Starting a Revolution in Office-Based Care

A nationwide experiment is asking practices to forget the way they've always done it and pursue the ideal in patient care.

Brandi White

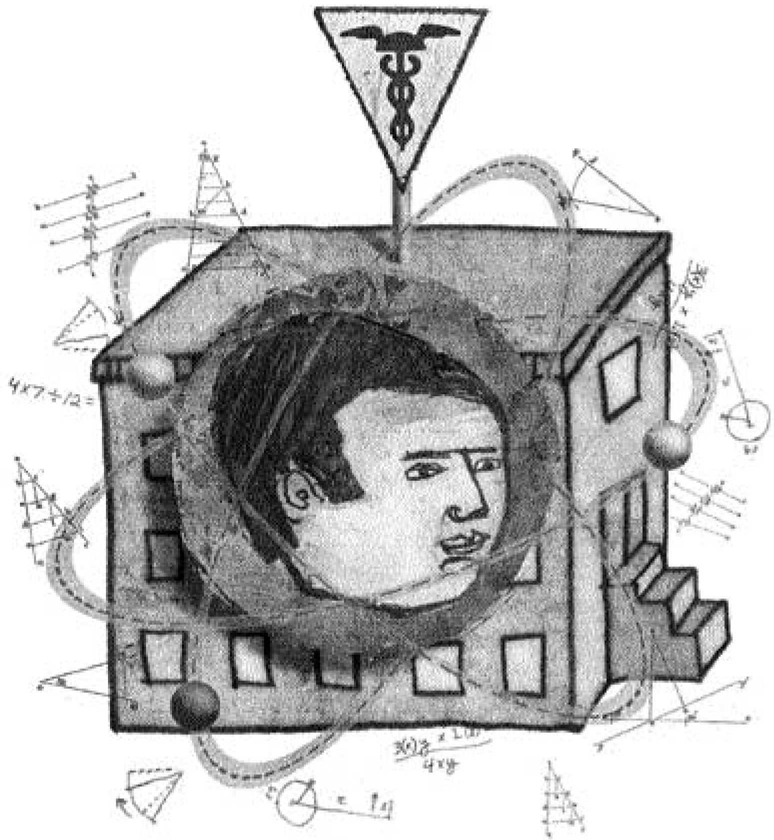

ILLUSTRATION BY RICHARD BORGE

Where is it written that revolutions can't be fun? Yes, they require great effort and sacrifice, and yes, they are opposed furiously by the almighty status quo. But among those who share the vision of how much better things *could* be, there is an unmatched sense of innovation, courage and optimism – three things health care could use more of today.

Small pockets of revolution are springing up in office-based practices all across the country. Led by the Institute for Healthcare Improvement (IHI) and its Idealized Design of Clinical Office Practice (IDCOP) initiative, 42 medical practices throughout the country have spent the last two years experimenting with and implementing innovations in office-based care. Their goal has been to create ideal practices of which patients are able to say, "They give me the help I want and need exactly when I want and need it." Through a combination of strategies, from "open-access" scheduling to e-mail communication to staff development, they've hoped not only to achieve truly patient-centered practices but to improve clinical quality, make money and enjoy their healing art. Sound impossible? Without question, it's a tall order, but two years later, the practices are reporting progress, and some say a full-scale revolution has begun.

Why bother?

Although clinical office practice is arguably better off than many other parts of the health care system, IHI wanted to begin its redesign efforts there, at the heart of the health care system. What happens in the office-based setting has a tremendous impact on the larger system; however, office performance often falls well below what could be achieved, IHI says. Patients wait weeks for appointments and wait more at every stage of their office visits. Charting systems are inefficient. The telephone is poorly managed. Finances are strained. There are gaps between medical evidence and actual practice. And the system is often frustrating to doctors, patients and staff members alike.

"All the way from the grand to the mundane, there are problems that are beginning to drown out the good stuff in health care," says Gordon Moore, MD, a family physician with Strong Medical Group in the Rochester, N.Y., area, which supported two IDCOP

Brandi White is a senior associate editor for Family Practice Management. *Conflicts of interest: none reported.*

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Through the Idealized Design of Clinical Office Practice (IDCOP) initiative, 42 medical practices throughout the country have spent the last two years experimenting with office innovations.

