

FOUND! REVENUE YOU MAY BE LEAVING ON THE TABLE

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Part 1: Helping Patients Shoulder Their Share

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Part 1: Helping Patients Shoulder Their Share

The more efficient your medical practice is, the less it costs to run, and the better your patient service! Sounds like a great combination, so why do most practices struggle to achieve it?

Too many don't realize that office processes themselves can cause revenue leaks, and plenty more are unable to effectively solicit help from every possible quarter — including their patients. Let's start by looking at one of the most costly problems occurring in the average medical practice: an inefficient patient scheduling system. You may be surprised to learn that poor scheduling can result in lost revenue, higher expenses, lower productivity, poor patient compliance, and inferior service to your patients.

SCHEDULING FOR MAXIMUM REVENUES

Begin with the assumption that a single perfect solution does not exist. Mastering appointment scheduling depends on what will be the best model for an individual practice. The goal is to implement a system that serves patients well, optimizes productivity, and keeps the doctor on time.

Unfortunately, most practices simply don't take a good hard look at the schedule to find out why it isn't working — but they do know it's not efficient because of these telltale signs:

- ▼ Standing room only in the reception area.
- ▼ Patients asking, "How much longer am I going to have to wait?"
- ▼ Patients left waiting in the exam room.
- ▼ Physicians and staff unable to leave the office on time.
- ▼ Stacks of work unfinished at the end of the day.

Sound familiar? There's hope: Study of the scheduling operations in hundreds of practices in nearly every specialty shows that these problems are both common and treatable.

Examine Past Habits and Trends

The first step in solving a scheduling problem is to admit that you have one. Recognize just how big the issue is,

and what it's costing the practice in real numbers. For example, assume that your average per-patient revenue (calculated by dividing the average number of patient visits per month by the average monthly revenue) is \$125. If you have an average of four missed appointments on the schedule each day, those lost appointments result in \$500 lost revenue. That adds up to an alarming \$120,000 in lost revenue in a year's time. This will certainly get the average hard-working physician's attention!

Next, examine your existing scheduling patterns (post-visit) and the implications over a two-week period. For each patient, note:

- ▼ Scheduled appointment time;
- ▼ Arrival time;
- ▼ Time she is roomed;
- ▼ Time when the physician enters the room; and
- ▼ Amount of time the provider spends with the patient.

Many in-office studies reveal that half of the typical 15-minute appointment is whittled away with patient waits and room turnover. Physicians should instead be moving from room to room while those things are happening. If your own study reveals that the actual time the physician dedicates to a patient visit is less than 9 minutes, 10-minute visit increments may be a better scheduling model. We will discuss this later.

For this two-week study period, calculate the potential revenue lost because of missed appointments. Determine the percentage of total scheduled patients this represents, then examine ways of lowering the number. Consider a few typical reasons patients miss their appointments:

- ▼ They are accustomed to waiting an unreasonable length of time in a packed reception room and figure they'll never be missed. Basically, you don't honor their time, so they don't honor yours (the appointment)!
- ▼ Their appointments are booked too far out, resulting in the patient forgetting about it, feeling better, or simply going elsewhere for care.
- ▼ Staff inadvertently gives a message that the appointment isn't really an important commitment. They may say such things as, "If you can't make it, let us know," or, "Doctor Jones can squeeze you in."

During the two-week study period, also explore what

causes the physician to fall behind. The nurse will need to document these reasons on the schedule. Does the physician start late or get interrupted, or is the chart or patient improperly prepared for the visit? Maybe the primary cause of back-ups is that the doctor needs more time with the patient than the schedule allows. Or maybe the doctor is taking business calls between appointments, resulting in time spent going back and forth from the treatment room to his private office down the hall.

Get a clear understanding of the demand for appointments. Check each physician's schedule to see when the next available appointment is. If the open appointment slot is more than three days out for a routine visit or more than a week for a new-patient visit, demand is exceeding access. That pent-up demand puts pressure on the schedule, and may result in the inefficient habit of double booking.

Gathering all of this important data provides an overview of how the existing scheduling template functions, and should be the impetus to take corrective action where needed. Scheduling isn't a one-size-fits-all proposition. Every system has pros and cons, but arming yourself with historical information will help you examine how the existing system performs. You'll be much better prepared to determine which scheduling model represents the best system for your practice style.

