians could pursue Dr. Moore's model, they would need more detailed information regarding how he pays for malpractice insurance, his family's health insurance and other items not shown in his budget; how he deals with capitated and other HMO contracts; how he convinced the neighboring practice to offer him assistance; etc.

I heartily endorse the principles of Dr. Moore's series and his model of simplicity. There are many ways to make practice more complicated and expensive, but few of them are essential. Doing the work yourself is cheaper and simpler if you are willing to learn how.

Patients are absolutely happiest when they have direct contact with their doctor. Start a patient, finish a patient, don't get sidetracked and lose track of the details, and do it right the first time. These are all good ideas. The model most practices have now is based on a factory model of mass production. It is a poor way to practice medicine.

Susan Thompson, MD
Great Barrington, Mass.

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To streamline the process of scheduling patients, verifying their insurance, collecting co-pays and making referrals, Moore focuses assiduously on process.



The concept of “continuous flow” requires that you carry a task to completion at the very moment it arises, which ultimately results in a more efficient office.



Any practice configuration can deliver on the promises of access, interaction, reliability and vitality, but it must find a way to balance patient demand and physician capacity.



Your capacity is determined in part by how many hours per week you are willing to work; your demand is driven by multiple variables, some of which you may not be able to alter.

◀ ▶
In any practice configuration, some part of the equation must flex in order to achieve a balance between capacity and demand.

◀ ▶
Some physicians may achieve this balance through a smaller panel size. Others will achieve it by adding staff.

◀ ▶
Physicians in any situation should be cautious about the capitation contracts they sign, but the risk is particularly high for individual physicians.

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Physicians that can demonstrate their quality and service will be able to secure contracts that respect both their patients' needs and their own.

The FP's value is in 'being there'

To the Editor:

Dr. Moore is to be commended for structuring his new practice to avoid putting distance between himself and his patients, for example, by taking all his own night call and not hiring helpers. He is among the few family physicians who have not lost sight of why we are here.

After 23 years of rural family practice, I am now chief medical officer of a health plan. Family practice has changed "since I was a boy." Patients seek medical care and wellness care; they also seek advocacy, friendship and counsel from their doctors. I chose family practice because I felt I could deliver optimum patient care if I knew my patients well, including their ecosystems – their family, friends and community. I could not do that without a long-term, longitudinal relationship with each patient. Such a relationship cannot be measured in years; it must be measured in encounters.

If you see a patient once a year for her annual well-woman examination but you miss her other three visits per year because she was not sick during your 32-hour office week, you have missed three opportunities to know her better and to engender trust and confidence. You also let her down by not being available and eroded her confidence in you.

What can family doctors do better than other specialists? Almost nothing! We don't deliver better heart

care than a cardiologist or better skin care than a dermatologist. But we do provide better *people* care – care for the whole patient – if we are available. Crucial point: The only value family physicians bring to health care is longitudinal availability to patients. Without that, not only are we not delivering better care than other specialists, we are adding cost without adding value. No one can add cost without adding value for long; dollars are too precious.

Access barriers make you miss the episodic care your patients need. If you don't take call frequently, you miss the rest of it. You can minimize the gap between you and your patients by seeing today everyone who calls today. There is plentiful evidence that maximizing availability *reduces* demand, increases your satisfaction and your patients' satisfaction.

Get to know your patients, gain their confidence and be there for them as many hours of the year as you can. When you have their confidence, it only takes a few moments to talk them out of an unnecessary MRI or help them to lose weight without a gastric stapling operation. Add value to the process! You can be part of the solution to the cost crisis in health care.

Gordon Moore, I salute you. May many follow your example in practicing availability and longitudinal medicine.

Roger K. Howe, MD
Little Rock, Ark.

increase the team composition with an MD, NP, RN, LPN, MA, secretary or whatever position is most appropriate in your situation.

