Tailoring New Physicians to Fit Your Practice

Find out how one group created an orientation program that assimilates new doctors more quickly and creates an increased sense of loyalty.

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ILLUSTRATION BY BILL BRUNING

In the traditional model of physician orientation, the established physician introduces the eager, young physician to his or her nurse, points out the new physician's three exam rooms and lets him or her know about the established physician's upcoming two-week vacation in Europe. The hope is that when the established physician returns, the new physician will know how to find the emergency room, be familiar with the local specialists and understand the peculiarities of the office staff. All this accomplished without a lot of pesky questions for the senior doc, right?

Well, the problem with this – and similar orientation models that assume a new physician can immediately jump in and be successful – is that they don't quite work. Instead, it takes longer for new physicians to become oriented to the practice and, thus, longer to feel like an integral part of the practice.

At Austin Regional Clinic (ARC), the multispecialty group I work for, this is something we learned the hard way – and something that made us rethink how we integrate new physicians into our practice. Our clinic has 125 providers, 50 of whom are family physicians, but this program could easily be adopted by a practice of any size with any specialty focus. ➤

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Orientation models that assume a new physician can immediately jump into a practice and be successful don't work.

Rather, these models make it harder for the new physician to become oriented to the practice and feel like part of the group.

ARC's old orientation program left the physician's schedule up to the clinic manager and nurse, creating a passive attitude from the physician.

Problems with morale, loyalty, buy-in and physician turnover led ARC to improve its orientation program.

Time for a change

Although the "traditional" orientation program at ARC was less draconian than the model described in the introduction, it was still unstructured beyond two days of introductions and meetings with human resources, quality assurance, information technology and credentialing, among others. Subsequently, the clinic manager and the new physician's nurse played large roles in setting up the new physician's schedule, which didn't encourage the physician to take charge of his or her practice and productivity. Instead, it created a passive attitude from the new physician toward the practice.

When we started to see a growing decline in finances, morale, loyalty and buy-in – and a sharp increase in physician turnover – senior leaders determined that we needed to expedite the assimilation of new physicians. I was tapped to develop a new orientation and integration program.

KEY POINTS

- This group's orientation program sets a visit-frequency target for new physicians: 25 visits per day within the first seven to eight weeks.
- Physicians' coding and documentation are reviewed after one and four months of employment as part of the program.
- New physicians receive guidance through a mentoring program and short vignettes about various practice management issues.

The old orientation program didn't encourage the physician to take charge of his or her practice and productivity.

Improving new-physician orientation

The goals we established for our new program were to accelerate the new physicians' gradual increase of visit volume, optimize their coding and documentation and instill in them a sense of group loyalty and recognition of the benefits of shareholder status. This involved making changes in the new-physician scheduling system, putting more emphasis on coding and documentation accuracy, developing a "chief orientation" to highlight citizenship and benefits issues, and providing more advice and assistance – in the form of mentoring and practice-management tips – to the new physicians. We began by reorganizing the administrative portion of the orientation to allow the physicians to see patients on their first two afternoons instead of devoting their entire first two days to orientation. Then we rolled out the components of the new program.

PRACTICE MANAGEMENT PEARLS

As part of the new orientation and integration program at Austin Regional Clinic (ARC), the physicians developed single-page, practice management pearls to advise new physicians and increase consistency in the clinic. They chose the topics of the pearls based on which subjects prompted the most questions, problems or complaints from new physicians in the past. Here is the complete list of pearls offered at ARC:

- Angry patients
- Charting
- Coding
- Discharging patients from the clinic
- Manipulative patients
- Patients with lists
- Phone-message management
- Physicals
- Physician-patient communication
- Poor outcomes and unexpected deaths
- Procedures
- Referring patients to the after-hours clinic
- Refills
- Same-day appointments
- Specialty phone advice
- Utilization management
- Workers' compensation

This article features four selected pearls (two on pages 41 and 42 and two, "Refills" and "Angry patients," online at www.aafp.org/fpm/20010400/39tail.html).

Scheduling. The biggest change we made to the scheduling system was to set visit-frequency goals. In our old program, the new physicians weren't building volume quickly enough, partly because we had not set any targets for them (i.e., see X number of patients by Y date). In our new program, the new physicians' schedules initially allow 30 minutes per visit, which gives them time to become familiar with the use of our billing system, referral network, medical records format, etc. Then, we work with them to gradually increase their visit frequency to 25 visits per day (21 15-minute visits and four 30-minute physicals) within the first seven to eight weeks.

