The broad range of professional activities a doctor engages in each day makes it challenging to stick to a strict schedule of 15-minute appointments day after day. Fortunately, there is more than one way to schedule your workday. The trick is finding the method that meets both your needs and those of your patients.

**Chapter in Brief:**

▲ Practices can improve the efficiency and effectiveness of their office schedules by analyzing practice data to identify opportunities to optimize the physician’s time.

▲ A computerized appointment system can help a practice function at its full capacity without keeping patients waiting.

▲ A daily staff “huddle” can help smooth out bumps in the schedule. Make sure there’s a plan for what happens when the practice gets busier than expected.

▲ By reviewing practice financial statistics, it’s possible to set goals for increasing volume without compromising care.

If you like variety, you are in the right profession. Consider how many different things you think about and do that are directly related to patient care over the course of just one morning. You may gather information and make a diagnosis in exam room one, then shift quickly to room two, where you are faced with delivering difficult information and providing reassurance to a patient and her family. In room three you perform a simple procedure for a pediatric patient; then it’s on to room four to conduct an annual physical.
I have type 2 diabetes. This is... my 24/7 glucose control

Indications and usage
Levemir® is indicated for once-or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia.

Important safety information
Levemir® is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

Hypoglycemia is the most common adverse effect of all insulin therapies, including Levemir®. As with other insulins, the timing of hypoglycemic events may differ among various insulin preparations. Glucose monitoring is recommended for all patients with diabetes. Levemir® is not to be used in insulin infusion pumps. Any change of insulin dose should be made cautiously and only under medical supervision. Concomitant oral antidiabetic treatment may require adjustment.

Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. Levemir® should not be diluted or mixed with any other insulin preparations. Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia in patients being switched to Levemir® from other intermediate or long-acting insulin preparations. The dose of Levemir® may need to be adjusted in patients with renal or hepatic impairment.

Other adverse events commonly associated with insulin therapy may include injection site reactions (on average, 3% to 4% of patients in clinical trials) such as lipodystrophy, redness, pain, itching, hives, swelling, and inflammation.

Whether these observed differences represent true differences in the effects of Levemir®, NPH insulin, and insulin glargine is not known, since these trials were not blinded and the protocols (eg, diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences in weight has not been established.

For your patients with type 2 diabetes, start once-daily Levemir®
Levemir® helps patients with diabetes achieve their A1C goal.

- 24-hour action at a once-daily dose
- Provides consistent insulin absorption and action, day after day
- Less weight gain

To access complimentary e-learning programs, visit novomedlink.com/Levemir


Levemir®
insulin detemir (rDNA origin) injection

Please see brief summary of Prescribing Information on adjacent page.

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135155-R1
November 2008
Levemir®
insulin detemir (rDNA origin) injection
Rx ONLY
BRIEF SUMMARY. Please see package insert for prescribing information.

INDICATIONS AND USAGE
LEVEMIR is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long acting) insulin for the control of hyperglycemia.

CONTRAINDICATIONS
LEVEMIR is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

WARNINGS
Hypoglycemia is the most common adverse effect of insulin therapy, including LEVEMIR. As with all insulins, the timing of hypoglycemia may differ among various insulin formulations.

Glucose monitoring is recommended for all patients with diabetes.

LEVEMIR is not to be used in insulin infusion pumps.

Any change of insulin dose should be made cautiously and only under medical supervision. Changes in insulin strength, timing of dosing, manufacturer, type (e.g., regular, NPH, or insulin analogs), species (animal, human), or method of manufacture (rDNA versus animal-source insulin) may result in the need for a change in dosage. Concomitant oral antidiabetic treatment may need to be adjusted.

PRECAUTIONS

General
Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. The first symptoms of hyperglycemia usually occur gradually over a period of hours or days. They include nausea, vomiting, drowsiness, flushed dry skin, dry mouth, increased urination, thirst and loss of appetite as well as acetone breath. Untreated hyperglycemic events are potentially fatal.

LEVEMIR is not intended for intravenous or intramuscular administration. The prolonged duration of activity of insulin detemir is dependent on injection into subcutaneous tissue. Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia. Absorption after intramuscular administration is both faster and more extensive than absorption after subcutaneous administration.

LEVEMIR should not be diluted or mixed with any other insulin preparations (see PRECAUTIONS, Mixing of Insulins).

Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy.

Lipodystrophy and hypersensitivity are among potential clinical adverse effects associated with the use of all insulins.

