PRACTICE EFFICIENCY:
IMPROVING QUALITY AND
PATIENT SATISFACTION

Mary S. Applegate, MD, FACP, FAAP
Clinical Asst. Professor Medicine
The Ohio State University College of Medicine
Private Practice, Marysville, OH

ACP, Washington, D.C.
May 2008
Mary S. Applegate, M.D. has contracted services with the State of Ohio for duties as Medical Director of Ohio Health Plans (Medicaid).
OBJECTIVES

- Key elements to improve physician efficiency and productivity
- Techniques to optimize office staff function
- Work flow: The key to saving time and improving quality
- Implementing change effectively
OBJECTIVES

➢ WORK IN REAL TIME, NOW

➢ DEVELOP AN OFFICE IMPROVEMENT PLAN
  ❖ Issues and Questions
  ❖ Problem and Resolution identification
  ❖ First next steps toward implementation
PHYSICIAN PRODUCTIVITY

- ADAPTING TO CHANGE AS A SURVIVAL STRATEGY

- THE IMPORTANCE OF PHYSICIAN TIME
  - The most valuable asset of a medical practice
  - The primary financial driver of profits
  - The main source of job satisfaction and quality health care
PHYSICIAN PRODUCTIVITY

 WHAT DO YOU DO WITH YOUR TIME?
 MAKE A LIST
 DIVIDE TASKS
  - Productive, only-I-can-do tasks
  - Wasted, of-no-value-to-office tasks
  - Delegated, someone-can-help me-do tasks
# PHYSICIAN PRODUCTIVITY: TIME MANAGEMENT

<table>
<thead>
<tr>
<th>URGENT</th>
<th>NOT URGENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>I ACTIVITIES:</td>
<td></td>
</tr>
<tr>
<td>Crises</td>
<td></td>
</tr>
<tr>
<td>Pressing Problems</td>
<td></td>
</tr>
<tr>
<td>Deadline-driven projects</td>
<td></td>
</tr>
<tr>
<td>II ACTIVITIES</td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
</tr>
<tr>
<td>Relationship-building</td>
<td></td>
</tr>
<tr>
<td>Planning/strategizing</td>
<td></td>
</tr>
<tr>
<td>Recreation</td>
<td></td>
</tr>
<tr>
<td>III ACTIVITIES</td>
<td></td>
</tr>
<tr>
<td>Interruptions</td>
<td></td>
</tr>
<tr>
<td>Some calls, mail</td>
<td></td>
</tr>
<tr>
<td>Some reports, meeting</td>
<td></td>
</tr>
<tr>
<td>Proximate matters</td>
<td></td>
</tr>
<tr>
<td>Popular activities</td>
<td></td>
</tr>
<tr>
<td>IV ACTIVITIES</td>
<td></td>
</tr>
<tr>
<td>Trivia</td>
<td></td>
</tr>
<tr>
<td>Busy work</td>
<td></td>
</tr>
<tr>
<td>Some mail, calls</td>
<td></td>
</tr>
<tr>
<td>Meaningless conversation</td>
<td></td>
</tr>
<tr>
<td>Pleasant activities</td>
<td></td>
</tr>
</tbody>
</table>
## PHYSICIAN PRODUCTIVITY

<table>
<thead>
<tr>
<th>NON-CLINICAL TASKS</th>
<th>POSSIBLE SOLUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE NOTES</td>
<td>Templates, Triage protocols, Low threshold to make appointments</td>
</tr>
<tr>
<td>PHARMACY REFILLS</td>
<td>Automated line, set times/days to do, 3 month protocols, Faxes, Train patients/staff to do @ visit</td>
</tr>
<tr>
<td>SEARCHING FOR CHARTS, TESTS</td>
<td>Pre-visit planning process</td>
</tr>
<tr>
<td>LOOKING UP NUMBERS, INFO</td>
<td>PDA, Online tools, common lists</td>
</tr>
<tr>
<td>PATIENT EDUCATION</td>
<td>Pre-printed packets, websites, Delegate</td>
</tr>
<tr>
<td>DRUG SAMPLES</td>
<td>Eliminate, delegate</td>
</tr>
<tr>
<td>TELEPHONE CALLS</td>
<td>Publicize set times, text, page to get results without interruption</td>
</tr>
</tbody>
</table>
PHYSICIAN PRODUCTIVITY

