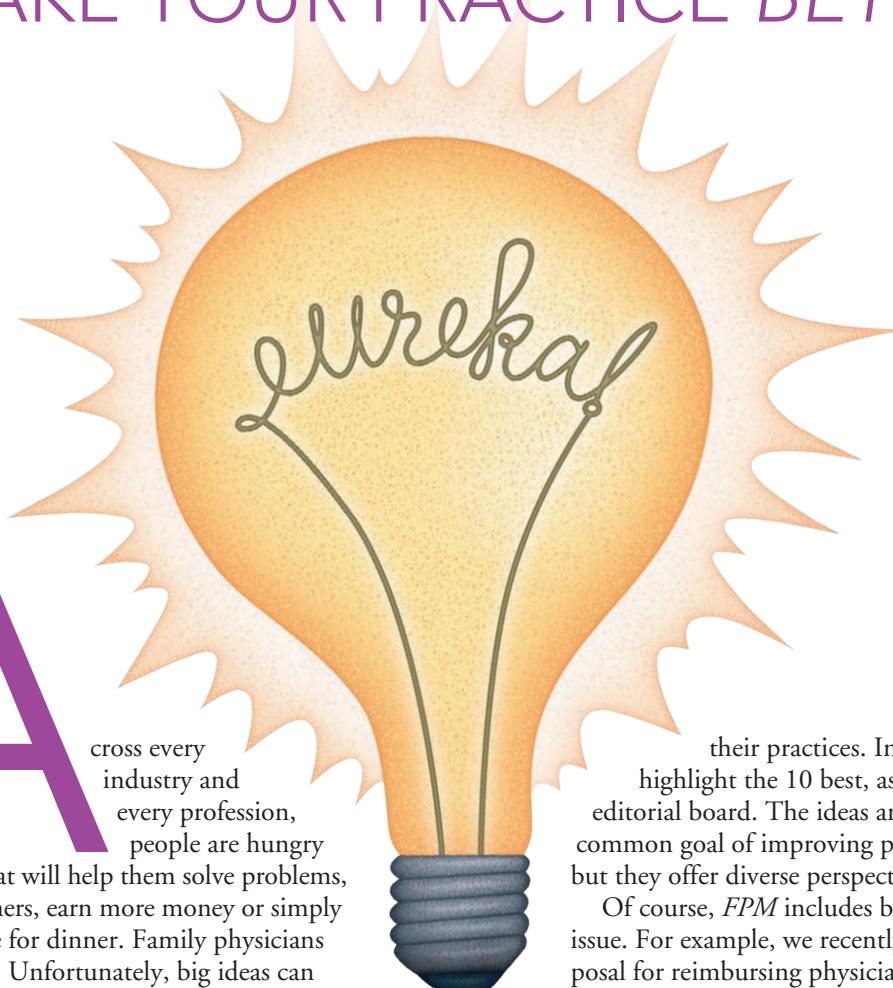


Could your practice benefit from some fresh thinking?
Get inspired by these 10 ideas that have made a difference for your colleagues.

10 Big Ideas THAT COULD MAKE YOUR PRACTICE BETTER

Across every industry and every profession, people are hungry for good ideas that will help them solve problems, help their customers, earn more money or simply get home in time for dinner. Family physicians are no exception. Unfortunately, big ideas can be hard to come by, especially in a troubled economy with stagnant Medicare payments and rising costs. When you find yourself sailing in rough waters, it's difficult to think about anything other than just staying afloat. But that's exactly when you need a big idea.

Several months ago, *Family Practice Management* cast its net for big ideas, asking readers to share the solutions, strategies and principles that have made a difference in



their practices. In this issue, we highlight the 10 best, as selected by our editorial board. The ideas are focused on the common goal of improving primary care practice, but they offer diverse perspectives.

Of course, *FPM* includes big ideas in every issue. For example, we recently published a proposal for reimbursing physicians for multiple evaluation and management services at a single visit¹ and we've highlighted national initiatives to pay a monthly care management fee to practices that qualify as medical homes.² While those ideas are undoubtedly big, so too is their implementation, which would require the likes of an act of Congress. In contrast, the ideas in this issue are doable at the practice level.