Block Scheduling

The typical block appointment system is the most common. It schedules patients in 15-minute time slots, allowing more slots for patients for whom greater time needs are anticipated, as with a new-patient visit or in-office procedure.

Unfortunately, block scheduling doesn't work particularly well in its purest form. In a high-demand practice, the schedule fills up quickly and harried appointment schedulers end up double booking where they *think* it

Gathering all of this important and relevant historical data provides an overview of how the existing scheduling template functions. It should be the impetus to take corrective action where needed.

will work. Often, the scheduler doesn't realize how her decisions will affect patient flow in the clinic.

New-patient visits, preoperative appointments, and annual physicals also pose a problem under a block scheduling system. Physicians may be kept waiting while the nurse spends five or six minutes prepping the patient for the visit. It's inefficient to have the doctor waiting, when half an hour later she'll be playing catch-up because someone has double booked patients. Worse, those double-booked patients may get short-changed as the doctor rushes to get back on schedule.

If the data from your practice suggest that a 15-minute block schedule is still the best bet, carefully design ways to make it more efficient. For example, limit double booking to placing a follow-up patient alongside a new patient or at the top of a half-hour appointment slot. That way, the physician can see the follow-up while the patient requiring more preparation for the visit is being handled by the nurse. Double booking might also make sense if two family members are being seen at the same time — a natural for pediatric practices or for quick visits such as suture removals. Follow these visits with 30-minute appointments to avoid falling behind.

Wave Scheduling

The wave schedule allocates time by stacking patient appointments at the top of the hour: Instead of scheduling every 15 minutes, four patients are scheduled on the hour, and the nurse and physician work their way

TABLE 1. Sample Visit Types for Go-Ten Scheduling

Short (10 Minutes)	Standard (20 Minutes)	Complex (30 Minutes)
<ul style="list-style-type: none"> • Single symptom (e.g., rash/mole, ear infection, blood pressure check) • Simple recheck or medication check • Minor complaints 	<ul style="list-style-type: none"> • Multiple symptoms • Infections • Established patient with chronic problems • Monitoring patient with multiple problems • New patient with minor complaints 	<ul style="list-style-type: none"> • Annual exam • Pre-employment physical • Established patient with complications • New patient with chronic or major complaints

through these patients until the top of the next hour.

A wave schedule neutralizes the lost time for no-shows and ensures that the physician won't end up waiting for a patient. Unfortunately, this is accomplished at the patient's expense and jeopardizes customer service.

The wave appointment system is the epitome of poor service and makes patients feel trivial. It guarantees a wait time for as many as 75 percent of them. Imagine four patients checking in at the same time and knowing they all have a 3 p.m. appointment. Patients don't like this scenario and quickly begin trying to outsmart the practice by beating the clock — and the other patients — by coming in early. Patients end up unhappy, the reception area gets packed, and bottlenecks form at check-in, making for a disgruntled receptionist.

Open-Access Scheduling

The open-access schedule eliminates advanced scheduling. It is aimed at putting the patient first, leaving the schedule wide open for same-day appointments. Although this system ensures immediate access, it assumes that enough patients will call in to fill the day and keep everyone productive. Planned appointments, such as annual physicals and pre-ops, are put on the books in advance, but for the most part your schedule and the revenue it garners rely on patient demand. This approach cedes much of the planning and control over how the day will work. And, as with the missed appointments, an unfilled schedule will result in lower revenues at the end of the day.

'Go-Ten' Scheduling

Scheduling in 10-minute increments provides more flexibility and increased patient volume. I call this system "Go-Ten" scheduling, and I have implemented it successfully for many practices in recent years. Consider a practice whose schedule is open between 8:30 a.m. and noon and again from 1:30 to 5:00 pm: That's 28 slots with a 15-minute schedule and 42 slots with the Go-Ten system, an increase of 14 appointment slots. Imagine the revenue implications — a gain of as much as 50 percent — especially if the practice also adopted an EMR system to make visit documentation more efficient, accurate, and timely. With the added flexibility of scheduling

based on actual time needed with the patient, physicians and staff enjoy the advantages of increased capacity, staying on schedule, and higher revenues. Patients appreciate quicker access and being given the right amount of time with the doctor.