As with all insulin preparations, the time course of LEVEMIR action may vary in different individuals or at different times in the same individual and is dependent on site of injection, blood supply, temperature, and physical activity.

Adjustment of dosage of any insulin may be necessary if patients change their physical activity or their usual meal plan.

Hypoglycemia
As with all insulin preparations, hypoglycemic reactions may be associated with the administration of LEVEMIR. Hypoglycemia is the most common adverse effect of insulin. Early warning symptoms of hypoglycemia may be different or less pronounced under certain conditions, such as long duration of diabetes, diabetic nerve disease, use of medications such as beta-blockers, or intensified diabetes control (see PRECAUTIONS, Drug Interactions).

Such situations may result in severe hypoglycemia (and, possibly, loss of consciousness) prior to patients’ awareness of hypoglycemia.

The time of occurrence of hypoglycemia depends on the action profile of the insulins used and may, therefore, change when the treatment regimen or timing of dosing is changed. In patients being switched from other intermediate or long-acting insulin preparations to once- or twice-daily LEVEMIR, dosages can be prescribed on a unit-to-unit basis; however, as with all insulin preparations, dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia.

Renal impairment
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with renal impairment.

Hepatic impairment
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with hepatic impairment.

Injection Site and Allergic Reactions
As with all insulin therapies, allergic reactions may occur at the injection site and delay insulin absorption. Other injection site reactions with insulin therapy may include redness, pain, itching, hives, swelling, and inflammation. Continuous rotation of the injection site within a given area may help to reduce or prevent these reactions. Reactions usually resolve in a few days to a few weeks. On rare occasions, injection site reactions may require discontinuation of LEVEMIR.

In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique.

Systemic allergy: Generalized allergy to insulin, which is less common but potentially more serious, may cause rash (including pruritus) over the whole body, shortness of breath, wheezing, reduction in blood pressure, rapid pulse, or sweating. Severe cases of generalized allergy, including anaphylactic reaction, may be life-threatening.

Intercurrent Conditions
Insulin requirements may be altered during intercurrent conditions such as illness, emotional disturbances, or other stresses.

Information for Patients
LEVEMIR must only be used if the solution appears clear and colorless with no visible particles. Patients should be informed about potential risks and advantages of LEVEMIR therapy, including the possible side effects. Patients should be offered continued education and advice on insulin therapies, injection technique, lifestyle management, regular glucose monitoring, periodic glycosylated hemoglobin testing, recognition and management of hypo- and hyperglycemia, adherence to meal planning, complications of insulin therapy, and timing of dosage, instruction for use of injection devices and proper storage of insulin. Patients should be informed that frequent, patient-performed blood glucose measurements are needed to achieve effective glycemic control to avoid both hyperglycemia and hypoglycemia. Patients must be instructed on handling of special situations such as intercurrent conditions (illness, stress, or emotional disturbances), an inadequate or skipped insulin dose, inadvertent administration of an increased insulin dose, inadequate food intake, or skipped meals. Refer patients to the LEVEMIR “Patient Information” circular for additional information.

As with all patients who have diabetes, the ability to concentrate and/or react may be impaired as a result of hypoglycemia or hyperglycemia.

Patients with diabetes should be advised to inform their health care professional if they are pregnant or are contemplating pregnancy (see PRECAUTIONS, Pregnancy).

Laboratory Tests
As with all insulin therapy, the therapeutic response to LEVEMIR should be monitored by periodic blood glucose tests. Periodic measurement of HbA1c is recommended for the monitoring of long-term glycemic control.

Drug Interactions
A number of substances affect glucose metabolism and may require insulin dose adjustment and particularly dose monitoring.

The following are examples of substances that may reduce
the blood-glucose-lowering effect of insulin: corticosteroids, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, albuterol, terbutaline), isoniazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogens, progestogens (e.g., in oral contraceptives).

The following are examples of substances that may increase the blood-glucose-lowering effect of insulin and susceptibility to hypoglycemia: oral antidiabetic drugs, ACE inhibitors, disopyramide, furoxan, fluoxetine, MAO inhibitors, propoxyphene, salicylates, somatostatin analog (e.g., octreotide), and sulfonamide antibiotics.

Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hypokalemia. In addition, under the influence of sympatholytic medicinal products such as beta-blockers, clonidine, guanethidine, and reserpine, the signs of hypoglycemia may be reduced or absent.