So if your practice is facing a problem or could use a little inspiration, read on. ▶



Understand the value of half a day's work

Bob Newbell, MD
Hazel Green Family Practice
Hazel Green, Ala.

Many doctors take half a day off during the week. While a short day may provide time to attend to personal matters and reduce job-related stress, it can also exact a financial toll on a practice. Assuming that a physician sees three to four patients an hour at a reimbursement of \$50 per patient – both fairly conservative assumptions – this would translate into \$600 to \$800 of lost gross revenue per week. I hope that Wednesday afternoon off was relaxing: You certainly paid a lot for it.

From the beginning, I decided against taking a half-day off during the week at my practice. In fact, I decided to work an additional half-day on Saturday mornings from 9 a.m. to noon. Staff members would rather sleep in on Saturday, just as I would, but rotating the schedule so staff members only have to work every other Saturday mitigated resistance to the idea. Some extra money in their paychecks didn't hurt either.

On a typical Saturday morning, we will see 20 patients. No Pap smears or lengthy procedures are scheduled, only relatively quick visits like head colds and blood pressure rechecks, which keep the patient volume per hour comparatively high. Our charges for a Saturday morning are rarely less than \$1,000. That's \$4,000 a month. Assuming the office will be closed eight Saturdays a year due to vacation, holidays, etc., the additional revenue from starting the weekend just a little later comes out to around \$44,000 a year. The main expense involved is the additional payroll, but we operate with only a skeleton staff on Saturday mornings, which keeps those costs to a minimum. After our first 11 months in practice, we were free of the debt from our start-up expenses, in part due to the extra revenue from working three hours on Saturdays.

Take-away lessons

There is a famous nursery rhyme that begins "For want of a nail." The poem details how the absence of a nail leads to the loss of a horseshoe ... and then a horse, a rider, a battle and, finally, an entire kingdom "all for want of a nail." The verse is a reminder that something seemingly trivial can set into motion a series of events leading to a disproportionately large problem.

To a busy clinician, a half-day off may seem like a

trivial and well-deserved respite. But the resulting loss of revenue can cascade over months and years. For want of a few extra patient visits a week, a practice may have to postpone raises, cut health insurance benefits, forgo purchasing a piece of equipment or maybe even downsize staff.

You may have a morning or afternoon *off*, but you'll never have a morning or afternoon *free*.



Let staff members share a job

Dee Schafer, Practice Manager
Kase, Speelman & Cullen,
MDs, Inc.
Medina, Ohio

In many medical practices, staff turnover at the front desk isn't just high; it's like a revolving door. Even when the position is filled, finding backup when the front-desk person is sick or on vacation can be a major crisis. When others fill in, whether for one hour or one day, the results are usually disastrous: errors, grumbling and general dissatisfaction. Ultimately, the patients suffer.

For two years, our practice has been free of this horror, not only for our front-desk position but for others as well. Our solution was job sharing. While interviewing for a new position, I ended up with two great candidates who were open to working part time instead of full time. So, I decided to try a job-share arrangement, which our practice has expanded to four other positions. Here's how it works: One person will work Thursday and Friday the first week, followed by Monday, Tuesday and Wednesday the next week. (You should hear the laughter around here on Wednesday evening when the job-share staff start their "Friday.") When the first person is off, the job share partner comes in. Each person works a Saturday morning every five or six weeks.

Job sharing has prevented burnout for these employees and has decreased turnover. This has eliminated the need for constant training and filling in, which caused poor performance, poor service to our patients and inefficiency all around.

Staff comments suggest that our job-share program is a success. One employee says she appreciates the "flexibility for my personal needs with my family, especially my elderly mother. I don't have to worry if I need a day off.

My job share partner will cover, and I won't have to make up work when I come back. Together we problem-solve to make our job more efficient. It works wonderfully."

Another employee remarks: "Job share is the best invention in the world! My partner and I are flexible enough with our schedules that we can switch days when we need to. I don't mind working for her in a pinch because I know she will do the same for me."