Deciding what time parameters are needed for various patient types is essential to the success of implementing a 10-minute schedule. Limiting appointment times to no more than four options will help simplify the model. The sample practice example shown in Table 1 has only three appointment lengths, making the schedule easy to understand and work with.

Go-Ten/Modified Open Access Scheduling

The most efficient scheduling system may be Go-Ten combined with modified open access. To implement such a system, practices will need to add another element to studying their historical scheduling patterns: Every day, track on a simple spreadsheet how many patients call in wanting to be seen on the same day. Look at those you worked into the schedule, those you ended up booking further out, and those who didn't bother to schedule. This will help you measure actual demands on the schedule and determine the number of appointment slots that should be reserved for open-access (same-day) appointments.

Aside from simply managing your day better, the goal of a smart scheduling system is to enable revenue-producing resources — physicians and exam rooms — to be used to full capacity at all times. To further improve your practice's financial picture, explore the following additional ways to master the schedule. The efficiencies most practices stand to gain are astounding.

Reduce Missed Appointments

Missed appointments cost more than simply the lost visit revenue, even at the \$125,000 annual level estimated earlier. There's a high cost in terms of the staff time needed to schedule the appointment, pull the chart, and prepare for the visits. Then, after the fact, the patient needs to be called to find out why he didn't show up. The reason must be documented in the chart, the appointment rescheduled, and the chart returned to its filing spot. At the same time, the no-show patient is often taking up a slot for another patient who was denied an appointment.

Staff and patients will not take missed appointments seriously unless the physician and manager take action. Begin by introducing changes designed to manage the schedule better and reduce the no-show rate. Automated appointment reminder systems go a long way in supporting this objective. This patient care investment

Practices have the ability to help the patient help them, but everyone must honor the schedule. If the doctor starts on time and stays on time, patients will stand up and take notice.

TABLE 2. Improved Communication With Patients

Situation	What NOT to Say	What to Say
Confirming an appointment	Let me know if you can't make it. <i>Message: We know you might not make it, and that's OK.</i>	We're expecting you. We've dedicated this appointment to you. <i>Rationale: Strong words reinforce the patient's obligation.</i>
Booking an appointment	I'm squeezing you in. <i>Message: You'll never be missed if you don't show up, and you can expect to wait when you get here.</i>	I have an opening for you at 3 p.m. <i>Rationale: We have time for you and want to see you.</i>
Calling the no-show appointment	I'm calling to reschedule the appointment you missed. <i>Message: Missed appointments are not your responsibility.</i>	We're concerned that you missed an appointment. It's important that you come in. <i>Rationale: Emphatic, but empathetic.</i>
When a patient calls to cancel	Did you want to reschedule the appointment? <i>Message: It's OK with us if you change appointments at any time.</i>	It's really important that you keep the appointment. The time is reserved and doctor would like to see you then. <i>Rationale: The appointment is important and so are you.</i>
When you are behind schedule	I'm sorry we're running a little late. <i>Message: We don't have a handle on our schedule, and we're rushed.</i>	Dr. Jones needed more time than expected with a couple of our patients. I apologize for the delay. <i>Rationale: We give patients the time they need, but don't like to keep you waiting.</i>
When you need to reschedule a patient's appointment	Dr. Smith has to cancel your appointment. <i>Message: We're more important than you or your time.</i>	Unfortunately, we need to move your appointment. When would be a convenient time for you to come in? <i>Rationale: "Need" implies that changing the appointment could not be avoided. Your technique for rescheduling lets the patient know that you don't want to inconvenience him.</i>

saves staff time and improves reliability and consistency. It provides a tracking tool, improves patient compliance, and ultimately adds to the bottom line.

Some physicians argue that patients want to be reminded by staff, not a machine, but hard evidence doesn't bear this out. People — even senior citizens — are accustomed to voicemail and automation. In fact, the best way to use an appointment reminder system is to collect patients' e-mail addresses and cell phone numbers (almost everyone has them), and ask them about their preferred way to be reached.