<table>
<thead>
<tr>
<th>NON-CLINICAL TASKS</th>
<th>POSSIBLE SOLUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FILLING OUT FORMS, ORDERS</td>
<td>Delegate to Nursing Staff</td>
</tr>
<tr>
<td>BILLING ISSUES</td>
<td>Delegate to Coder, biller</td>
</tr>
<tr>
<td>MEETINGS</td>
<td>Be realistic about time</td>
</tr>
<tr>
<td>CONFLICT NEGOTIATION</td>
<td>Delegate to Office Manager</td>
</tr>
</tbody>
</table>

ASSUMPTION: Must put the time into training & developing processes for delegated tasks
PHYSICIAN PRODUCTIVITY

- GOAL: Maximize face-to-face time with patients
THE VALUE CHAIN: COST/MINUTE

Check-In $1.30
Room-In $1.62
Provision of Care $7.50
Clinical Follow-up $1.62
Check-Out $1.30
End of day fatigue

- 1 minute longer per patient to remember the encounter
- Less accurate documentation/dictation
- Staff stays late to add forgotten labs/do forms
- Physician leaves late with to-do stack for Nursing
- Patient leaves practice wasting time, chart, and future revenue
- Lower satisfaction

Day starts with work flow (& morale) disrupted
- Staff batches their work
- Staffs time wasted by reorganizing calls and forms and staving off concerned patients
- Doctor takes three minutes per patient to apologize
- Batches more work
- Behind schedule
- Doctor starts late

Batches more work

Depression? Anxiety?
PHYSICIAN PRODUCTIVITY

- EVALUATE WORK HABITS AND PROCESSES
- BATCHING CREATES NEW WORK OF REORGANIZING THE WORK TO BE DONE
- GUIDE OURSELVES TO FINISH ACCUMULATED WORK EVERY 2-4 PTS: The Virtual Exam Room
PHYSICIAN PRODUCTIVITY: HOW TO WORK IN THE NOW

- **COMMIT TO TIMELINESS**
- **PLAN IT**
  - Limit interruptions
  - Pre-visit planning and anticipation
- **DO IT**
  - Don’t leave room until you are done
- **BE A TEAM LEADER**
  - Huddle
  - Allow staff to help
PHYSICIAN PRODUCTIVITY

- WORK IN THE FIELD (with 3 rooms minimum)
### Efficiency of 3 Exam Rooms

<table>
<thead>
<tr>
<th></th>
<th>Room 1</th>
<th>Room 2</th>
<th>Room 1</th>
<th>Room 2</th>
<th>Room 3</th>
<th>Room 1</th>
<th>Room 2</th>
<th>Room 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15 min appointments</td>
<td>5 min check in &amp; out</td>
<td>15 min appointments</td>
<td>5 min check in &amp; out</td>
<td>Variable appointments</td>
<td>Variable check in &amp; out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>00</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>05</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>⚫</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>20</td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td>20</td>
</tr>
<tr>
<td>25</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td>⚫</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>30</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td>⚫</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>35</td>
<td></td>
<td></td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td>⚫</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>40</td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td>⚫</td>
<td></td>
<td></td>
<td>⚫</td>
<td>40</td>
</tr>
<tr>
<td>45</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td>⚫</td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>50</td>
<td></td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td>⚫</td>
<td>⚫</td>
<td>50</td>
</tr>
<tr>
<td>55</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td></td>
<td></td>
<td>⚫</td>
<td>55</td>
</tr>
<tr>
<td>00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>⚫</td>
<td>⚫</td>
<td>⚫</td>
<td>00</td>
</tr>
</tbody>
</table>

**Summary:**
- Room 1: 4 patients seen, 25 minutes downtime, total patient wait time: 25/4 minutes
- Room 2: 4 patients seen, 20 minutes downtime, total patient wait time: 70/4 minutes
- Room 3: 5 patients seen, 0 minutes downtime, total patient wait time: 60/5 minutes

<table>
<thead>
<tr>
<th>Room 1</th>
<th>Room 2</th>
<th>Room 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>$240</td>
<td>$280</td>
<td>$360</td>
</tr>
</tbody>
</table>
Efficiency of 4 Exam Rooms

<table>
<thead>
<tr>
<th></th>
<th>Room 1</th>
<th>Room 2</th>
<th>Room 3</th>
<th>Room 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 minute appointments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 minutes check in &amp; out</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td>++</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary:
- 6 patients seen
- 0 minutes downtime (with cooperative work)
- Total patient wait time: 65/6 minutes

$420
PHYSICIAN PRODUCTIVITY

GENERAL OFFICE CONFIGURATION

- Cluster exam rooms to save steps
- Close to reception area to save staff time
- Centralized nursing station / telephones
- Consider triage exam room for quick checks
- Exam room layouts should be identical
PHYSICIAN PRODUCTIVITY: MAXIMIZE CAPACITY