To ensure that everyone is up-to-date, the employees in each position keep a log of communication that they pass back and forth. The office also uses e-mail to share information with the staff and physicians.

Take-away lessons

As the saying goes, "Every problem is a solution waiting to happen." Get creative and experiment with job sharing for your staff. When your staff are happy, proud of what they contribute and renewed by time off, then your office is filled with laughter rather than grumbling, and patients feel it.



Ask, "What does my waiting room say about me?"

John L. Pfenninger, MD
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Physicians are not always known for their sensitivity to patient needs in the waiting room. Chairs with small chrome legs are packed together. Lighting is poor. Carpeting is old and dirty. Magazines frequently are torn and literally years old. Patients wait without any attention to their basic needs. If there is a television, it's blaring so everyone hears it or it airs ads on medical products or services.

When I built my medical office several years ago, I demanded that it be just as functional for those who had to wait "out front" as it was for those of us "in the back." The office was set up to demonstrate our respect for patients. We accomplished this in several ways.

The reception room is broken up into three separate sections: the bistro area, the fireplace area and the television viewing area. (You can view photos or take a virtual tour at <http://www.mpcenter.net/002.htm>.) Throughout each area, there are three types of chairs but no chrome;

instead, everything is warm and comfortable. Some of the wooden chairs have arms for the elderly because it's easier for them to stand up by bracing on these arms. (This suggestion was given to us in our suggestion box.) A couch was recommended by my staff. In most waiting rooms, there is no place to put an infant carrier. The couch allows the parent to either put the carrier there or to lay the child on the couch. Simple comforts, but so appreciated.

The small bistro area always has coffee and hot tea available. The under-counter refrigerator has small cans of juice and soda (including diet types). Patients are surprised to find that the refreshments are free. During holiday seasons like Christmas, St. Patrick's Day and Memorial Day, we provide cookies that are decorated to the theme.

The fireplace is used during the winter. Several patients have asked if they could just come and curl up with a book. It's inviting and comforting.

We have a flat panel television with several sets of wireless headphones. Those who want to listen to the TV can do so without disturbing others. Similarly, each exam room has a TV with remote to keep the children – and adults, too, when the big games are on – occupied.

The waiting room, as well as the exam rooms, have high windows to provide light and yet maintain privacy. Light provides an excellent working environment for staff, and it's appreciated by patients.

I have been overwhelmed with the positive response to the patient-centered design of our waiting areas. The predominant comment is that "it shows you really care about us." The first week of every month, we collect patient surveys to evaluate our care. I never guessed how much patients would express their appreciation for these creature comforts.

Take-away lessons

Many family physicians could set up shop in an old dingy office and still have a full compliment of patients because of the need. But what I have learned is that your office represents you. Even though it's a "doctor's office," it can still be inviting and relaxing to patients.

A respectful office likely reduces liability too. Think about those patients who have been waiting in a cramped area for 30 minutes. They are already upset when they see you, and if something goes wrong, they will quickly become angry. On the other hand, if they are comfortable reading the newspaper and having a cup of coffee, even if they have to wait a while, they know that you are concerned and care about them. They come back to the exam room in a good mood, which paves the way for a successful visit. ▶



Create a medical home in your home

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Three years ago, I opened a 170-square-foot office in my home, which serves as the "medical home" for my patients. I have no staff, which keeps my overhead extremely low, but I offer timely, personalized care via electronic medical records, same-day appointments, phone and e-mail access, and home visits.

A typical workday goes something like this: After biking with my children to school, I stop by a patient's home to drain her ascites fluid and visit. She needs to talk about why her oncologists won't return her calls now that she has decided to stop chemotherapy. After I return to my home office, I check messages and do a little research on a question one of my patients e-mailed to me. I also receive an e-mail from a patient's husband about how she has been unable to sleep for 10 days following two deaths in the family. I set up an appointment for later that day when I can go to her house to evaluate. She can't believe her doctor cares enough to make a home visit.