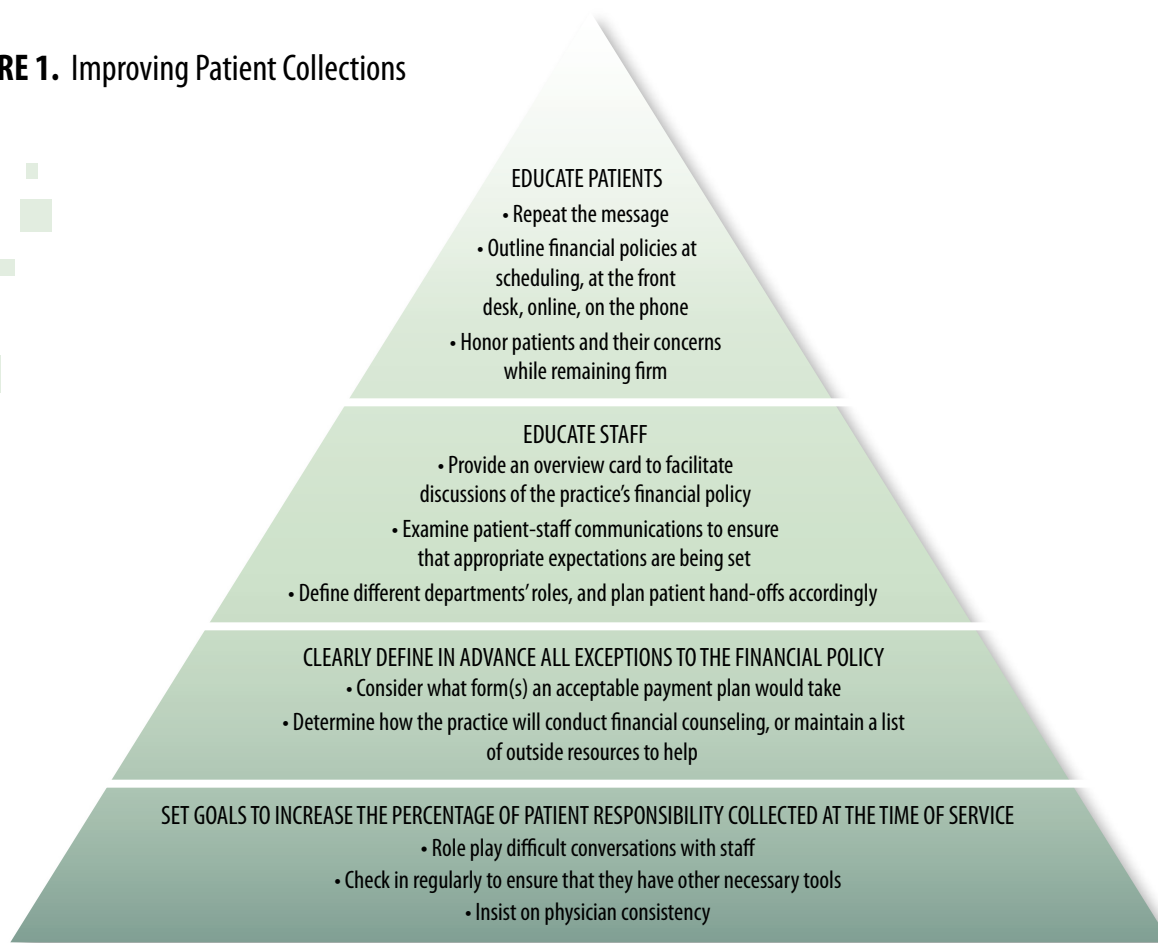
Further support patient adherence to appointments

by giving employees tools to improve communication. Aim to help staff help patients understand that missed appointments are not OK, and that last-minute cancellations are reserved for emergencies.

To improve appointment compliance and place the emphasis where it needs to be, carefully select the words used when talking with patients. Table 2 provides some great examples of improved communications with patients.

An important note: Practices have the ability to help the patient help them, but everyone must honor the schedule. If the doctor starts on time and stays on time,

FIGURE 1. Improving Patient Collections



patients will stand up and take notice. They will be on your team, and you can eliminate those costly missed appointments that compromise efficiency and revenue.

Meet Visit Needs

Staying on time is much easier if time is taken to plan for the visit. For example, the nurse needs to be sure everything is ready for the physician in advance, including a review of the chart to make sure all diagnostic study results and treatment is documented before the patient arrives. When the patient is roomed, the preparation for the visit includes history-taking and documentation, and making sure that the patient is appropriately undressed for the type of exam needed. Based on this prep work, the nurse should be able to perceive the doctor's needs and have treatment aids readily available, again making optimal use of those revenue-producing resources.