Clinical office practice is the heart of the health care system, but it needs improvement in areas such as patient waiting times, charting efficiency and financial performance.

Within the IDCOP model, the ultimate goal of each practice is to redesign its systems to be truly patient-centered.

To achieve dramatic improvements in patient care and service, practices must be dramatically redesigned; making small modifications or simply trying harder won't work.

pilot sites. "I had only been in practice five years and already the shine had worn off and I was wondering, 'Is this it? Is this as good as it gets?'"

Hardly so, says IHI, but it could be "as good as it gets" if practices were to rebuild their systems around patient needs. For Bruce Bagley, MD, former president of the AAFP and a practicing family physician at Latham Medical Group in Latham, N.Y., the emphasis on improving patient service is what drew him to IDCOP. Family physicians generally do very well providing patient care in the exam room, he said.

> **"I had only been in practice five years and already the shine had worn off and I was wondering, 'Is this it? Is this as good as it gets?'"**

"But when you start talking about telephones and waiting times for appointments and prescription refills and referral requests and all that kind of stuff, it all goes right down the tubes. Those are all systems issues, and we have to redesign our systems to promote excellent service."

IHI emphasizes *system redesign* because it believes that to produce dramatically improved outcomes, you must dramatically change the way you do things. Making small modifications or simply trying harder won't work. "I think that there's a lot of frustration and cynicism and burnout in a lot of practices these days with people working really hard trying to do the right thing, but they're caught in systems that aren't designed to help them succeed," says Patricia Rutherford, MS, RN, IHI's vice president for Idealized Design. "By focusing on redesigning the system, we feel that we can revitalize physicians and nurses and others who are deeply committed to making a difference in patients' lives."

The grand design

Over the course of roughly two years, the 42 pilot sites have experimented with the IDCOP design for idealized office-based care. While they achieved varying degrees of success, every organization made improvements, says Rutherford. (See a sampling of results on page 32.) "We know, through the pilot sites' results, that if you apply these

KEY POINTS

- Physicians nationwide have been involved in an experiment to dramatically improve patient care and service in office-based practice.
- Among the improvement strategies is open-access scheduling, in which practices aim to see patients on the same day they call the office.
- To succeed at creating truly patient-centered systems will require that practices create the will for change and secure adequate reimbursement for their efforts.

innovations to a practice, you will get good results from the patient's perspective and from the provider's perspective, and you will have a financially viable practice. That's what we have proven with this model," she says.

The IDCOP model has four themes:

Access – Patients have access to the care and information they need when they need it.

Interaction – The interaction between the patient and the care team is personalized and meaningful.

Reliability – The practice provides only safe and effective care.

Vitality – The practice is financially successful, its employees are happy, and it fosters a spirit of innovation.

[For more information on IDCOP's model for ideal office practice, see page 31 and Kilo CM, Endsley S. "As Good as It *Could* Get: Remaking the Medical Practice," *FPM,* May 2000, page 48.]

Supporting each of the four themes are strategies such as the following:

Open-access scheduling. Open-access scheduling is simply a system for offering every patient an appointment for the day the patient calls your office. Its motto is "Do today's work today," which requires that you first work down your backlog of booked appointments. For most of the IDCOP pilot sites, open access was the first change they tackled – and the biggest success. [See Murray MM, Tantau C. "Same-Day Appointments: Exploding the Access Paradigm," *FPM,* September 2000, page 45.]

At ThedaCare's Kimberly Clinic, in Kimberly, Wisc., Greg Long, MD, and his colleagues began the IDCOP project with a several-month wait for physicals. Now, on

the heels of the practice's implementing an electronic medical records system, "patients can still get in to see us for anything, including physicals, within one to three days," said Long. And patients couldn't be happier. "We hear daily, if people can get in that same day for a physical or for anything, how elated and excited they are about that. In turn, the staff feels good and the docs feel good, just knowing that patients are satisfied."

At Bellin Medical Group in the Green Bay, Wisc. area, open access worked so well for the original pilot sites that it's being implemented in all 18 of the group's sites, reports Randi Burnham, NP, team leader for Bellin Medical Group administration. At one of the Bellin clinics, open access even helped turn around the group's financial performance by creating room in the schedule to see more patients and generate more income.