I don't run late because of the breathing room in my schedule. Charts are never missing. Patients are never given misleading information by a remote call center. No time is wasted triaging a problem to determine how long a visit can safely be postponed. And test results are never misplaced; they're available in my electronic medical record, and I typically e-mail them to patients the same day I receive them. I no longer provide obstetrical services or admit patients, but I do follow their care until they are referred back to me. Patients love the access, comfort, privacy and convenience my home-based practice provides.

By keeping my overhead low, I can limit the number of patients I need to see per day and I can spend more time with them. And with total control over my practice schedule, I am more successful at meeting the challenges of being a working parent of school-aged children. I can drive my girls to their clarinet and drum lessons, host after-school gatherings of their friends, be a Girl Scout leader, and attend soccer, basketball and softball games.

Opening a home office is certainly not for everyone. City codes restrict home businesses, and some municipalities prohibit physicians from seeing patients in a private home. Safety is another factor to consider. I chose to create a membership practice so that I know all my patients.

I was concerned about professional isolation in a solo practice, but I am actually more connected to other family doctors now than when I shared a too-busy office. I have created a support community for myself by participating in physician e-mail discussion lists, attending conferences and teaching medical students one half day a week.

Practice volume is also an important consideration. I practice part time, which works well for my family, my neighbors and my patients. My income of \$60,000 per year is not at the national average for family doctors, but neither are my working hours or stress level. My patients receive the care they want and need when they need it. For the first time in my career, I have been able to be with a patient when she died at home, take call without feeling like my time was being invaded and give patients the amount of time they need during each visit. Additionally, my family life is fulfilling, my marriage is happy and my friendships are no longer neglected.

Take-away lessons

A low-overhead, solo practice can give you the freedom to see fewer patients but provide better care to them. It can also strengthen your family life. My initial plan when I started this practice was to use my home office as a temporary location until my volume grew enough to support the high rent for office space in Southern California. Now, I can't imagine practicing any other way.



Solve problems the Toyota way

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We were short-staffed and frustrated when our patient visits increased substantially from one year to the next without an increase in providers. Abandoned phone calls, wait times and complaints from everyone — patients, staff and residents — were at an all-time high. Staff morale was already low, and to top it off we had two staff on long-term medical leave. Could it be worse? Of course! It was cold and flu season. We desperately needed to maximize our efficiency. And it needed to be done now.

We called a meeting of all staff, residents and faculty, and surveyed everyone to identify their top three dissatisfiers with clinic operations. After grouping similar complaints, we were left with a finite list of top dissatisfiers. We addressed each item, focusing on *why*. For example, everyone was frustrated that clinic sessions were ending late. *Why?* Doctors were behind schedule. *Why?* Patients were being roomed late. *Why?* The clinical staff noticed that charts were put in the rack late. *Why?* The clerical staff were constantly interrupted by phone calls while they were checking in patients. *Why* were our phone volumes so unmanageably high? The front staff complained about a high volume of calls from pharmacies for non-formulary prescriptions.

This approach exemplifies a well-known quality improvement technique known as the “Five Whys,” which was developed by Toyota.

Through this exercise, everyone learned how inefficiencies in clinic operations create a domino effect. When doctors write non-formulary prescriptions, it creates extra calls from the pharmacy. When the receptionist is busy answering unnecessary phone calls, patient check-in is slowed and patients are roomed late. As a result, doctors are behind schedule, clinic sessions run over and everyone leaves unhappy. Additionally, for every pharmacy message, the chart needs to be pulled, which adds more filing at the end of the day. The results are unbridled inefficiency and preventable misery. Our meeting was eye-opening in that everyone saw how their individual actions affect clinic operations.

With a clear idea of what our problems were, we commenced “Operation Efficiency.” Our purpose was to maximize office efficiency, eliminate rework and improve satisfaction for everyone. Because staff directly involved in office processes are most knowledgeable about them, we needed the staff to be the main solution finders. We formed a task force with representation from the front desk, the clinical area, the chart room and three residents, one from each class. We purposefully didn’t have any of our clinical coordinators or the chief resident on the task force. We needed fresh, new ideas from those individuals we rarely heard from.

