Scheduling Techniques for Success

As I was chatting with a busy pediatrician about her priorities for managing her successful practice, I realized how often she mentioned the word, "*schedule*." Perhaps it's not a surprise, as the schedule defines the delivery of the practice's most important asset – in this case, her time, and that of her colleagues. Without an appointment slot, there is no encounter, no CPT code, no bill, no payment. Most importantly, there is no delivery of care to the patient who needs it. The schedule is truly the backbone of the practice, as it is the means to deliver the precious, perishable inventory of a physician's time.

Let's explore opportunities to effectively construct a schedule:

***Be intentional*.** Because the schedule represents your inventory, it serves as the basis for achieving the goals for your practice. For example, if your overhead represents $300,000 per year and you want to bring home $200,000 per year, you need to come up with a bit more than $500,000 to be sure to cover your variable costs, such as medical supplies. If you clear an average of $150 per patient encounter, you need to bill for 3,333 visits annually. If your identified "no show" rate is 10%, you'll need to build slots for (at least)

3,704 appointments into your template for the year.

In addition to the volume that you need to run your practice, the percentage of new patient appointments is important. How many new patient appointments do you need in the clinic to optimize your surgery schedule (or any subsequent or adjacent service)? Every specialty will have a different lens on this topic of "new" patients– for example, my pediatrician friend embeds newborn appointments into her schedule. It's an opportune time to consider your schedule as a vital tool in managing practice growth.

***Recognize the importance of every appointment slot*.** Even if the schedule looks really busy, patients may cancel in the days or hours prior to their appointment. Cancellations may be due to scheduling conflicts, cured illnesses, or any host of reasons. Redeploy the slot by implementing an automated waitlist that offers availability through the afternoon before that appointment. Supplement these efforts by assigning a "gap management specialist" or (my favorite!) "chaos scheduler" to review the next day's schedule each late afternoon as the waitlist stops throttling. Actively work the schedule by calling patients who are scheduled in the days or weeks ahead to determine if they wish to be seen earlier. (Be intentional about the process – for example, provide guidance to your team so that a new patient doesn't get scheduled into a 10-minute slot.) For many practices, unfortunately, an empty slot is celebrated – start changing the culture today.

***Identify the duality of no-shows*.** Missed appointments have a significant impact – the patient misses their care, but the nonarrival also represents an opportunity cost for the practice. Therefore, missed appointments need to be addressed from the patient's perspective – and the practice's perspective. From the patient's perspective, institute a robust confirmation process to urge the patient to present. Consideration may be given to financial penalties, which may be invoked for frequent offenders. On your end, consider leveraging predictive analytics. At the patient level, you could analyze their likelihood-to-show, and determine whether to overbook the appointment slot. Alternatively, you could build in an extra slot(s) based on your overall nonarrival rate. In sum, address the issue from both perspectives – the patient's and yours.

***Template construction is vital*.** There are several key methods to build a template. Some opt for an open template where any patient can be put in any slot; others have a very rigid grid with designated attributes (e.g., new patients, post-surgery). The best method is one that works for you – and your patients, but likely falls between these two extremes. One of my favorites is a modified wave schedule. Let's say you're an obstetrician. You have a new Ob patient scheduled at 8 a.m. – and she's likely to spend at least 15 minutes with the pre-visit tasks of urine samples, undressing, vitals etc. Schedule an established patient sick visit at the same time (8 a.m.) and see that patient in those initial 15 minutes.

In addition to the daily construction of the office schedule, be thoughtful about the week and the year. For example, consider holding more sick- and new-visit slots on Mondays (instead of return visits). December is always a high-volume month for elective surgeries as patients scramble to use their post-deductible insurance coverage.

For many practices, the schedule remains an administrative task that is nearly an afterthought. Being intentional about your schedule can create value for your practice – and your patients.

Is Your Practice Prepared for a Disaster?

SVMIC recently held a disaster preparedness “tabletop” drill where it tested the company’s Business Continuity Plan, an exercise we wholeheartedly recommend for all our members and practices.

Disaster preparedness is a topic that often falls through the proverbial cracks because it is time-consuming, and can feel like time wasted, getting ready for something that may never happen. Common sense tells us, however, that the time spent preparing in advance will pay tremendous dividends if and when a true disaster does come to bear.

We asked Owen Dahl, a former medical practice executive who wrote The Medical Practice Disaster Guide Book and has experience managing a medical facility through Hurricane Katrina and other natural disasters, to put together a quick guide for SVMIC practices to follow in setting up your own Business Continuity Plan. This quick guide can be found here by logging into your Vantage® account.