For Long, taming the schedule through open access allowed him to focus on fewer, generally more robust visits and be more efficient throughout the day. "Every one of my appointments is now 20 minutes, but if I see an ear pain, for example, it may only take me 10 minutes. That gives me time to do all my dictation, go through phone messages, call in prescriptions – so by the time my day ends, if my last patient is at 5:00 or 5:30 in the evening, most of my work is already done," Long says.

Continuous flow. The concept of continuous flow developed in the manufacturing world, where long processes were broken down into cells or components and workers would move through these components in one continuous motion. In the office, an example of continuous flow would be the following, says Moore. "You come into your office, you slit open an envelope, you pull out the piece of paper, you look at it, you figure out what you have to do with it and you do it right then. And then that paper is put away once and for all, forever," he says. "It doesn't go into another in basket that you'll deal with later or into another bin that you'll file later. No, it is done."

In current medical practice, as opposed to continuous flow, there is an abundance of "batch and queue," or waits and delays. Explains Moore, "The batch is the patient signing in at the receptionist window. The queue is the patient waiting for the next thing."

So what would continuous flow look like from the patient's perspective? Moore explains, "You [the patient] walk into the doctor's office and are met by a greeter. The greeter says, 'Nice to see you, Mr. So-and-So. Room one.' You walk into room one, the door closes and the physician walks in immediately and takes care of business. When you leave the room, everything is

THE MODEL FOR IDEAL OFFICE PRACTICE

The Idealized Design of Clinical Office Practice (IDCOP) initiative of the Institute for Healthcare Improvement has been leading 42 pilot sites throughout the country as they pursue the ideal in patient care. Its model involves various strategies, from group visits to population management, categorized under four themes: access, interaction, reliability and vitality. For more information on each of the strategies, visit the IDCOP Web site at www.ihi.org/idealized.

Access	Interaction	Reliability	Vitality
Open access Continuous flow	Customized communication Interaction technology	Knowledge management Population management	Research and development Staff development

Alternatives to 1:1 visits (e.g., group visits)

Optimized care team/master schedule

Leadership/measurement systems/financial management

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The IDCOP pilot sites have made significant improvements in the quality of their patient care and service by employing multiple strategies, such as open-access scheduling.

Under open-access scheduling, practices aim to see patients on the very day they call the office for an appointment.

Open-access not only pleases patients but also improves morale as practices tame the schedule and can work more efficiently.

The concept of continuous flow means simply that you move through a process (or one component of a long process) without stopping until it is complete.

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In most medical practices, there is an abundance of "batch and queue," or waits and delays.

Under the principle of continuous flow, a patient would move through the practice continuously, with very little waiting time along the way.

Computerization is essential to the idealized practice, in part because it provides new ways for patients to interact with the practice and access information.

Computerization also helps practices better manage patient data and provide care that is proactive and safe.

done, your co-pay has been collected, your follow-up visit has been scheduled. You walk out of room one, directly out the front door and back into your car."

If it weren't for the fact that Moore actually practices this way, it would seem impossible. Yet in his practice – which Moore opened just over one year ago as a truly solo family practice (he has no staff) – patients spend more than 90 percent of their time in the office with him, which means they spend almost no time waiting. "Part of what drove me into doing this was that I was just sick of walking into the exam room and, almost 100 percent

A SAMPLING OF RESULTS

The Institute for Healthcare Improvement used a variety of measures, such as the ones shown here, to assess whether its Idealized Design of Clinical Office Practice pilot sites were improving their performance. This sampling of results shows what the pilot sites were able to achieve by redesigning their care systems.