The results of in-vitro and in-vivo protein binding studies demonstrate that there is no clinically relevant interaction between insulin detemir and fatty acids or other protein bound drugs.

Mixing of insulins
If LEVEMIR is mixed with other insulin preparations, the profile of action of one or both individual components may change. Mixing LEVEMIR with insulin aspart, a rapid acting insulin analog, resulted in about 40% reduction in AUC insulin aspart compared to separate injections when the ratio of insulin aspart to LEVEMIR was less than 50%.

LEVEMIR should NOT be mixed or diluted with any other insulin preparations.

Carcinogenicity, Mutagenicity, Impairment of Fertility
Standard 2-year carcinogenicity studies in animals have not been performed. Insulin detemir tested negative for genotoxic potential in the in-vitro reverse mutation study in bacteria, human peripheral blood lymphocyte chromosome aberration test, and the in-vivo mouse micronucleus test.

Pregnancy: Teratogenic Effects: Pregnancy Category C
In a fertility and embryonic development study, insulin detemir was administered to female rats before mating, during mating, and throughout pregnancy at doses up to 300 nmol/kg/day (3 times the recommended human dose, based on plasma Area Under the Curve (AUC) ratio). Doses of 150 and 300 nmol/kg/day produced numbers of litters with visceral anomalies. Doses up to 900 nmol/kg/ day (approximately 135 times the recommended human dose based on AUC ratio) were given to rabbits during organogenesis. No drug-dose related increases in the incidence of fetuses with gal bladder abnormalities such as small, bilobed, bifurcated and missing gall bladders were observed at a dose of 900 nmol/kg/day. The rat and rabbit embryo/fetal development studies that included concurrent human insulin control groups indicated that insulin detemir and human insulin had similar effects regarding embryotoxicity and teratogenicity.

Nursing mothers
It is unknown whether LEVEMIR is excreted in significant amounts in human milk. For this reason, caution should be exercised when LEVEMIR is administered to a nursing mother. Patients with diabetes who are lactating may require adjustments in insulin dose, meal plan, or both.

Pediatric use
In a controlled clinical study, HbA1c concentrations and rates of hypoglycemia were similar among patients treated with LEVEMIR and patients treated with NPH human insulin.

Geriatric use
Of the total number of subjects in intermediate and long-term clinical studies of LEVEMIR, 85 (type 1 studies) and 363 (type 2 studies) were 65 years and older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. In elderly patients with diabetes, the initial dosing, dose increments, and maintenance dosage should be conservative to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly.

ADVERSE REACTIONS
Adverse events commonly associated with human insulin therapy include the following:

Body as Whole: allergic reactions (see PRECAUTIONS, Allergy).

Skin and Appendages: lipodystrophy, pruritus, rash.

Mild injection site reactions occurred more frequently with LEVEMIR than with NPH human insulin and usually resolved in a few days to a few weeks (see PRECAUTIONS, Allergy).

Other:

Hypoglycemia: (see WARNINGS and PRECAUTIONS).

In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, the incidence of severe hypoglycemia with LEVEMIR was comparable to the incidence with NPH, and, as expected, greater overall in patients with type 1 diabetes (Table 4).

Weight gain:
In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, LEVEMIR was associated with somewhat less weight gain than NPH (Table 4). Whether these observed differences represent true differences in the effects of LEVEMIR and NPH insulin is not known, since these trials were not blinded and the protocols (e.g., diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences has not been established.

Table 4: Safety Information on Clinical Trials

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Hypoglycemia (events/subject/month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td># of subjects</td>
</tr>
<tr>
<td>Type 1</td>
<td></td>
</tr>
<tr>
<td>Study A</td>
<td>LEVEMIR</td>
</tr>
<tr>
<td></td>
<td>NPH</td>
</tr>
<tr>
<td>Study C</td>
<td>LEVEMIR</td>
</tr>
<tr>
<td></td>
<td>NPH</td>
</tr>
<tr>
<td>Study D</td>
<td>LEVEMIR</td>
</tr>
<tr>
<td>Pediatric</td>
<td>NPH</td>
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<tr>
<td>Type 2</td>
<td></td>
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<tr>
<td>Study E</td>
<td>LEVEMIR</td>
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<td></td>
<td>NPH</td>
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<tr>
<td>Study F</td>
<td>LEVEMIR</td>
</tr>
<tr>
<td></td>
<td>NPH</td>
</tr>
</tbody>
</table>

* Major = requires assistance of another individual because of neurologic impairment.