Practices who need assistance with disaster planning or other practice management issues can reach out to SVMIC's Medical Practice Services group at 800.342.2239 or ContactSVMIC@svmic.com.

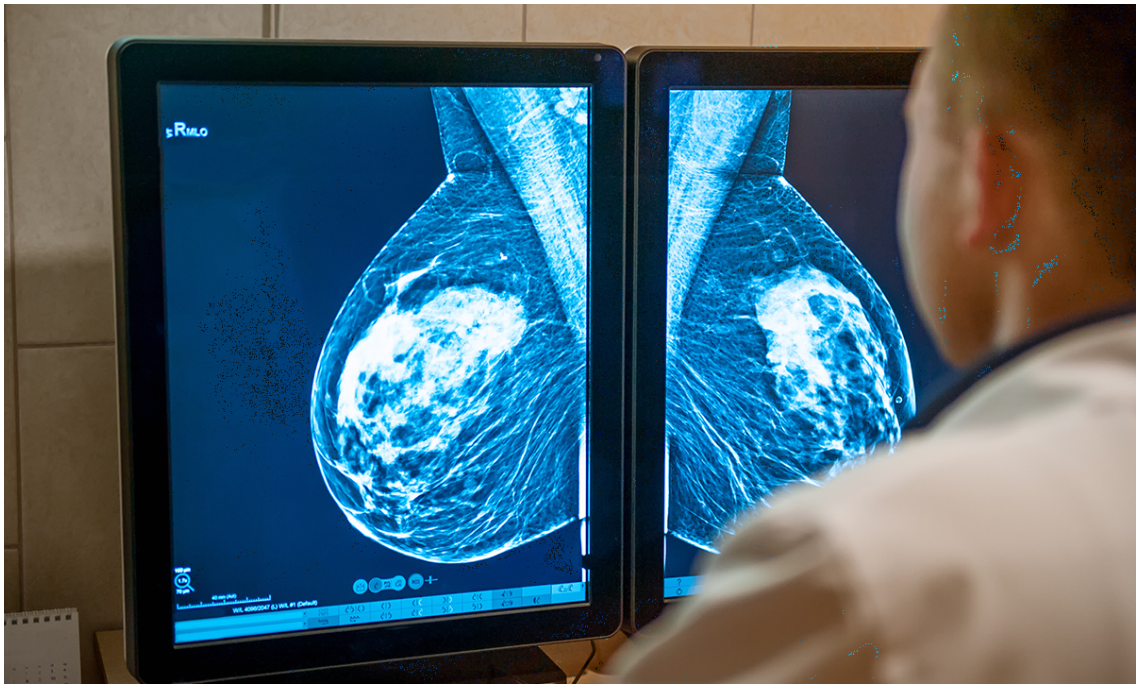
Risk Matters: Side Businesses

Many physicians are finding ways to earn income in addition to their regular employment. These “side businesses” typically utilize a physician’s specialized skills, knowledge, and licensure to perform. Not all of them increase a physician’s risk of malpractice - for example, teaching/lecturing, authoring/editing books and journals, and serving as an expert reviewer for claims and lawsuits carry little, if any, malpractice risk. However, many side businesses do have the potential to increase the risk of a malpractice claim.

An area of particular concern that can significantly increase the risk of malpractice is one that involves the supervision of others. Physicians who agree to serve as a Medical Director for an outside facility such as a prison, nursing home, or MedSpa are at a higher risk. Similarly, physicians who supervise or collaborate with Advanced Practice Practitioners who are not associated with their practice are at an increased risk of potential liability. In these supervisory situations, physicians are not only responsible for their own actions or inactions, but also for the care provided by those they supervise. Some of the legal theories advanced by plaintiff’s attorneys in malpractice claims against supervising physicians include vicarious liability, negligent supervision, negligent hiring, practicing/supervising outside the applicable standard of care, and failure to adhere to state required rules (such as an absence or deviation from written protocols).

A physician should thoroughly consider all risks before engaging in these types of side businesses. Our Claims Attorneys are available to help if you have any questions or concerns. You will also need to notify our Underwriting Department if you are engaging in a side business that potentially increases your liability risk or is outside the occupation or specialty you identified on your SVMIC application.

Clear Communication Is Critical



“Tell the audience what you’re going to say, say it; then tell them what you’ve said.” This quote is attributable to Dale Carnegie, but it is also something that was impressed upon me by a supervising attorney early in my legal career regarding how to write effective and persuasive legal briefs. I was reminded of this advice while reflecting on the following closed claim review involving a radiologist’s mammogram report.

