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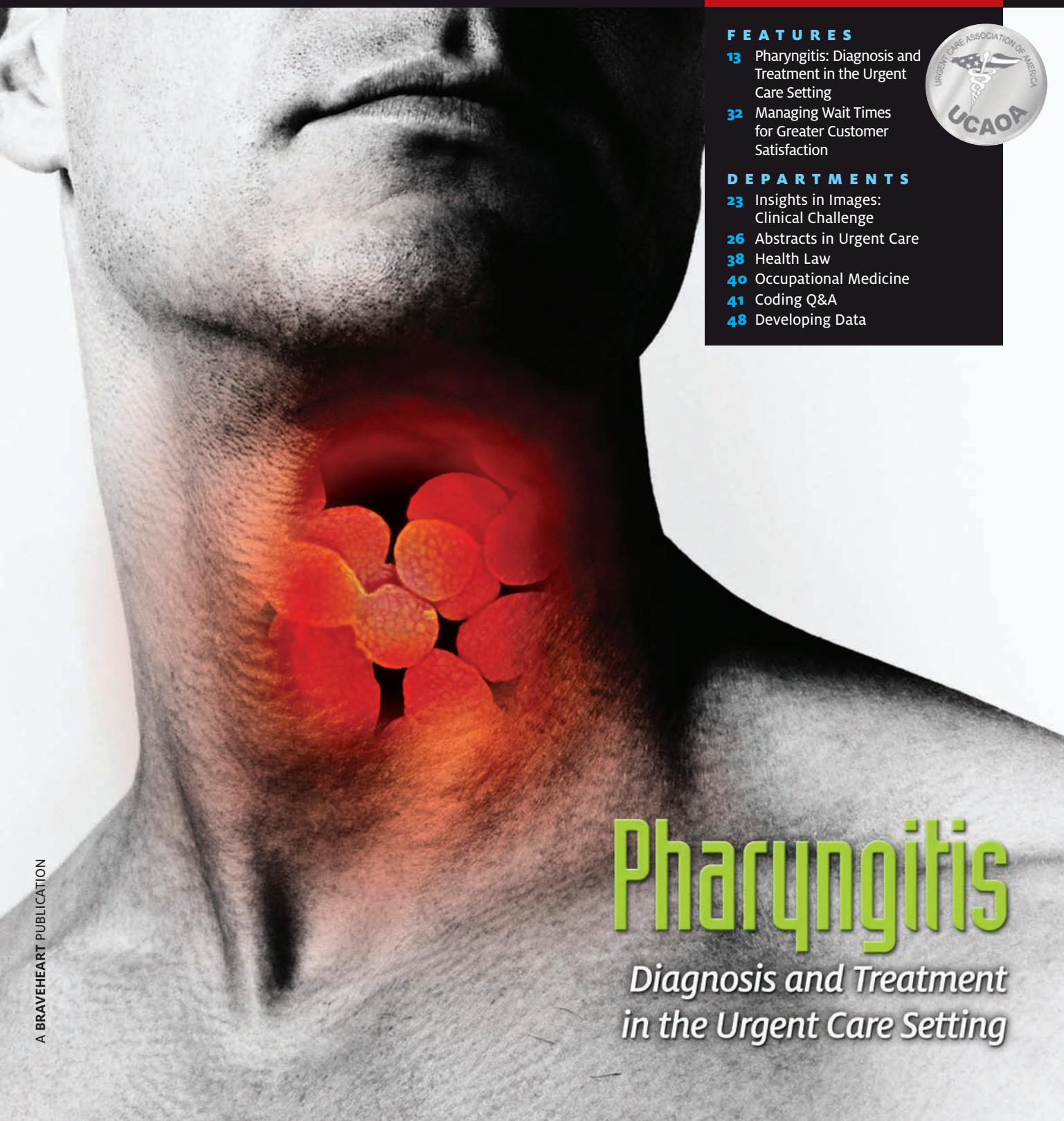