Measure	Results	Practice
ACCESS		
Average number of days until the third next available appointment	1.8 days (reduced from 4.3 days two years earlier)	Cambridge Health Alliance, Cambridge, Mass.
Office efficiency (average length of patient visit, from check-in to check-out)	32 minutes (reduced from 50 minutes in previous year)	Buffalo Medical Group, Orchard Park, N.Y.
Future capacity (percentage of appointment slots that are open)	79 percent (increased from 63 percent in previous year)	Cambridge Health Alliance, Cambridge, Mass.
Provider/patient match (percentage of patients seeing a member of their own care team)	95 percent (increased from 88 percent in previous year)	MeritCare/Desk 35, Fargo, N.D.
INTERACTION		
Visit benefit (percentage of patients reporting that they received more help than they expected)	80 percent (increased from 34 percent in previous year)	MeritCare/Desk 35, Fargo, N.D.
Average rating of physicians' explanations of care	6.5 (on a seven-point scale) across two sites *	ThedaCare, Appleton, Wisc.
Percentage of patients satisfied with physicians' explanations of care	95 percent*	Strong Health/Fairport Internal Medicine, Rochester, N.Y.
RELIABILITY		
Percentage of patients with diabetes receiving an HbA_{1c} test every 6 months	100 percent (increased from 82 percent in previous year)	Bellin Health System, Green Bay, Wisc.
Percentage of patients with LDL less than 100	90 percent (increased from 64 percent in previous year)	Buffalo Medical Group, Ocean Park, N.Y.
Percentage of patients with diabetes whose HbA_{1c} levels are less than or equal to 7.5	91 percent (increased from 65.5 percent in previous year)	Tonawanda Medical Associates, Buffalo, N.Y.
Percentage of patients with hypertension whose BP is less than or equal to 140/86	95 percent (increased from 67 percent in previous year)	Tonawanda Medical Associates, Buffalo, N.Y.
VITALITY		
Percentage of staff recommending the practice as a great place to work (agree plus strongly agree)	95 percent (increased from 60 percent in previous year)	MeritCare/Desk 35, Fargo, N.D.
Monthly operating margin	$27,000 (two sites; increased from $15,000 in previous year)	ThedaCare, Appleton, Wisc.
Average panel size	4,100 (increased from 1,500 two years earlier)	Strong Health/Fairport Internal Medicine, Rochester, N.Y.

** No comparison data available.*

of the time, the first thing out of my mouth was, 'Sorry I've kept you waiting,'" he says.

Today, the batch and queue is gone and Moore's patients are thrilled. "When I survey patients and I ask them the question, 'Have you had enough time with the doctor?' I get 100 percent 'yes.' No surprise," he says. And

> "Almost 100 percent of the time, the first thing out of my mouth was, 'Sorry I've kept you waiting.'"

when he asks, "Did you receive the help you expected?" 90 percent of his patients are consistently saying they're getting more than they expected. "That is customer delight," says Moore. "In the world of customer satisfaction, that's the Holy Grail." [For more information on Moore's move to a solo, idealized practice, read his upcoming series, beginning in the February 2002 issue of *FPM*.]

Computerization. In the idealized practice, computerization is essential. First, it creates new ways for patients to interact with their physicians (e-mail) and to access information from the practice (a practice Web site). Second, it helps practices better manage patient information and provide more proactive, safer care. For Bagley's group, the move to electronic medical records was key to improving the rest of their office systems. "I think that's been the biggest clear win for us, to computerize our records and then to redesign our systems with the support of the computer in a way that we never would have been able to do without the computer."

For example, computerized records can enable practices to keep better track of patients requiring follow-up care and to better analyze their patient outcomes to make needed improvements. In addition, computerized records are simply more efficient, says Moore. While working with a local group to improve its charting system, Moore counted the number of places that secretaries could look to find a chart if it were not in the medical records file room. "There were 39 places in this little nine-exam-room office," he says.

If you consider the fact that roughly 70 percent of overhead in a typical practice is related to staffing, the waste associated with paper charts becomes alarming. "Here we are, we're killing ourselves paying for people to play the game called Find the Chart," Moore says. "Nobody's intending to be knuckle-headed about this, but where's the will to solve this issue for once and for all and move to electronic records?"

Staff development. If you want a practice that provides excellent care, wows patients and makes money, "You have to have a positive work environment, an environment that fosters innovation," says Bagley. "And generally, people work better in that kind of an environment."

The Bellin Medical Group pilot sites have worked hard to create that environment by empowering staff to take part in the change process. "They can bring their ideas to a meeting and say, 'We've noticed this is a problem in our clinic right now. What can we do to make this better?'" says Burnham. "It's an opportunity they've never had before. Now, a lot of the staff feel that we've given them a lot of respect by enabling them to be a part of the whole process, and that's how it should be. They're the frontline people. They understand the most what's going on. We need them to be involved – and they usually have the best ideas."