On September 18, Ms. Tilley[1], a 57-year-old female, presented to a mobile mammogram bus for a routine mammogram. The mammogram was read and reported by Dr. Wall. Dr. Wall noted the following in the findings of the mammogram report: “Asymmetrical 3.2 cm density is seen in the right breast at 10:00 position posteriorly. Additional imaging needed.” The impression of the mammogram report, however, provided the following inconsistent statement: “NO EVIDENCE SEEN TO SUGGEST MALIGNANCY.” Subsequent to the impression, Dr. Wall’s report recommended a follow-up mammogram in one year. On September 20, a letter from the breast center, signed by Dr. Wall, was sent to Ms. Tilley informing her that there were no abnormalities seen on the mammogram. Additionally, Dr. Wall’s detailed mammogram report was sent to Ms. Tilley’s primary care provider.

On May 12, approximately eight months later, Ms. Tilley presented to her primary care provider with concerns of a self-detected mass in her right breast. The primary care

provider performed an examination and confirmed that Ms. Tilley would need a mammogram. The primary care provider also informed Ms. Tilley, for the first time, that the September 18 mammogram report indicated there was a mass seen in the right breast (the primary care provider admittedly failed to review the entire mammogram report when it was received eight months earlier). Unsurprisingly, Ms. Tilley was “shocked” and “floored” to learn that approximately eight months had elapsed without being informed of a mass in her right breast.

Ms. Tilley had another mammogram performed on May 18, which confirmed the right breast mass. Ms. Tilley was seen the same day for a biopsy, which confirmed grade 3 invasive ductal carcinoma. Ms. Tilley’s breast surgical oncologist presented Ms. Tilley with the options of segmentectomy versus mastectomy (single or bilateral depending on genetic testing). One month later, Ms. Tilley underwent a modified radical mastectomy of the right breast, with lymph node evaluation, and a prophylactic left mastectomy. The tumor measured 5.7 cm and was characterized as estrogen receptor positive, progesterone receptor negative, and HER2 negative. The tumor was graded at 3 of 3. Four out of nine evaluated lymph nodes, at the time of surgery, were positive for metastatic carcinoma with evidence of extranodal extension present. Ms. Tilley’s tumor had an anatomic stage of IIIA and a prognostic stage of IIIB. Ms. Tilley also received chemotherapy and radiation treatment.

Ms. Tilley filed suit alleging that Dr. Wall, the primary care provider, and the hospital (breast center) were negligent. SVMIC insured only Dr. Wall. The allegations against Dr. Wall included: (a) failing to properly read the September 18 mammogram; (b) failing to identify certain conditions visible on the September 18 mammogram; and (c) failing to properly report the conditions visible on the September 18 mammogram.

As the case proceeded, and although there was evidence of a “flaw” in the hospital’s software systems used to view mammograms and generate reports,[2] it was evident that there was no viable standard of care defense available to Dr. Wall. Despite Dr. Wall correctly identifying the mass in the findings and correctly recommending additional imaging in the findings, Dr. Wall “signed off” on a report where the impression communicated that the mammogram was normal. Also, despite Dr. Wall having expert support to show that the eight-month delay did not change the treatment that Ms. Tilley received or her long-term prognosis, Dr. Wall elected to pursue mediation. All Defendants participated in mediation where an agreement was reached with Ms. Tilley to settle the case.

As in universal precautions, when every needlestick is presumed infected, it may be prudent to assume that the Impression is the first section of the report to be read. If the Impression is incorrect, critical information may be lost or overlooked. That is the precise scenario that played out in this closed claim review – the ordering provider only read the impression and never learned, until the patient presented eight months later with a self-detected mass, that Dr. Wall had identified a mass on the September 18 mammogram and had recommended additional imaging. Thus, it is imperative that the impression accurately

communicate to the ordering provider the radiologist's meaning and interpretation of the findings. Ultimately, the impression may be the only chance for the radiologist to tell the ordering provider what was just conveyed in the findings in a way that provides the most direct and meaningful patient care.

The lessons to learn from this closed claim review do not only apply to radiologists. As John T. Ryman, JD stated in the September 2023 Sentinel newsletter, "communication, communication, communication" is often the most important thing in healthcare. Whether it's a radiology report, a letter to a patient, a consultation note, etc., the provider must always be cognizant of their intended audience and effectively communicate what needs to be said. Effective communication is essential to providing appropriate patient care.

[1] All names have been changed.

[2] The breast center required the radiologists to utilize two separate software systems to view mammograms and generate reports. For example, when reviewing a new mammogram, the radiologist had to first open the mammogram through one software system on one monitor, while opening the same mammogram in a separate software system on a second monitor to generate the mammogram report. As a result, the radiologist could inadvertently have one patient's mammogram pulled up on the first monitor while dictating the report for a different patient on the second monitor.