AMPING UP PATIENT COLLECTIONS

The next step to making the most of each day is getting paid for what you do. Keen attention here has become more critical as employers and insurance companies pass more of the cost of care on to patients. Patients now

face high deductibles, larger copays, and more shared expense for procedures and testing. It's a good time to look at how the practice handles patient finances and implement strategies to address these changing trends (see Figure 1).

Establish Financial Policies

Setting and implementing standard financial policies is easier said than done. All stakeholders must agree on the standard and how it will be enforced. And although much of the responsibility for collecting from patients falls to the staff, physicians must comply as well — this means *no sacred cows*.

Staffers are too often seen doing their best to collect from a patient, only to have the patient respond with, "Dr. Goodguy said I don't have to pay today." When a physician does this, the formal policies become mute. Physicians must instead explicitly support the practice's financial policies. These policies should define what financial expectations will be placed on their patients, how those goals will be achieved, and exactly what exceptions will be allowed.

If your policy states that copays are due at the time of the visit, make sure you're really collecting them. Likewise any fees for bounced checks, missed appointments,

TABLE 3. Ramping up OTC Payments to Increase Patient Collections

Over-the-Counter Payment Goal	Average Daily OTC Collections	Payment (% of Patient's Balance)
Historical performance	\$500	10%
30-day target	\$2,900	40%
60-day target	\$3,599	70%
90-day target	\$4,500	90%

and so on. It sounds obvious, but avoid having on the books policies that do not align with your philosophy so that following up consistently will be a matter of course.

Additional areas to consider covering in your financial policies include:

- ▼ Details on the practice's billing cycle — outline for patients, right at the beginning of your relationship with them, how many statements they can expect to receive from your office, and when.
- ▼ Information on discounts — avoid making ad hoc or last-minute decisions with self-paying patients.
- ▼ What constitutes grounds for dismissal from the practice — truly an option of last resort for most practices, and a step to be undertaken only with care, but dismissing a patient who consistently doesn't pay her bills may be necessary. Consider potential referral source ramifications, as well as whether an individual patient may become angry and look for reasons to seek legal retaliation.

Anticipate the difficult questions, and determine in advance how you'll answer them. What will happen when a patient pays off an overdue balance? Will he be allowed to continue seeing physicians in the practice with no restrictions? Or will he have to meet predefined criteria such as always paying for visits up-front, or perhaps accepting appointment slots only during less-busy days and times?

Consider whether you want to offer payment plans at all — is the administrative time you spend setting up a schedule and chasing down installments worthwhile? — or whether you'll simply ask for a credit card instead. Although many worry about possibly opening themselves to fraud allegations, some practices even require that all patients allow them to keep a valid credit card number on file. When going this route, practices generally notify the cardholder before making any charges to an account, and their financial policies should clearly lay out the circumstances under which

such charges will happen.

Regardless of the nature of any restrictions a practice chooses to safeguard its cash flow, make sure staff applies policies and penalties consistently, whether a particular patient is a pleasant delight or a nagging nuisance to deal with.

Educate Staff

Is your reception staff committed to collecting from patients, and trained to do so? If a consultant came into your office and asked whether staff is collecting everything patients owe, on the spot, would the answer be, "We try"?

We try is only half of a commitment. Such a response generally means that staff doesn't think patient over-the-counter (OTC) collections are important enough, or that they feel they don't have the training and tools to succeed. The practice manager has an important role to play in shifting staff's attitude and motivating them. Needed support includes training sessions — spend some time discussing the "what if" scenario, or how to deal with patient objections.

If the patient never had to take responsibility for paying when he was in the office in the past, you're bound to encounter some resistance. Role play with staff on

how to deal with this and other obstacles that get in the way of collecting what is owed. A good response is, "Mr. Welcome, I realize this is new to you, but as of March 1 our policy has changed. It's my responsibility to collect what is owed. I'm sure you understand."