- Calculate new visits/total visits
  - Industry AMA median for PCP is 10%
  - 25% for new physicians
- Visit volume growth over time
  - Consider patient demographics/services
- Check access measures
  - Time to 1st, 3rd visit opening
- Consider referrals and admissions as gauges of acuity and complexity of patients (in addition to RVUs, procedure codes)

DOES DEMAND EXCEED CAPACITY??
PHYSICIAN PRODUCTIVITY: MAXIMIZE CAPACITY

POSSIBLE REASONS FOR SUBOPTIMAL CAPACITY

- Location inconvenient
- No one knows (marketing, yellow pages, website)
- Saturated market
- Distinguishing value not evident
- Provider cultural or attitude mismatch
- Operational barriers
  - Poor phone access & service
  - Scheduling/administrative hurdles
  - Inconvenient hours/parking
  - Long waits
PHYSICIAN PRODUCTIVITY: THE PATIENT ENCOUNTER

5 FUNDAMENTAL STEPS OF AN EFFICIENT VISIT

1. Opening the interview (most important)
2. Establishing patient expectation
3. Understanding patient beliefs
4. Making decisions
5. Closing the interview
PHYSICIAN PRODUCTIVITY: THE PATIENT ENCOUNTER

RESEARCH SHOWS THAT GOOD COMMUNICATION

- Improves patient outcomes
- Improves patient satisfaction
- Improves office efficiency
- Improves physician satisfaction
STAFF OPTIMIZATION: TELEPHONE MANAGEMENT

- The telephone is the barometer for efficiency of scheduling, billing, patient education and other office procedures.
- Expect 100 – 200 calls/physician/day (75 – 125 if specialist)
- 30% of calls to a practice are repeats
- Use hands-free sets, protocols, automation
- Set callback expectations for results, scheduling
- Clarify best mode to contact patient
- Decentralize scheduling
STAFF OPTIMIZATION: TELEPHONE MANAGEMENT

Reduce unnecessary inbound calls

- Schedule follow up visits at time of visit
- Have a 3 month schedule template, even with open access as people plan vacations, days off, transportation
- Ask physicians to stick to schedule to avoid rescheduling
- Automate appointment reminders
- Let schedulers schedule without interrupting physician
- Prescription refills, inefficient!
STAFF OPTIMIZATION:
TELEPHONE MANAGEMENT

Other ways to reduce unnecessary calls

- Anticipate and answer questions before patient leaves office
  - (50% of calls to practice are from patients seen in the last week)
- Improve written and verbal communication after visit action plan, hand outs, website
- Billing and referral calls go to dedicated number or billing @droffice.com - Have clear billing statements
- Ask hospital, ECF, colleagues to text page, email or fax
- Reduce the rework – Do it right the first time (triage nurse.......)
- Utilize telephone technology (auto attendant with less than 5 options)
- Automated call distribution, call accounting, call forwarding
- Time expands to fill the task requirement
  - ** staff talks 25% longer to patients on Friday because of lower volume compared to Monday
STAFF OPTIMIZATION: SCHEDULING

- HOW TO IMPROVE SCHEDULING ACCESS
  - Develop effective record retrieval (EMR)
  - Plan for contingencies (Mid level provider?)
  - Schedule patients with chosen physician
  - Empower staff to meet patient needs
  - Speed internal communication
  - Eliminate appointment distinctions
  - Avoid follow-up clusters (not on Monday)
  - Free the template: Med Express, Sick Bay
STAFF OPTIMIZATION: SCHEDULING

Better Scheduling Can Lower Fixed Costs

- Adjust schedule for seasonal variation
- Evaluate current trends (Monday Madness)
- Analyze office use 8am – 6pm
- Use capacity analysis to make a difference
  - staff physician and staff lunches to keep rooms full
  - first appointment comes in 15 minutes early
  - 7am – 7pm 2 days a week
  - no catch up work during busiest times
- Avoid delays: only one complicated patient per hour
- Manage “No Shows” and schedule delays
Dr. Jones is experiencing a rapid decline in his new patient appointments as a percent of his total appointments. If his volume of encounters remains the same, he will soon experience a decline in revenue. If he is a surgeon or a proceduralist, revenue will fall dramatically.
STAFF OPTIMIZATION: REGISTRATION

- Registration is the financial “pre-visit” to check eligibility and benefits
- National benchmark for registration = 5 – 8 minutes
  - (2 minutes if established, 14 minutes if new)
  - If 15 minutes, patient spends more time than with physician!
- IF done well, eliminates need for check out!
- Solutions
  - Pre-registration by phone (at the time of scheduling visit)
    - by mail (with appointment reminders)
    - by fax, computer (patients can download the registration form)
  - Get Information/Co-pay Before the Appointment
  - Simple forms, Clinical aspects handled by clinical staff
  - Kiosks
WORK FLOW EFFICIENCY