** Minor = plasma glucose <56 mg/dl, subject able to deal with the episode him/herself.

OVERDOSE
Hypoglycemia may occur as a result of an excess of insulin relative to food intake, energy expenditure, or both. Mild episodes of hypoglycemia usually can be treated with oral glucose. Adjustments in drug dosage, meal patterns, or exercise may be needed. If severe, hypoglycemia with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid reoccurrence of hypoglycemia.

More detailed information is available on request.
Rx only
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Manufactured by Novo Nordisk A/S, 2880 Bagsvaerd, Denmark
www.novonordisk-us.com

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novonordisk®
Elizabeth Woodcock is a practice management expert, author, and speaker based in Atlanta, Ga. The author of Mastering Patient Flow: Using Lean Thinking to Improve Your Practice Operations (MGMA Press, 2007), Ms. Woodcock says that physicians should consider both their own work style and their patient population when deciding how to schedule. “Think of scheduling in a more strategic way to manage the most precious asset—your time,” she suggests. “The number-one goal is for the doctor to stay busy. There is no CPT code for the doctor’s waiting,” says Ms. Woodcock.

Helen Kollus, MD, is serious about scheduling strategically. One of three internists in a hospital-based multi-specialty group in Cleveland, Oh., Dr. Kollus feels fortunate that she was trained during residency to use a sophisticated electronic medical record system that she still uses in her practice today. She studies her appointment numbers and work flow regularly, then makes scheduling adjustments to maximize efficiency and best meet the needs of her patients. She has kept data for every year she’s been in practice, and she can use that information to plan her time accordingly. “I can look back month to month or at seasons. Is June different from December? Was two years ago the same as this year? Do I see more patients in the afternoons or mornings?” she says. “You have to have solid information to know how your schedule really works.”

Based on her most recent analysis, Dr. Kollus has started seeing patients earlier on Tuesdays, which have always been a busy day in her office. She has instructed her staff to add work-ins at 11 am and again at 1 pm, times when she found it was easier to squeeze in an extra patient without falling behind. “Strategic double-booking has helped me increase my productivity,” says Dr. Kollus. Another advantage of not seeing all of the work-ins at the end of the day is that she’s more likely to leave the office on time.

What Works for You?

If you have a reliable patient population and don’t suffer from an unusually high number of no-shows, a standard 10-, 15-, or 20-minute schedule (depending on your specialty) may work fine. If, however, you have a patient population that often misses
appointments or arrives late because of transportation, childcare, or other problems, Ms. Woodcock recommends a system of grouping appointments.

If you can comfortably see six patients each hour and experience a 10- to 25-percent no-show rate, she says, schedule eight for the hour instead. “Schedule four at the top of the hour, two more at 15 minutes after the hour, and two more at half past the hour,” recommends Ms. Woodcock. With this system you will always have patients to see, and it’s unlikely that any patient will have to wait beyond 45 minutes. At the top of each hour, if all goes as planned, start the process over with eight more scheduled patients.

Ms. Woodcock favors keeping appointment scheduling as simple as possible. “We get too focused on the micro level of scheduling,” she says. The objective is to get as many patients in as possible, without overwhelming the doctor or compromising quality of care. “I don’t believe you need more than two types of appointments—short and long,” says Ms. Woodcock. Forcing staff to gather a lot of information from patients in an effort to schedule perfectly is usually a waste of time, according to Ms. Woodcock.

Unless you are in a solo practice with one staff member at the front desk, a computerized appointment scheduling system offers many advantages. An electronic system is efficient, can be used by many people simultaneously, helps you gather data about your practice, and reduces your liability exposure. “Most
scheduling systems allow you to track cancellations, and from a risk management standpoint that’s a good thing to do,” says Ms. Woodcock. If you have a computerized billing system, an appointment-scheduler component is probably built in. “You’re not paying extra. If you have it, use it,” advises Ms. Woodcock.

But even the fanciest computer scheduling program and the most efficient front-office team can’t guarantee efficiency if you and your staff are not clear on what you want in terms of patient flow. Rhonda Holloway, the practice administrator at Dermatology and Skin Surgery in Shreveport, La., says clarity and communication are critical to this six-physician, 50-employee practice and the patients they serve. “We sit down with each doctor to determine exactly how many work-ins they can handle.