With patients who are not prepared to pay, the follow-up might be, "Mr. Welcome, let me give you an envelope and ask you to mail in the payment within 10 days. Next time you will be prepared. Is there anything else I can do for you today?" Doesn't that sound like a staffer who wants to provide the best in service, but also wants the patient to take responsibility for his obligations? It works well. The best approach is to remain firm, but honor the patient.

Like it or not, a medical practice is a business, and managing patient finances is becoming a larger portion of practice finances.

Once you've gone through a few scenarios, have the staff work with you to define reasonable OTC goals in terms of hard numbers. For example, if the typical day's patient load consists of a total patient balance owed of \$5,000 and the staff historically has collected only \$500 of that, what is a reasonable new OTC collections goal? How long would it take to achieve that goal?

In the case illustrated in Table 3, the staff has traditionally collected only 10 percent of patient OTC payments, a long way from hitting the goal. By setting targets along the way, the desired end result appears more reasonable, making it easier for staff to buy in and take responsibility. The practice manager can sit down with the staff involved in collecting OTC payments each week to see if they are on target and provide additional support.

The foundation for patients to take their payment responsibilities seriously is dependent on staff and physician communication — when the patient schedules the appointment, when she is in the office, and at the close of the visit.

Educate Patients

Before you launch a new financial policy, you'd better inform your patients. Educate them on what is expected, and help them be prepared. There may be some resistance, but if the practice itself is well-prepared and communicates effectively — and consistently — patient collections will improve.

Without question, the best time to ask for and collect a patient balance is when he is in the office, especially with more patients shouldering increased payment responsibility. This presents a problem for practices that are accustomed to only collecting copays when the patient arrives and ignoring old balances. Rather than letting patients off the hook, a better course is to say, "Mrs. Good Intentions, we now collect payment at the end of the visit, when we can review the account and collect your share of the anticipated balance."

The patient visit should be the second time the patient is informed of your payment expectations. The first time is when the scheduler makes the appointment. Coach this staff member on how to inform each patient of the new policy. The patient should be reminded that he will be expected to pay his balance at the next visit. If the patient balks, transfer the call to the billing department, where the financial policy will be enforced.

Repeat — and repeat again. This is the best way to educate patients and reinforce the new financial policy. The message communicated needs to consistently define your expectations. Create an overview card for staff to give to patients when they explain the new financial policy and what it means. This supports the need for patients to be prepared to pay as they go, including copays and other financial responsibilities no longer covered by pay-

ers. Further reinforce expectations by posting the patient financial policy on your practice's Web site, and let everyone know in outgoing phone messages and during the on-hold message where to look for the policy online.

These practical tools will help improve patient compliance, but everyone — doctors, nurses, receptionists, billers, and management — needs to be on the same page, supporting the written financial policy. Such consistency (and determination) enables practices to succeed at optimizing OTC payments and helping patients understand their financial obligations.

Define Payment Exceptions

When drafting financial policies, it is important to deal with exceptions up front. Paying at the time of service may not always be possible — or desirable. Hardships will undoubtedly arise, or there may be cases of uncertainty as to whether the patient or the insurer holds the responsibility for payment. Clearly define those exceptions, and outline what constitutes an acceptable payment plan.

For example, consider a patient who is accumulating a fair amount of expense because of a hospitalization and a chronic condition that requires close follow-up. How does the practice expect to get paid? Develop a formula that the stakeholders can agree on. What if the patient's balance is \$5,000 and will continue to grow because of needed medical care? You might want to set a policy that requires a zero balance within five months, meaning that the patient would need to pay \$1,000 a month, plus all that is due on each additional visit at the time of service.

When it comes to large balances, conducting a financial counseling session is an excellent way to reach agreement. Put the details of the conversation and any subsequent plan in writing, and have the patient sign it. Most physicians want to be sensitive to the patient's position, but like it or not, a medical practice is a business. Managing patient finances is becoming a larger portion of practice finances.

More important than the details of any plan or policy is the forethought that goes into developing it, and in its consistent application. Helping patient shoulder their share is all about commitment and compliance — better compliance with keeping appointments, following the doctor's orders, and taking responsibility to pay their share of medical expenses. Through better communication and consistency, the relationship between the practice and the patient will be stronger. So will the practice's bottom line. ■

Judy Capko is a healthcare consultant, speaker, and author of the books "Secrets of the Best Run Practices" and "Take Back Time — Bringing Time Management to Medicine."