Our task force first adopted a new office motto: “Do Today’s Work ... Today” to reflect our goal of maximal efficiency. We challenged *why* we did things the way we did and brainstormed for solutions.

As consensus decisions were made, a task force member was assigned responsibility for implementing each idea, and then each item was reviewed at the next meeting. We met every two weeks for four months.

To address the problem of unmanageable phone volume, we tracked and categorized our patient phone calls. As the front staff was already painfully aware, one

of the most common types of phone calls was from the pharmacy regarding non-formulary prescriptions for our public aid patients. To reduce these calls, obviously we needed to consistently write for formulary medications. A large portion of our patients are on public aid, so we simply copied the formulary and posted it in each exam room to be right at our fingertips at the time of prescribing. One task force member is permanently assigned to update our copies as the formulary changes. The front staff happily noticed a large reduction in the number of phone calls from pharmacies about this, and the data we’ve collected confirmed it.

This is just one of the many improvements we’ve made in clinic operations through Operation Efficiency.

Take-away lessons

When you’re tackling a practice problem, the following are keys to success:

1. Choose those directly involved in the process for your task force.
2. Help others understand the domino effect of their actions.
3. Persistently ask *why* for each step in your process.
4. Look for objective ways to measure your success.

Although the feeling of improvement is satisfying, it’s especially rewarding to see the data that proves it.



Add a procedure to your practice

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We’ve all heard the stories of how the “old GPs did everything.” They delivered babies, performed appendectomies, repaired hernias and carried out hysterectomies. Not only have these procedures been dropped by most primary care physicians, but even the simple things such as skin biopsies, treatment of hemorrhoids, vasectomies, and incision and drainage of abscesses have been eliminated. It’s time to reacquire some of these basic skills.

Many excuses are made to exclude procedural skills from practice. Among them are liability concerns, start-up

costs and lack of training. These are lame excuses and don't justify the loss of benefits that procedures can provide.

Doing procedures has increased the quality of care for my patients. Too often patients are referred to me for a single genital wart that has been treated with multiple courses of imiquimod. I simply snip off the wart, and it's done. My charges are far less than the two courses of medication, and this simple procedure helps the patient avoid prolonged discomfort and anxiety. Similarly, rather than using a course of antibiotics for an infected toenail, I simply remove the corner of the nail. The treatment for a foreign body (the ingrown nail) is removal, not antibiotics.

Performing procedures helps me learn more about the disease. When a patient presents with an unknown skin lesion and is referred to a dermatologist, feedback is often delayed six to eight weeks. But if I take the few minutes to do a skin biopsy, I can have the results in hand within a couple of days. I may not know initially that the lesion is a keratoacanthoma, but the biopsy provides the information necessary to treat it and also to recognize it in the future.

Procedural skills can also reduce health care costs. Whenever a patient is referred elsewhere, the initial consult charge is significant and is added to the procedure charge. Most procedures performed by other specialists are carried out in ambulatory surgery centers and in hospital operating rooms. That's how they were trained. Sebaceous cysts, lipomas, skin cancers (basal cells, squamous cells and melanomas) and more can all be easily treated in the office. A surgeon recently wanted to remove a sebaceous cyst on my neck in the operating room. I have a \$2,500 deductible, and I was not going to pay it to the hospital. I gave him three options: 1) He could come to my office to do the procedure, 2) I could bring my equipment to his office or 3) I could go elsewhere. He took out the cyst with my instruments in his office in 25 minutes with a savings to me of more than \$1,500!

By doing procedures, I am more likely to meet patients' expectations. People prefer to be treated by someone they know and trust. They don't want to be sent somewhere else and wait longer than necessary to find out their diagnosis. In addition, when patients come in for a sebaceous cyst or follow-up of a small basal cell that I treated, I can follow up on whether they had the colonoscopy I recommended or how they are doing on their efforts to stop smoking.