Pharyngitis

Diagnosis and Treatment in the Urgent Care Setting

A **BRAVEHEART** PUBLICATION

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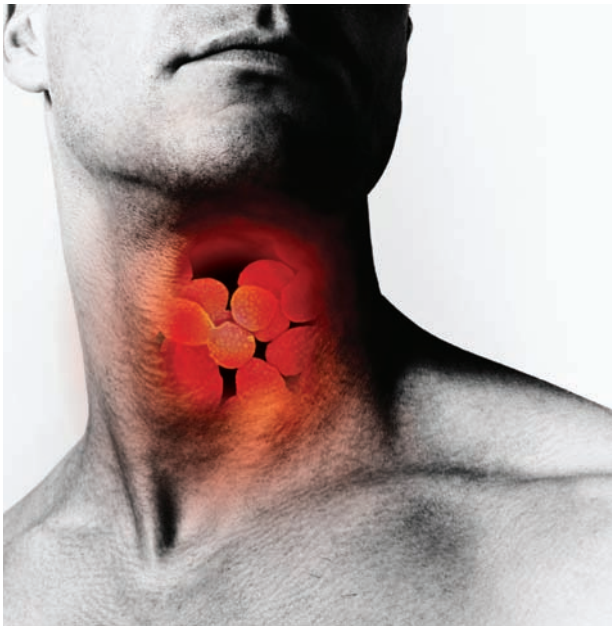


CLINICAL

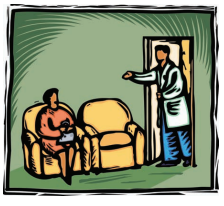
13 Pharyngitis: Diagnosis and Treatment in the Urgent Care Setting

"Sore throat" is a complaint heard commonly in urgent care. Adequate analgesia and judicious use of antibiotics can lead to high patient satisfaction without adding to the problem of resistance.

By William Gluckman, DO and Jessica Kay, PharmD

PRACTICE MANAGEMENT

32 Managing Wait Times for Greater Customer Satisfaction



Time spent in the waiting room may be inevitable for many patients, but it can also sour them on returning to your practice and lead to bad word-of-mouth. Efficient flow from sign-in to sign-out can make for a better experience for the patient, staff, and practitioner.

By Alan A. Ayers, MBA, MAcc

***In the next issue of* JUCM:** *Understanding classification, in addition to familiarity with treatment options, can enable the urgent care clinician to treat most patients presenting with epistaxis on site.*

JUCM CONTRIBUTORS

Chances are, you've either encountered a patient with the generic complaint of "sore throat" recently or will in the very near future. And within the scope of those encounters, you're bound to get involved in more than one discussion about antibiotics—often with a patient who insists he absolutely must leave your office with a prescription, whether your advanced education, years of experience, and clinical judgment agree or not.


Often, that prescription will be warranted; other times, not so much. And therein lays the problem, which is one of the subjects addressed in Pharyngitis: Diagnosis and Treatment in the Urgent Care Setting (page 13) by **William Gluckman, DO** and **Jessica Kay, PharmD**.

Dr. Gluckman has contributed to *JUCM* in the past, as co-author of an article on urinary tract infections (*JUCM*, October 2007) and on an ongoing basis as a member of our Editorial Board. He is associate medical director of emergency services and associate EMS medical director at St. Joseph's Regional Medical Center in Paterson NJ, assistant professor of surgery at New Jersey Medical School, and medical director of the New Jersey State Police Homeland Security Section's Urban Search and Rescue team. He is also a partner and medical director of Lifesaving Associates, LLC in Watchung, NJ, and a member of UCAOA.

Dr. Kay is currently the clinical pharmacist in the emergency department at St. Joseph's Regional Medical Center. She received her doctorate degree in pharmacy from St. John's University and completed her general residency at the Northport VAMC.

This issue also looks at another topic that may sometimes breed conflict between patient and provider or staff: time spent in the waiting room. True, it is an unavoidable fact that patients have to wait sometimes, but Managing Wait Times for Greater Customer Satisfaction (page 33) by Alan A. Ayers, MBA, MAcc analyzes ways to address the cause in order to minimize negative impact on the patient's visit and the practice in general.