Two obstacles

While IHI paints a compelling vision of how good office practice could be, operationalizing the concepts can be challenge. "I don't want anyone to think that you can walk in, flip a switch and this is all going to happen," says Bagley. "This is a societal transformation, almost. It's a mega-trend. It's not something you can do by opening up some book and following step one, step two, step three."

> "I don't want anyone to think that you can walk in, flip a switch and this is all going to happen."

Getting paid. In a health care system that still tends to reward doctors for cranking patients through the office, many wonder whether the IDCOP design is financially feasible. If a practice is holding appointment slots open until the day of business, communicating with patients via e-mail and spending money on computer systems, how could it possibly be making any money? The answer may very well depend on your

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Computerization helps end once and for all the expensive and inefficient task of searching for patient charts.

A positive work environment can help motivate staff and physicians to be more efficient, productive and innovative.

Empowerment to improve their work processes is a new experience for many staff members, but their frontline input is critical.

Because most payment systems reward doctors for their volume of face-to-face patient encounters, many wonder whether the IDCOP design is financially feasible.

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Physicians who aren't capitated, who aren't salaried and who don't receive quality bonuses, may need to explore other financial strategies.

If innovations such as e-mail communication or open-access scheduling result in fewer office visits, practices can boost their patient panels and provide more robust visits, where appropriate.

Some insurers are already experimenting with e-mail reimbursement, and several organizations are encouraging payers to explore innovative payment systems.

Not every practice is willing or able to tackle the task of creating truly patient-centered systems.

payment structure. "Much of what is advocated by IDCOP is very difficult to do in a pure discounted fee-for-service environment without some kind of a primary care bonus or some other way to fund this work," says Bagley. "Primary care practice is a narrow-margin business, and if you still have an incentive to do discounted fee for service, which means bring everybody in and send them a bill, then it just doesn't work."

"If you are only looking at what makes sense within the current payment system, then many times you won't do the right thing in terms of patient outcomes."

In Bagley's practice, approximately 60 percent of revenue comes from capitation, which provides sufficient financing for the idealized approach, he says.

For physicians who aren't capitated, who aren't salaried and who don't receive quality bonuses that would fund the IDCOP innovations, there may still be ways to succeed at this. Many of the innovations that would seem to decrease a practice's income don't actually do so, says Long. "With open access, I went from 32 patients a day on average to about 26, and we watched what happened to the RVUs. They actually went up," he says. "If you do more per visit and you code appropriately and you get reimbursed for that, then we've found that that offsets the decreased volume. So when you look at it from a reimbursement standpoint, it should at least be the same." [See Kilo CM, Horrigan D, Godfrey M, Wasson J, "Making Quality and Service Pay: Part 1, The Internal Environment," *FPM,* October 2000, page 48.]

While this strategy of creating more robust visits is working for Long's group, they wouldn't mind reimbursement for the time they spend on e-mail interactions, for example, and are discussing that possibility with ThedaCare's HMO. In fact, some insurers, such as Blue Cross and Blue Shield, are already experimenting with e-mail reimbursement. [See Kilo CM, Horrigan D, Godfrey M, Wasson J, "Making Quality and Service Pay: Part 2, The External Environment," *FPM,* November/December 2000, page 25.]

Groups such as the Robert Wood Johnson Foundation, the Leapfrog Group and the Agency for Healthcare Research and Quality are currently experimenting with innovative pay structures and are trying to engage payers in dialogue on this issue. "We're working in parallel with them," says Rutherford, "but we see that our [IDCOP's] role in this whole initiative is to come up with good ideas to improve care, and hopefully, there will be parallel processes to align incentives with the health care payment system."

Until then, says Rutherford, "We're encouraging teams to do the right thing in terms of getting patient outcomes. We know that, for example, if you integrate e-mail care into your practice and you're a fee-for-service practice, then you don't get paid now for the visit – but it's still the right thing to do if that's what the patient prefers. It's our belief that if you are only looking at what makes sense within the current payment system, then many times you won't do the right thing in terms of patient outcomes."

The will to change. Reimbursement challenges aside, not every organization is ready for fundamental change, and even those that are find change isn't easy. The ability to execute change and achieve redesign is affected by three things, says Rutherford. "First, are there any other changes going on in the practice or organization that will divert attention from the redesign and improvement effort? Second, what is the practice's readiness and capability for change? And third, what is the infrastructure support within the organization to help the group sustain the improvements and spread that throughout their organization?"