- Evaluate cycle time (Time pt enters and leaves office)
  - Track where and when patient waits
- Eliminate waiting whenever possible (? Altogether)
- Smooth the demand by scheduling techniques e.g. flu clinic, yearly checks in summer
- Adjust service capacity – part-time physicians, flexible shifts, patient co-production, appropriate staff when busiest, set tasks for “idle” time (e.g. mail)

- Ideas for Medical Practice
  - Make use of patient time: Note pads that say “Be sure to discuss with doc today”, Refills needed, Education kiosks
  - Patient paperwork is done ahead of time (?on line)
  - Send statements by email, pay accounts on line
  - Maintain treatment plan log online, assess own care with clinical algorithm
WORK FLOW EFFICIENCY

- Tennis ball exercise
- Lessons Learned:
  - Minimize patient movement (universal room)
  - Structured (scripted) process helpful
  - Consistent application of process/procedure
  - Care team surrounds and is focused on patient
WORK FLOW EFFICIENCY:
THE PATIENT-CENTERED MEDICAL HOME

- Personal medical home
- Patient-centered care
- Team approach
- Elimination of barriers to care
- Advanced information systems
- Redesigned offices
- Whole person orientation
- Care in community context
- Emphasis on quality and safety
- Enhanced practice finances
CHRONIC CARE MODEL

COMMUNITY

RESOURCES & POLICIES

HEALTH SYSTEM

ORGANIZATION OF HEALTH CARE

SELF-MANAGEMENT SUPPORT

DECISION SUPPORT

CLINICAL INFORMATION SYSTEM

DELIVERY SYSTEM DESIGN

INFORMED ACTIVATED PATIENT

PREPARED PROACTIVE PRACTICE TEAM

FUNCTIONAL & CLINICAL OUTCOMES
WORK FLOW EFFICIENCY:
THE CARE TEAM

- Clear goals with measurable outcomes
- Standardization of routine tasks of care via clinical & administrative systems
- Clearly delineated roles & tasks (division of labor)
- Appropriate training
- Willingness to substitute non-physician for physician tasks as appropriate
- Good communication
WORK FLOW EFFICIENCY: THE CARE TEAM

FUNCTION:
- Analogous to football team
- Different plays
- Not all quarterbacks
- Can respond quickly with a change in strategy
WORK FLOW EFFICIENCY: THE CARE TEAM

- Physician
- Medical Assistant
- Midlevel Provider
- LPN/RN* (shared by 3 teams)
- Scheduler*
- File clerk*
- Pharmacist
- Nutritionist
- Disease Management Consultant
- Psychologist or other Behavioral Health consultant
- Social worker
- IT genius
WORK FLOW EFFICIENCY: THE CARE TEAM

COMMON PURPOSE:
- To meet short-term (Process) and long-term (Outcome) goals:
- To operationalize THE PATIENT-CENTERED MEDICAL HOME (PCMH) within the Chronic Care Model (AAFP, ACP, AAP, AOA)

- Personal Physician
- Physician-directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality & safety are priorities
- Enhanced access to care
WORK FLOW EFFICIENCY: THE CARE TEAM

- TEAM MISSION: Patient visit

- CONCEPT: The 4 stage office visit:
  - Pre-visit (The prior day)
  - Visit
  - Post-visit
  - In-between visits
## WORK FLOW EFFICIENCY: WHO DOES WHAT?

<table>
<thead>
<tr>
<th>TASK</th>
<th>DOC</th>
<th>MLP</th>
<th>RN</th>
<th>MA</th>
<th>FO</th>
<th>CLK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart preview</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Filing/test results</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Forms</td>
<td>*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ret calls</td>
<td>*</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Samples</td>
<td>*</td>
<td></td>
<td>X</td>
<td>X</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Dx, Rx,…</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
WORK FLOW EFFICIENCY: THE CARE TEAM

• KEY FUNCTION: THE HUDDLE
  • Includes link to care/case management

• CARE TEAM BENEFITS:
  • Improved quality
    • Continuity of care
    • Access to care
    • Patient satisfaction
  • Lower costs
  • Improved work/career satisfaction
IMPLEMENTING CHANGE: PROCESS

- Identify potential areas for improvement
- Set meaningful goals
- Establish concrete, actionable measures
- Form a team
- Implement change (PDSA)
- Spread success through CQI
IMPLEMENTING CHANGE: POSSIBLE MEASURES