We also try to help our new physicians

PRACTICE MANAGEMENT PEARL 1

PATIENTS WITH LISTS

Some patients view any office visit as either an opportunity to catch up on all their neglected health care issues for the preceding months or to get an expert opinion on a variety of inconsequential items for which they would never consider making an individual appointment.

The problems

Trying to handle the multiple problems on a patient's list in a 15-minute office visit can be difficult for several reasons:

- It inhibits your ability to stay on schedule.
- It inconveniences your other patients.
- It increases your stress.
- It forces you to spend the first moments with your next patient explaining why you're late, which starts the visit on a negative note.
- It increases your medicolegal risk. You may forget an instruction, or the patient may not hear one because he or she is trying to remember so many things. Because more documentation will be necessary and you'll have less time to do it, it may not be as complete. Remember that patients and attorneys hold you to the same standards no matter how many problems you deal with during one visit.
- It generates lower reimbursement for the clinic and might reduce your productivity. For example, reimbursement for one level-IV visit would be less than for two level-III visits.
- It may cause patients to bring a list of multiple problems to every visit.

Suggested interventions

- Ask your nurse to watch for patients with lists and express doubt to them about your ability to take care of several problems in one visit.
- Try to determine at the beginning of the visit whether the patient has a list. Look for the list itself, several problems noted by the nurse, very thick charts, hovering relatives, etc. It's better to get the list out in the open in the beginning than to wait for it to pop up after you've initiated closure.
- Describe the risks associated with quickly skimming over several problems in a 15-minute visit as opposed to adequately and safely addressing each of the problems. This reinforces that it's a 15-minute visit, that you want them to have safe care and that you do care about addressing each of their problems (just not right now).
- Encourage follow-up visits to deal with each problem. Be cautious, though, about telling the patient to come in for a physical to do everything at once. The patient may bring in a list reaching to the floor.
- Stay focused, and keep patients focused on the reason they're there. Redirect the history discussion when necessary.
- Choose problems wisely. Watch for a patient who spends 12 minutes talking about his or her arthritis pain before bringing up a new chest pain.
- Use good judgment. Be resolute without being mean and confrontational.

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The goals for the new orientation program were to increase productivity and loyalty and optimize coding and documentation.

The new program sets visit-frequency goals for the new physicians.

The target is 25 visits per day (21 15-minute visits and four 30-minute physicals) within the first seven to eight weeks.

New physicians are also expected to have between 30 percent and 70 percent same-day appointment availability.

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ARC has always done a coding review approximately three to four months after a new physician starts.

Now, an additional coding and documentation assessment is done approximately one month after a physician starts.

At the new "chief orientations," the department chiefs discuss citizenship and benefits issues with the new physicians.

The goals of these orientations are to decrease misunderstandings, improve practice consistency and foster positive peer pressure.

PRACTICE MANAGEMENT PEARL 2

PHYSICIAN-PATIENT COMMUNICATION

Occasionally, patient complaints are rooted in a general dissatisfaction with the experience of an office visit. These complaints transcend whether the patient got well, or even whether the physician was on time. They might arise because the patient left the exam room feeling as if he or she had not been properly heard or that the physician didn't properly explain things to the patient. Comments such as, "She didn't listen to my explanation," or, "He barely looked at the rash," signal deficiencies in the physician-patient relationship for that interaction.

The "happy glow"

We've all seen the patient who leaves a visit with a smile on his face because he's just seen a doctor who listened to his problems and offered help: He has the "happy glow." Here are some ways to increase the number of patients with the "happy glow" each day:

- Be confident. You only have a fair chance of curing the patient's problem, but you have a 100-percent chance of helping him or her feel better on at least some level.
- Look at the chart before entering the room to determine whether you've ever seen the patient previously. This changes the first words out of your mouth from, "Good morning, Mrs. Jones. I'm Randall Grimshaw," to, "Good morning, Mrs. Jones. Long time no see." Using the wrong greeting creates a bad impression.
- Handle tardiness appropriately. If you're more than 10 minutes late, apologize at the beginning of the visit. If you're more than 25 minutes late, apologize at the beginning and end of the visit.
- Smile at the beginning and end of the visit.
- Make some physical contact. Offer a handshake or a pat on the shoulder at the beginning of the visit, touch the patient during the exam (even if it's just to listen to the heart and lungs) and offer a handshake or a pat on the knee or shoulder at the end of the visit.
- Acknowledge others in the room (e.g., "I see you brought your assistant!").
- Sit, even if it's just for a few seconds.
- Look the patient in the eye, but avoid stare-downs. Keep your expression empathetic or positive.
- Give the patient permission to call back (e.g., "Let me know if you have any trouble with your medicine, or if you're not better in a week.").

build a loyal patient base by emphasizing same-day appointment availability. Although the number of same-day appointment slots a physician can have varies greatly by the physician, the clinic and even the time of year, we suggest that new physicians try to have between 30 percent and 70 percent of their total daily or weekly appointment slots available for same-day appointments when they begin.