Doing procedures may actually reduce liability risks. Take for instance a mole that might look a little atypical. It's easy to do a punch biopsy. If a physician doesn't have these skills, he or she is more likely to avoid doing

anything since setting up a referral takes time and energy. Not a good scenario if that "atypical mole" ends up being a melanoma.

Performing procedures in the office and the hospital also increases the financial bottom line. It is difficult to bill, let alone get paid, \$600 for a 30-minute service, but that's the reimbursement for a vasectomy. Similarly, the majority of basal cell cancers can be treated in less than five minutes for an average payment of over \$250.

Take-away lessons

The reasons for doing procedures far outweigh all the excuses not to do them. If you say you can't, you'll be correct – you can't. But, if you say you can, you will also be correct! Not only can you perform procedures, but you can do them well.



Move the market to support your practice

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The 45 doctors in our family medicine group, which is composed of 13 separate clinics, were discouraged after we studied our experience of providing care to our Medicare patients and learned that our payments did not cover our costs. We had been hard at work transforming our practice according to the principles of idealized practice redesign.³ We knew that our number of Medicare patients was increasing, and we saw no move by insurers or the government for meaningful support of our innovation and improved results. To stem the tide, we stopped accepting new Medicare patients into our practice, but we continued to see those we already had committed to.

Looking at our patient demographics, it became clear that even without taking new Medicare patients, our number would soar over the next 10 years as our existing patients aged. To make matters worse, patients were presenting unannounced with many new Medicare Advantage plans that were confusing to bill and administer but still only paid the inadequate Medicare fee schedule.

It seemed that we faced a stark and unacceptable

choice: rush people through our office to try to lower our costs, or stop seeing Medicare patients altogether. That's when we got our big idea: approach Medicare Advantage insurers and ask them to support our work financially to provide patients with a personal medical home, and then limit Medicare Advantage plans in our practice to only our endorsed plans and educate our patients about our new policy. Our goal was to raise our reimbursement to equal what our commercial insurers paid.

The key to our plan was one of our patients, a retired Medicare insurance executive who had come to understand the problem and wanted to help as our consultant. Our initial request was to receive a \$15 per member per month fee to help support our disease registries and practice redesign efforts, for which we could document marked quality improvements. Negotiations were difficult, but we were finally able to interest three local insurers, representing four plans, to work with us. Three plans now pay us enhanced fees for our services, including a thorough preventive history and physical visit, something Medicare has never paid for. The other plan pays us a capitated rate for our primary care, adjusted by age, which allows us to tailor care to the needs of the patient instead of the insurance plan. They also pay us for administering our own congestive heart failure program.

To educate our patients, we worked with a local insurance agent who understood our cause and represented all of the plans we would accept. For our existing patients, we decided to continue accepting Medicare supplement and employer-sponsored plans, but new Medicare patients would have to belong to one of our endorsed plans. This gave a great marketing edge to our endorsed plans, which they appreciated.

Although we are in the early stages of implementing our plan, we are already seeing a positive difference. For the first time, our patients are aware of Medicare access issues, which they had been insulated from. We are able to say yes to new Medicare patients we formerly could not admit to our practice. The insurance companies have been sensitized to how their actions have hurt primary care, and we have received some financial support to continue our efforts to give our patients the care they need. We are empowered and no longer feel like victims. Over time, we plan to ask all of our patients who have a choice to choose an endorsed plan when they become eligible for Medicare. This action alone has the power to dramatically change the economics of providing care to our older patients.

Take-away lessons

It is possible to work with private Medicare insurers at the local level to offer improved coverage for our work

as family physicians. It is also possible to educate our patients about dysfunctional and inadequate payment policies that limit their choice of medical care, and ask them to choose plans that help us. We believe that our experience can be replicated by other interested practices. The recent decision by the National Committee for Quality Assurance to offer an accreditation program⁴ for the medical home provides family physicians with an opportunity to demonstrate their value to private insurers as well and to advocate for fair contracts that financially support our work.