You may have the luxury of picking your ideal panel size or dropping EKG and phlebotomy (as I have done). If these are non-negotiable, then other parts of the equation must flex more to achieve the balance of capacity and demand. Attention to this balance will reduce the weight of burnout that is crushing our profession.

How do your patients get X-rays, EKGs, blood draws, etc.?

Moore: In my community, it is the norm to have patients go "down the street" to a free-standing phlebotomy center or imaging center. The nearby lab will also perform EKGs. The idea behind this is paring practice down to bare essentials so that I may create the balance that makes it sustainable.

Your business model assumes an average of \$65 per office visit. Would it work if you had capitation contracts?

Moore: If I were able to determine, based on the historic utilization for the population in question, that the contract would compensate me close to the rate of \$65 per office visit, I would consider – with great trepidation – signing it. (From what I have seen of my referral and utilization patterns from local HMOs, I do "well" in their eyes with lower downstream costs, age/sex adjusted, than many of my colleagues. Their definition of "well" is wrapped almost entirely in "medical loss;" that is, medical expense. One of the fundamental problems with the current schemes of physician reimbursement and evaluation is that there is an almost singular focus on money. What you measure you can change. If we measure only the money in health care – utilization is a proxy



To achieve a higher than usual level of coding, a physician must perform the unusual.



With longer office visits, Moore does not have to ask patients to make another appointment to address something other than the chief complaint.



Moore bases the care he provides not only on what the patient wants but what the patient wants *and needs*.



By offering small incentives to the support staff in a neighboring practice, Moore gains their assistance, as needed.

Been there, done that

To the Editor:

I liked the second part of the ultimate solo practitioner's story, but I've been there. I work for my office manager when she goes on vacation, and it is doable but not fun. I would suggest Dr. Moore see one or two more patients a day to cover the expense of an employee and hire someone who can multitask and make his professional life a pleasure.

*Sanford J. Brown, MD
Mendocino, Calif.*

If we measure only the money in health care, we lose track of the essence of what we do.

for money – we lose track of the essence of what we do: Reduce suffering and improve health.)

The risk associated with capitation is very high for individual physicians unless the stop-loss rates are set at a reasonable level (determined by the scope of practice risk, utilization risk, etc.). I have been on the other side of the managed care fence and know that it is almost impossible to adjudicate the risk and set reasonable stop-loss limits. If you can deliver on access, interaction and reliability, you will be able to fill your practice with contracts that respect patients and their needs and eschew those that do not.

You write that your typical office visit is a 99214, which seems higher than the typical FP's office visit. How do you achieve this level of service?

Moore: The higher than usual level of coding is based on performing the unusual. I have more time to spend with each patient. I no longer have to ask patients to make another appointment to address something other than the chief complaint. In fact, I

have the time to turn the tables on them. "So tell me about your continued use of tobacco," or "How about that colon cancer screening?" I do more than the usual and base what I do not only on what the patient wants but what the patient wants *and needs*. I document what I do and bill appropriately for that work. I do in fact have 99213 and even 99212 visits, as there are occasions where those

codes best approximate what my patients want and need.

When do you find time to perform tasks such as cleaning your instruments and exam room or ordering supplies?

Moore: I have one exam room. It doesn't take long to clean off the exam table, swipe my stethoscope, etc. I use disposable speculæ. A colleague in Wichita, Kan., told me about disposable suturing supplies, so I may return to doing minor skin procedures. I had given them up as I had no place for dirty instruments and didn't want to get into contracting with a sterile cleaning service. I'm not thrilled with the disposable nature of

Money, money, money

To the Editor:

I've been so fed up with the current system of practice – and I'm only out of residency a year and a half! I'm an older graduate, but still it's a treadmill. All the talk is revenue, number of patients, documentation to squeeze out a higher code and money, money, money. The last quality meeting at my practice covered all of that and then someone said, "Oh, and we care about our patients too." Everyone laughed, except me.