• OUTCOMES MEASURES
  • % No shows
  • Future capacity (empty slots/month)
  • 3rd next available visit
  • Office cycle time

• PROCESS MEASURES
  • Patient continuity (% pts seen that were “yours”)
  • # new patients
  • Daily supply/demand (appt requests, UC referrals)
IMPLEMENTING CHANGE: POSSIBLE MEASURES

• BALANCING MEASURES
  • Patient satisfaction surveys*
    • Phone access
    • Availability of appointment
    • Office wait
    • Interpersonal aspects of visit
    • Communication/Information given

• CLINICAL MEASURES
  • NCQA, BTE, HEDIS, PQRI tied to P4P
IMPLEMENTING CHANGE:
PRIORITY SELECTION

- Eliminate waste (anything that does not add value)
- Improve work flow
- Optimize inventory
- Energize the physical work environment
- Customer service
- Waiting time management
- Unnecessary variation
- Error-proof processes (transparency)
- Focus on the specific service
IMPLEMENTING CHANGE:
OUTSIDE THE BOX: TRANSFORMATION

- Incremental change vs. Disruptive innovation
IMPLEMENTING CHANGE: LESSONS FROM INDUSTRY

- INNOVATION FACILITATORS:
  - Linking strategy to structure (acute care may require different structure than chronic disease management)
  - Establishing democratic access
  - Simplifying through technology
  - Centering consumer in the business model
    - Do not change customers, HELP them!
  - Pushing the work down the chain of command
    - Integrate across whatever is not good enough
IMPLEMENTING CHANGE: INNOVATIONS

- Self-care booths
- Virtual minute clinics
- E-consultations in real time, parcel-size purchasing of health care, mental or physical, for individual, school or employer benefit
- Web-based, touch screen access to MH/PH screens and info with link to resources, clinical practice guidelines (customized to pt), PHR
- E-networks (phase of life or condition specific)
- Hand held diagnostics: ultrasound, non-invasive lab, genetic biologics
IMPLEMENTING CHANGE:
PRACTICE PROCESS

- Assessments (SWOT)
- Redesign based on mission, vision, strategic plan
- EHR implementation
- Care management
- Medical Home Certification (or other NCQA initiative)
- Incentive programs
- Community connectivity
- Practice performance including satisfaction measures
Practice Evolution...

- Limited data review >> Dashboard >> Benchmarking >> Reporting
- Visit-based care >> Scheduled phone/email >> Remote monitoring
- Appts. by Phone >> Advanced Access >> PHR + Web-based portal
- Pre-Printed Education >> Computer-generated >> Customized + SMGs
- Books/charts >> Handheld PDA >> EMR + CDS
- Rx Pad/Pen >> e-Rx (alone) >> EMR+eRx
- Flow sheets >> E-registry >> EMR >> HIE
<table>
<thead>
<tr>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.acponline.org">www.acponline.org</a> (Practice Management link)</td>
</tr>
<tr>
<td><a href="http://www.improvingchroniccare.org">www.improvingchroniccare.org</a></td>
</tr>
<tr>
<td><a href="http://www.aafp.org">www.aafp.org</a></td>
</tr>
<tr>
<td><a href="http://www.ihi.org">www.ihi.org</a></td>
</tr>
<tr>
<td><a href="http://www.ama-assn.org">www.ama-assn.org</a></td>
</tr>
<tr>
<td><a href="http://www.improveyourmedicalcare.org">www.improveyourmedicalcare.org</a></td>
</tr>
<tr>
<td><a href="http://www.physicianspractice.org">www.physicianspractice.org</a></td>
</tr>
<tr>
<td><a href="http://www.ahrq.org">www.ahrq.org</a></td>
</tr>
<tr>
<td><a href="http://www.qualityforum.org">www.qualityforum.org</a></td>
</tr>
</tbody>
</table>
Join the evolution.

PHYSICIANS of the UNITED STATES of AMERICA,

in order to continually improve the care of patients nationwide and promote the general welfare of the profession, are asked to take the lead in deciding how best to care for our patients.

The Physician Consortium for Performance Improvement, comprising more than 100 national medical specialty and state medical societies, through a collaborative spirit, has developed more than 200 evidence-based measures on 31 clinical topics to help physicians lead the way in making sure patients receive safe, quality care.

PHYSICIAN-DEVELOPED. EVIDENCE-BASED. SPECIALTY SOCIETY-APPROVED.

Learn what the American Medical Association-convened Physician Consortium for Performance Improvement® is doing to improve patient care.

www.physicianconsortium.org