Follow the example of the hedgehog

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In his best-selling book *Good to Great*, Jim Collins categorized business leaders as either hedgehogs or foxes, quoting an ancient Greek poet who said: "The fox knows many things, but the hedgehog knows one big thing." Based on his research of hundreds of U.S. companies, Collins found that hedgehogs are most successful because they understand what they can be the best at, what they can make money at and what they are deeply passionate about. The best companies "translated that understanding into a simple, crystalline concept that guided all their efforts," Collins says. The foxes, on the other hand, were less successful because their efforts were scattered, diffused and inconsistent.

For many years, I ran my practice like a fox. I tried to do it all. I maintained a lab and X-ray equipment. I performed DEXA scans, treadmill stress testing, Holter monitoring, pulmonary function testing, sigmoidoscopies and colposcopies. I dispensed medications and nutritional supplements. And I saw patients in the office as well as at several hospitals and nursing homes. All of these things provided services to the patient, but they also required personnel, time and equipment that often offset the benefit to the practice. Eventually, I realized that I needed to focus.

In my practice I embraced a wellness approach. I didn't give up all procedures or cease being a family doctor, but I stopped trying to be all things to all patients

in every health care setting and I discontinued some of the services (and accompanying overhead) that were not directly related to the wellness concept. This allowed me to concentrate mostly on my outpatient practice, using the annual physical exam as the cornerstone of care that I offered. This enabled me to use my equipment more efficiently and to offer a comprehensive wellness program to my patients with chronic diseases.

I'll admit I did lose a few patients who were unhappy that I was no longer attending to them in the hospital or assisting at their surgeries, and I sometimes missed that part of my practice. However, I did not miss the inefficiency and loss of revenue caused by taking care of so few patients at so many sites.

By being more focused, I was able to practice more efficiently, reduce my staff and eliminate several expensive leases. Although I was no longer grossing \$1 million per year, I had more time to pay attention to insurance contracts and to manage my overhead, so my net revenue per patient visit as well as per hour actually improved. I spent less time working and more time with my family and hobbies.

Take-away lessons

Family medicine offers limitless practice options in which you can find your niche. First, determine what you do best and have a passion for. Then find the economic driver that makes it worth your time and effort. If you find your practice of medicine within those parameters, then you will not only be successful – you will be very successful.



Do it all – but get some help

Omar Khan, MD, MHS, FAAFP
Gilani & Khan, MDs
Wilmington, Del.

Our primary care practice was started by a solo physician who was doing it all: rounding on inpatients at several local hospitals and nursing homes and running a busy practice. It was working only because he dedicated most waking hours to his work; it was clear this was not sustainable.

When I joined the practice, it immediately became clear that we had to either commit to “doing it all” – and start doing it in a rational fashion – or cut back on what we did.

Our big idea was actually very simple. In our two-physician practice, only one physician at a time would be in the office; the other would be in the hospitals, and vice versa. Our plan boiled down to this:

Physician A would work Monday, Wednesday and Friday in the clinic from 9 a.m. to 2 p.m. On those days, Physician B would work outside the clinic doing hospital rounds, nursing home rounds, etc. Physician B would return to the office to work between 2 p.m. and 5 p.m. During this time Physician A would head to the hospital or nursing home, where he could re-round if needed (what an option!) or see late afternoon admissions.

On Thursdays, Physician A would round in the morning and work Thursday afternoon in the clinic. Physician B would assist with rounding only, without any clinic duties for that day. Tuesdays would be the exact opposite.

In essence, this system guaranteed the following:

1) A normal schedule. At most, each physician works 7.5 to 8 hours per day.

2) Not being rushed. If Physician A can't finish morning rounds in time, no problem. Physician B is done at the clinic by 2 or 3 p.m., and he can do the rest of the rounding.

3) Efficient workflow. Having one doctor in the office at a time means less staff and overhead, and no need to juggle two doctors' patients.

4) Excellent inpatient care. Everyone who needs to be rounded on is seen first thing. Someone who needs a discharge later in the day gets that from the afternoon rounnder. Late-day admissions are still usually seen the same day.

5) Preservation of inpatient skills and privileges. We have never used hospitalists and do not anticipate doing so. In fact, some of our colleagues who do not go to the hospital any longer admit to us instead, an honor and privilege we take seriously.