Also in this issue:

Nahum Kovalski, BSc, MDCM reviews abstracts of new articles on vasopressin in cardiac arrest, the balance between playground safety and a child's need for physical activity, the use of absorbable sutures in pediatric patients, and other relevant topics in Abstracts in Urgent Care.

John Shufeldt, MD, JD, MBA, FACEP continues his summation of bankruptcy issues as they apply to an urgent care owner in Health Law.

Frank Leone, MBA, MPH looks at the fear factor in occupational health sales—and how to use a customer's concerns to your advantage in Occupational Medicine.

David Stern, MD, CPC addresses questions about applying discount fees; reimbursement related to change or removal of surgical dressing; and some of the intricacies of the S9088 code in Coding Q & A.

We'd like to hear from you, so if you have a thought about an article you read here—be it a challenge to one of our author's conclusions, a general reaction to how we're doing, or an idea for a future article, please send an e-mail to our editor-in-chief, **Lee A. Resnick, MD**, at *editor@jucm.com*.

In Memoriam

We're sorry to report that Allan F. Moore, MD passed away July 24, 2008 from injuries he suffered in a traffic accident 12 days earlier. His wife, Dr. Rebekah Gee, was injured in the crash.

Dr. Moore co-authored our June 2008 cover article, Diabetic Emergencies in the Urgent Care Setting. He was a fellow in endocrinology and an internist at Massachusetts General Hospital, as well as a researcher on the subject of diabetes complications and disease prevention at Mass General and the University of Pennsylvania School of Medicine.

Dr. Moore, who was 31-years-old, is survived by his wife, his brother, and his parents. ■

To Submit an Article to *JUCM*

JUCM, *The Journal of Urgent Care Medicine* encourages you to submit articles in support of our goal to provide practical, up-to-date clinical and practice management information to our readers—the nation's urgent care clinicians. Articles submitted for publication in ***JUCM*** should provide practical advice, dealing with clinical and practice management problems commonly encountered in day-to-day practice.

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to *editor@jucm.com*. The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

Before submitting, we recommend reading "Instructions for Authors," available at *www.jucm.com*.

Managing Wait Times for Greater Customer Satisfaction

Urgent message: Though patient waits are often unavoidable, understanding—and addressing—the causes can help mitigate negative impact on the patient and the practice.

Alan A. Ayers, MBA, MAcc

The term "urgent care" conveys *immediate* medical attention, so it's no surprise that the greatest determinant of customer satisfaction for an urgent care center is how quickly patients are treated and released. But how does a busy walk-in clinic—which must be prepared to handle any condition while staffing at levels to remain profitable—minimize the negative impact of long waits?

The answer is in identifying the causes of patient waits while working to improve the overall patient experience.

Patient Perceptions of Wait

Concentra Urgent Care recently studied patient attitudes toward wait times at its 324 medical centers in 40 states. The analysis included systems data of total visit times (arrival to departure), wait time from arrival to being seen by a provider, and customer satisfaction scores pertaining to wait. [Disclosure: The author is assistant vice president of product development at Concentra, based in Dallas.]

Although one would expect patient attitudes to be more negative the longer they've waited, the Concentra study revealed that patients have negative attitudes towards *any* wait—even self-reported wait times of 15 minutes or less were frequently rated "too long." In addition, the longer patients waited, the more likely they were to report a time longer than their actual wait.

Perceptions of wait are important because they influence patient attitudes toward every other element of the experience—including the quality of medical care delivered. The Concentra study demonstrated that the

longer a patient waits to see a provider, generally the less satisfied they are with the amount of time the provider spends with them.

Perhaps after an extended wait, patients feel a provider "owes" them more time.

Because some patient wait is unavoidable, a successful practice should understand what factors cause wait time to occur and then manage the patient experience to reduce the negative impact.

Determinants of Wait

Length of stay—also known as throughput or turnaround—refers to the time that passes between a patient's arrival and departure. Intervals spent waiting may be caused by processes including registration, triage, charting and billing; staffing levels, including the number of providers and technicians; the type, number, and acuity of visits; and the layout and capacity of the physical facility.