### Scheduling to Solve Common Problems

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
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</thead>
<tbody>
<tr>
<td>Patients who are frequently late</td>
<td>Grouped appointments, such as 4 at the start of the hour, 2 at quarter-past, and 2 at the end of the hour.</td>
</tr>
<tr>
<td>High “no-show” rate</td>
<td>Grouped appointments and/or strategic over-booking based on your average no-show rate.</td>
</tr>
<tr>
<td>Frequent emergencies that require leaving the office</td>
<td>Create a plan to call patients to reschedule on a moment’s notice. (This may require additional staffing.)</td>
</tr>
<tr>
<td>Running behind schedule</td>
<td>Have a backup plan, such as setting a policy to offer patients the option of seeing another doctor in the practice if they wait more than a certain amount of time.</td>
</tr>
<tr>
<td>Bottlenecks and/or doctors with downtime between patients</td>
<td>Implement the “staff huddle” each afternoon or morning to review the daily schedule and make adjustments as needed.</td>
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</tbody>
</table>
each day,” says Ms. Holloway. “We also ask more questions of people who say they need to come in right away. We keep a list: poison ivy, a rash that’s changed . . . those are urgent and need to be seen today or tomorrow. Other things we may put off for two days,” says Ms. Holloway.

The practice still accommodates as many work-ins as the dermatologists can reasonably handle, but taking a little more time to understand what the doctors want and which patients genuinely need to be seen “now” has helped smooth out their schedule. “Everyone has the most difficulty with work-ins. We want to make sure the schedule is full, and we expect no-shows,” says Ms. Holloway, “but if they all show up, it’s difficult. When you please one patient and make three others unhappy because they have to wait, that’s not good.”

Ms. Woodcock recommends that practices hold a “staff huddle” at the end of each day to troubleshoot and set the tone for an efficient day to follow. She uses the football analogy of a huddle to explain the concept: “The players have worked together for years, but they still huddle before every play,” says Ms. Woodcock. (“Don’t ever call it a meeting,” she cautions, “because no one will show up.”) The objective is simply to run through the schedule looking for problem spots or anything that will require extra attention. If a patient on the schedule was admitted to the hospital the evening before, open up that slot for someone else. If there is a patient booked for a 15-minute appointment, the doctor or medical assistant may note that she is coming in only for a quick recheck and her time slot could easily be double-booked. “Efficient physicians look at their schedule for the next day. It’s just part of their natural work process,” says Ms. Woodcock.

When You Fall Behind

A 2007 study of more than 5,000 patients conducted by the independent research group DrScore (www.drscore.com), revealed that the amount of time a patient spends with his or her doctor is more likely to impact his or her satisfaction level than the waiting time to see the doctor. The study found that patients are willing to wait longer without becoming dissatisfied if they feel that, once they are with the doctor, they are not rushed
through the appointment. However, as one might guess, a long wait time followed by a brief visit with the doctor results in reduced patient satisfaction. According to the study, five extra minutes with a patient can make a meaningful difference.

“The number-one thing for patients is that they are seeing a caring doctor. If you keep patients waiting a long time, they may feel that you don’t respect or care about them,” says Dr. Steven Feldman, DrScore.com founder, practicing dermatologist, and patient satisfaction expert. “Sometimes we do have to keep them waiting; but when we do, we need to make sure they understand why and, more important, not try to make up for lost time by rushing through their appointment. Patients need to feel that their health concerns are being heard and addressed when they meet with their doctors.”

Even physicians with fine-tuned appointment systems and those who are remarkably efficient will occasionally fall behind schedule. Life intervenes, emergencies arise, chaos happens—that’s just the way it is. With one simple act you can avoid putting the full burden on your staff to calm frustrated waiting patients. Pam Vaccaro, nationally recognized speaker and owner of Designs On Time in St. Louis, Mo., advises physicians who

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**Computerized Scheduling: Sources of Information**

If you’ve not yet tackled the task of computerizing your office and don’t know where to start, check out these resources:

- The American Academy of Family Physicians Center for Health Information Technology (www.centerforhit.org) enables members to walk through the steps to adopting an electronic health record system including preparation, selection, implementation, and maintenance.
- The American College of Physicians Website (www.acponline.org) offers plentiful information on electronic medical records as well as informatics and mobile computing.
- The Certification Commission for Healthcare Information Technology (www.cchit.org) is a nonprofit organization dedicated to accelerating and improving the process of adopting health information technology.
- Capterra (www.capterra.com) will help you research, compare, and contact vendors for the most popular medical office software systems.
fall behind schedule to step into the reception area and announce to waiting patients, “I’m running behind. I’m sorry. I’ll be with you just as soon as possible.” Patients will be impressed with your attentiveness and perhaps less likely to give up and leave without being seen.