I'm always the last to finish because I *do* spend time with my patients and go the extra mile. My patients are extremely happy, but I always get dinged. I use a palm-top computer and am interested in electronic medical record systems, but I've wondered how to take the next step and integrate technology into a working, *patient-oriented practice*. And then I came across Dr. Moore's articles and found that such systems exist and work! Thank you for these articles! Perhaps we family docs will pull off the paradigm shift medical care desperately needs to make.

*Rebecca L. Hoffman, MD
Vancouver, Wash.*



A fast Internet connection and a bookmark to the CDC Web site for Vaccine Information Statements helps childhood immunizations occur more efficiently.



It is not helpful for physicians to perceive patient phone calls as "yet another thing those demanding patients are doing to keep me from my family."



A number of phone calls can be avoided simply by reviewing each patient's medication list during the visit and asking whether any refills are needed.



Being proactive and involving patients in the care process results in a more efficient and satisfying practice.

things but will try and quiet the environmentalist in me in this circumstance.

Ordering supplies is a simple phone call. I have yet to order another box of table paper. I have not yet run out of ear cures. My supply needs are pretty simple. Vaccines are the only things I order with any regularity, and I have a deal with a local pharmacy wherein I receive them within a day of my phone call. I simply drop by the pharmacy and pick up my order on my way to or from a meeting. This takes me maybe 10 to 15 minutes a month.

When you utilize one of the adjacent practice's office staff for chaperoning, how are they reimbursed?

Moore: I asked the support staff in the ophthalmology shop if they would be willing to accept \$5 for their time, and they were fine with it. I take it out of my wallet and hand it to them.

How are you able to do childhood vaccinations, with all of the accompanying paperwork and regulations, given that you have no support staff?

Moore: The regulations regarding vaccination are pretty straightforward where I practice, so there may be some things other physicians must accomplish that are alien to me (although, in general, New York state is pretty high on the regulatory side of things). I have a fast Internet connection and have the CDC site for Vaccine Information Statements bookmarked (www.cdc.gov/nip/publications/VIS). When the need arises, I click on the site, click on the appropriate form(s), press print and hand them to the parents.

We keep chatting as they read the forms and sign, and then we go on with the visit. If needed, I ask one of the parents to help hold the child during the shots. Overall, my vaccination process may take a bit more time, but it is not that big of a deal with the volume of patients in my office. It definitely does not push me beyond my capacity to do the work.

How are you able to manage time-consuming phone calls from patients requesting lab results, prescription refills, etc.?

Moore: First, I do not perceive phone calls as "yet another thing those demanding patients are doing to keep me from my family." Second, I try to anticipate the need as much as possible. When someone is in the office, I ask if there are any meds they might need refilled. If they are unsure, we review the list and look at the most recent fill date. That is the best clue. I'm happy to print out extra (non-controlled) prescriptions if they are uncertain, as that is less work than a phone call later followed by the phone call to the pharmacy or putting prescriptions in the mail.

When it comes to labs, imaging reports or updates, it is a part of my job to tell patients what is going on with them. I use the motto, "No news is no news." I tell patients that if they don't hear from me, something went wrong, so they should call me. That way, the patient is part of the fail-safe mechanism (albeit an imperfect fail-safe mechanism). I work to make that phone call not happen. I tell patients when they should hear from me. "It will take about a week for the results to come back to me and for me to review them and get them to you in the mail. Should I discover anything urgent, I'll be on the phone to you right away."

Another thing I do is schedule a chronic-care planned visit one week after the labs are drawn, so that we can review the results together and obviate the need for calling/ mailing. At the end of a visit that includes lipid management, for example, I might say, "Let's increase the dose from 10 mg/d to 20

mg/d. Here is the lab slip. I'd like you to get another fasting lipid profile and liver function test done in two months." By being proactive and involving patients in the care process, I virtually eliminate unnecessary phone calls without sacrificing patient satisfaction. **FPM**

A worthy experiment

To the Editor:

Dr. Moore is not only a pioneer but a true hero. His bold experiment is an exciting model to consider. The question is not whether it will succeed, for success is in the eye of the beholder.

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