Coding and documentation. New physicians tend to undervalue their efforts. Our group has always done an extensive coding review approximately three to four months after a new physician starts. Now, I also provide an informal assessment approximately one month after a new physician joins our group. I choose to do these assessments myself, but they could be well handled by a nonphysician coding expert.

Chief orientation. To highlight the importance of citizenship and benefits issues, we decided to handle these issues separately from the rest of the orientation with each group of new physicians. We call this part of the program "chief orientation," because it is led by our group's department chiefs. Our goals are to decrease the number of misunderstandings, improve practice consistency and foster some positive peer pressure among the new physicians. The chief orientations also give our new physicians a chance to develop some camaraderie and realize that settling in to a new practice is a challenge for everyone.

The two-hour chief orientations are held at one of the chiefs' homes. We discuss such issues as provider support, hours, sick days,

call, triage, professional courtesy and vacation benefits, among other things. We also take this opportunity to explain the benefits of shareholder status and invite discussion.

Mentoring. New physicians have always asked established physicians for advice. We decided to incorporate a more formal mentoring system into our orientation to ensure that new physicians have the opportunity to talk to physicians in other groups.

We identify and recruit specific mentors for new physicians prior to their arrival. Ideally, the mentors are positive role models from a different clinic site who are in their first two to three years of practice. They're asked to be available by phone and to meet occasionally with the new physicians in nonclinical settings, for example, by going out to dinner together.

Our "pearls" are intended to enhance consistency within the department and impart the wisdom of the ages on practice management issues.

In addition to the formal mentoring system, we encourage the department chief, clinic manager and administrative representatives to make scheduled contact with the new physicians through phone calls or drop-by visits at lunch to provide reinforcement and positive feedback.

Practice management tips. Another way we offer advice to our new physicians is with our new practice management tips, or "pearls." These single-page pearls are intended to enhance consistency within the department and impart the wisdom of the ages on such practice management issues as handling patients with long lists, physician-patient communication, refills and angry patients. After writing the pearls, I circulated them to the entire department for peer review before implementing them in our new orientation program. Although developed specifically with our clinic in mind, most of the pearls could easily be adapted to fit any type of practice. [For more about the pearls and to view some samples, see page 40.]

Early results

We only have initial impressions of the impact of our new orientation and integration program since we've just recently implemented it. However, so far we've generally seen positive results with each change:

- Visit volume is on pace or exceeding our goals in all cases.
- Productivity per provider is dramatically better than a year and a half ago.
- As we expected, coding reviews have shown a tendency to undercode, but there is enthusiasm for improvement; and documentation has been complete.
- The chief orientations have been well received and have generated some good discussions.
- Physicians are resuming shareholder equity buy-ins.
- The mentoring has worked well, although inevitably there's been some variation in the extent of the mentors' help.

Some mentors have been great, taking the new physicians out to lunch or dinner once or twice, some just call to make themselves available and, unfortunately, some volunteer but don't follow through.

- Just about all the responses to the practice management pearls have been positive. In fact, the internal medicine (IM) chief now gives copies of the pearls to the new IM physicians too.
- Morale is significantly improved.
- An unofficial, informal survey of the new physicians first oriented with this program indicated satisfaction with the process, awareness of the program's goals and a sense of control over their schedules and practices.

Leading the change

Recovering from our group's financial and turnover problems has been a tremendous challenge. However, we're a better department and a better group than we were two years ago due to the quality of the new physicians who've joined us as well as the group effort from our established physicians to make our new orientation program work and to hold the department together through difficult times. Perhaps a few years down the line it will be clearer as to whether the aged led the young or the young led the aged. FM

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A formal mentoring program allows new physicians to talk to physicians in other clinics.

The group offers practice management advice in the form of "pearls."

The pearls are single-page vignettes on practice management issues such as refills and handling patients with lists.

Although the new orientation program has only recently been implemented, the early results have been positive.