In Ms. Holloway’s dermatology office, physicians make a concerted effort to stay on schedule; but even the best-laid plans sometimes go awry. “Every now and then it’s because a surgery takes longer than expected, but it’s usually due to work-ins,” says Ms. Holloway. “Most doctors try to be so accommodating that they don’t realize when they’ve fallen behind,” she says. The practice has one employee responsible for rooming patients for all of the doctors. This same individual oversees who is lagging behind. If a patient waits more than 45 minutes, the office policy is to check the patient’s record to see if he or she has previously seen another doctor in the office. If so, the patient is given the option to change doctors for that day’s visit or continue to wait. “Some people can’t wait. They have to get back to work. Some people don’t want to wait. Forty-five minutes is the magic number . . . usually by then the patient has complained to the front desk,” says Ms. Holloway.

Catherine Kimball, DO, of Waterville, Me., admits that she often runs behind schedule. “I frequently start an office visit with an apology,” she says, “but then I make an effort to be fully present.” Dr. Kimball says she tries never to look at the clock when she’s with a patient and attempts to deal with whatever the patient needs that day. “I almost never say no,” she says. Occasionally when a patient has a long list of issues, she will manage by first hearing everything, then focusing on the most critical points, telling the patient that another appointment will be necessary to address the remaining concerns. But usually she’s extremely flexible. “I know that life doesn’t follow a schedule,” says Dr. Kimball, “and patients might have an appointment for a small follow-up, and in the meantime something even bigger has happened.”

Sometimes spending more time with a patient actually saves time, says Dr. Kimball. “Even if I’m not worried, I’ll spend time to reassure a patient,” she says. A few extra minutes during the visit often prevents fielding countless phone calls from the
patient later on. Dr. Kimball says tending to patients’ needs as they occur helps the patient feel better sooner and takes some of the pressure off fielding additional questions by phone later. “It pays off by people feeling that they are taken care of, and it’s less demanding overall,” she says.

When you do fall behind schedule, make sure your front office staff are empowered to deal with the situation on their end. They can alert patients of the situation upon arrival; and, if needed, they can reschedule those on a tight schedule who can’t wait to be seen. This approach is respectful of patients and may lighten your load temporarily and enable you to catch up. Patients who opt to reschedule should be given the next available appointment that is convenient for them.

**Improving the Bottom Line**

Honing time management skills enables the physician to deliver quality care, to spend more time at home and less time at the office or hospital, and to work without continually feeling rushed. Another benefit of being time-efficient for most doctors is improving their financial bottom line.

Rob Scroggins, a consultant with Cincinnati-based Clayton L. Scroggins Associates, Inc., says that working in a few extra office visits each day can be highly profitable. “If a practice is running 60-percent overhead, typically half of that will be fixed and half will be variable,” says Mr. Scroggins. The amounts you pay for rent, utilities, payroll, benefits, equipment costs, and insurance premiums are the same whether you see 18 patients a day or 20. The revenue from two extra patients each day adds up quickly and reduces your overhead percentage.

Mr. Scroggins advises physicians to do the math to determine how adding two 15-minute appointments to the schedule each
day will impact the bottom line. “Determine a physician’s number of average annual encounters,” says Mr. Scoggins. Use only E&M codes for established patients, levels 2 through 5. Then divide that number into annual revenue per physician to determine the average revenue generated as a result of each patient encounter. If you have 5,000 office encounters per year and collect $450,000, that’s an average of $90 per encounter. Add two extra patients per day, four days a week, 48 weeks each year, and you gain $34,560 in additional revenue. That’s enough to purchase a new piece of revenue-generating equipment or give your staff a raise.

Rhonda Holloway concurs with Mr. Scroggins’s view that increasing volume increases profitability. “It definitely affects your bottom line,” she says. “But you have to have the staff to do it. You can’t just add patients and not have the staff for it.” An adequate front desk staff is as important as having enough medical assistants. “There is so much paperwork now,” says Ms. Holloway. A bottleneck at the front desk is likely to slow everyone down.