Before a practice can begin a redesign effort, says Rutherford, "You have to create the will for change within your organization. In other words, there has to be an interest in making improvements. If you're pushing people to do something that they don't want to do, then it's not going to fly very well."

How do you create that will? "You create a vision of something new. We think we have done that very well [with the IDCOP model]. We've created a vision that people can get excited about and set their sights on," she says.

Still, not everyone in an organization will be ready to adopt even the best idea until they see it in action and working for others, says Long. "Not everyone in my clinic was as excited as I was to do open access, but we went ahead and tried it while the others just kind of sat on the sidelines and waited and watched," he says. "Not everybody's at the same level of understanding or belief. So we always proposed that you can't bring the whole process to a halt for one or two people. You just have to keep going if you think it's the right thing to do, and the others will follow once they see the results."

Finding those individuals willing to test innovations and champion the effort isn't as hard as it may seem, says Moore. "There are always some innovators out there – some people who want to try new things, who are a little bit adventuresome. Maybe they're the docs with the Palm Pilots, maybe they're the ones who are playing around with Dragon voice-recognition software, but they're out there. It's our job to find those people and figure out how to connect them with the knowledge and create that little bit of space or breathing room, so that they can experiment and get it going."

> **"You just have to keep going if you think it's the right thing to do, and the others will follow once they see the results."**

According to dissemination theory, pioneered by Everett Rogers, when an innovation spreads to 10 to 15 percent of a population, it begins to multiply exponentially.[1] "Fifteen percent is the tipping point," says Moore. "That's when changes take on a life of their own and become less of a struggle for each new practice. All of sudden, you start getting into the early majority who say, 'Gee, maybe I ought to try that as well.' And from there, people flood in."

What's next?

The IDCOP initiative was originally set for three years (1998 was spent defining the strategies; 1999 and 2000 were spent experimenting in the pilot sites), but it has not ended completely. "We're at sort of a transition point," explains Rutherford. "At three years, some organizations have fulfilled their commitment and are not going to be continuing in this, but the initiative is not ending. We feel that we have good content, good change concepts, good innovations in most of the components of the model, but we don't have them in all of the components. So we're going to continue to redesign in the four areas where we feel that there's more work to be done."

Those four areas are the following: making the business case for quality initiatives, patient safety within office practice, practice reliability (e.g. helping physicians provide population-based care rooted in the best clinical evidence), and human resource development.

The IDCOP practices continuing to work on these areas will be linking with IHI's Pursuing Perfection Initiative, "which is basically idealized care across the continuum," says Rutherford. "It's our hope that the entire health care system will be in alignment with this vision to redesign our systems to get better outcomes for patients across the continuum. We intend to prove that it can be different."

A truly patient-centered system is what patients are going to demand as the marketplace becomes increasingly consumer driven, says Bagley. "The first physician offices that are able to achieve the principles of IDCOP in a competitive situation are going to be the winners. Right now, nobody can do it very well, and the public's expectation of going to see the doctor is one of wait, wait, wait. So they're never disappointed. It's exactly what they expected. But once somebody figures out how to reduce the waiting times and delays, to have excellent communication, to have that personal interaction with the patient, whether it be at a visit or a non-visit encounter, they're going to be way ahead," he says.

Not only that, but they're going to be enjoying medicine again, says Moore. "What's in it for me? I'm doing this because I'm having a gas," he says. "And if I'm out here and I'm doing it literally alone with nobody else in the office, that means anybody can do it anywhere. It just comes down to will. If you have the will, there is a way." FM

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1. Rogers EM. *Diffusion of Innovations,* 4th ed. New York, NY: The Free Press; 1995.

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Practice leaders must create the will to change within their organizations by creating a vision people can follow.

Some physicians and staff will not be inspired to change until they see the concepts working for a colleague.

Not everyone in a practice needs to be convinced completely that a change is good; once 10 to 15 percent of a population enact it, it begins to spread exponentially.

The first practices to accomplish idealized patient care and service are going to have a competitive advantage in their markets – and feel more rewarded by their work.