6) Participation in teaching rounds. We can more easily interact with the house staff, teach and provide patient care.

7) Revenue neutrality or even enhancement. Hospital medicine is still well-reimbursed for us. Rather than having both of us in the same office five days a week solely dependent on seeing as many patients as possible, we take it easier, bill more accurately and take advantage of better reimbursed hospital-based admissions and consultations.

8) A flex half-day. Using that time to get paperwork done or stack nursing home visits is an efficient and enjoyable way to make the rest of the week smoother.

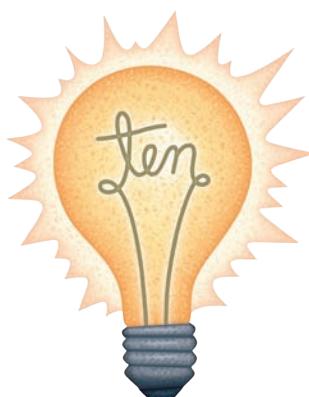
There were some barriers we had to address. Most

important, we had to figure out how to schedule it all. We spent a lot of time up front to make a workable schedule. In addition, we had to learn to accept ebb and flow. Some afternoons, Physician B is truly done with work and goes home at 3 p.m. That's fine; we don't have to work like crazy every day. There are plenty of days when that extra time comes in handy for meeting greater-than-expected demand.

Take-away lessons

You can have it all. Just be clear about what "all" is. We could opt for short-term gain and both squeeze 10-hour days into our office practice. But that would serve neither us, nor our patients. What would I do with the extra money each month? Probably spend it on therapy to get my life back in balance.

There is nothing more fulfilling, and consequently more important to us, than being able to see our patients in the clinic, follow them to the hospital, consult if they have a surgical issue, be their doctor if they go to rehab or a nursing home, and then take care of their newborn child or grandchild. It's not Norman Rockwell medicine; it's reality for us, and can be for anyone who commits to it and embraces the benefits.



Remember why you came to work today

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In the myriad tasks of primary care – charting, coding, paperwork and phone calls – it is easy to lose track of the value of our work. To help prevent this, our office team has started to share stories about "The Reason I Came to Work Today." Sharing these stories is one way we remind ourselves of the meaning and the mission of our work.

It began a few months ago when a patient told me she almost didn't keep her appointment for follow-up of depression. She changed her mind when she remembered how kind one of my nurses, Rachel, had been to her two

weeks earlier during the rooming and preparation process. Prior to that first visit, in the mini-huddle my nurses and I have before each patient encounter, Rachel told me this was a new patient here for headache and added, "She seems depressed." As I have encouraged my nurses to do, Rachel had gone deeper into the history and eventually asked the patient if anyone had been hurting her. The patient acknowledged that she was the victim of domestic abuse. Rachel gathered the referral information for our local domestic violence center and had it ready. With this preparation, I was in a much better position to care for this patient than if I had just walked into the room cold. Her care was a team effort.

I like to catch my staff doing a good job and publicly compliment them, so during a break when all of the nurses were gathered, I shared the story of this patient's gratitude for Rachel's kindness. Rachel said that when the patient told her the same thing, she responded, "You were the reason I came to work that day. And *you* are the reason I came to work today."

Rachel went on to tell us that every day she tries to find one encounter that is "the reason I came to work today" – one interaction that is particularly meaningful. So now, when one of us feels especially good about how we've served a patient, how an interaction went or an expression of kindness from a patient, we can share it with the others under the code of "The Reason I Came to Work Today."

I've noticed a subtle increase in our performance since we started sharing these stories – a little more compassion, a willingness to go the extra mile for a patient and a greater sense of vocation.

Take-away lessons

Intentionally sharing meaningful stories and experiences with our co-workers makes for a richer work life and builds on itself. Giving these stories a code name, such as "The Reason I Came to Work Today," can help overcome our natural reluctance to speak positively about the value of our work. **FPM**

Send comments to fpmedit@aafp.org.

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