Knowing total throughput time is a starting place; process improvement involves understanding how patients move through an urgent care center, identifying the steps where waits occur, evaluating the reasons for each wait, eliminating non-value-added activities, and finally, becoming responsive to patient needs.

Identifying Areas for Improvement

The current process is defined using a flowchart that illustrates all the steps a patient passes through.

For example, a patient signs in at the front desk and completes a patient information form; the front desk verifies insurance, enters data into the billing system, and assembles a chart; a medical assistant calls the patient back to the clinical area, records symptoms and takes vitals; and so on.

Once the process is documented, it's possible to identify the steps where patient waits are occurring. **Table 1** provides a sample template that can be attached to the cover of each chart to track the patient's time at various steps. The sample period should be at least one week.

In addition to providing an in-depth understanding of the patient experience from arrival to departure, the flowcharting and time-tracking activity should reveal causes of delays, including task dependencies, duplication of effort, unnecessary steps, and bottlenecks.

Addressing the Causes of Wait Time

Value-added activities are process steps that are necessary to treat the patient and assure that the center gets paid—collecting demographic information, verifying insurance, collecting copays, taking vitals, conducting a history and physical, and documenting findings in a chart cannot be avoided. It is possible, however, to make these activities more efficient.

While process enhancements may improve the overall patient experience, only improvements that target the cause of wait time intervals will reduce length of stay.

For example, the first impulse of many urgent care operators is to tackle wait time by applying technology to highly visible

Table 1. Sample Time Tracking Template for Patient Flow

Activity	Start time	Finish time	Total time	Wait time
Patient signs in, provides ID and insurance card, and picks up registration paperwork for completion. Front desk verifies insurance eligibility, copay, and deductible.				
Front desk reviews paperwork, collects copay, and enters patient demographic data in billing system. Front desk assembles chart and passes to the medical assistant for triage.				
Medical assistant calls patient back to the clinical area, records patient's symptoms, takes vitals, and puts the patient in an exam room. Patient chart is placed in the provider's queue.				
Patient is evaluated and treated by the provider. Provider documents chart, marks billing and diagnosis codes on charge ticket, and writes prescriptions.				
Medical assistant provides scripts and discharge instructions to the patient. Patient is escorted to the discharge counter, chart is coded, charges are determined, and balance is collected.				

processes. Installing a self-registration kiosk may reduce the amount of time required for the front desk staff to register a patient, but if patients typically wait 30 minutes to be put in an exam room, reducing registration time from 10 minutes to five minutes may not necessarily reduce *total* wait times. Most likely, the provider isn't sitting in the back waiting for patients to be registered; rather, it's the patients who are waiting for their turn with the doctor.

The most significant bottleneck in urgent care tends to be the medical provider. Thus, activities that focus on improving the efficiency of the provider are likely to have the greatest impact on total wait times.

A time study of the provider's activities should reveal how the provider prioritizes and moves between patients and time spent on charting and documentation, as well as tasks that could be performed by ancillary staff. Although a growing center may not have the resources or infrastructure to add a second provider during busy times, it may be able to utilize a nurse or midlevel provider to better triage patients and manage workflow during busy periods.

When Wait Time is Inevitable

When wait time cannot be eliminated, the urgent care operator should focus on improving patient perceptions by making the wait as pleasant as possible. **Table 2** provides some practical suggestions.

Generally, the longest wait in an urgent care center occurs after completing registration and before being placed in an exam room. Some urgent care operators rightly seek to minimize this wait by rooming patients quickly, following the logic that patients in the waiting room are anxious to move to the back and that a crowded waiting room may turn off prospective patients walking in to the center.

However, compared with the isolation of an exam room, a comfortable and well-equipped waiting room is actually the best place for patients to wait. Instead of "disappearing into to the abyss," patients can gauge wait times by seeing other patients being called to the back and then leaving the center. Having patients assembled in the waiting room also allows the staff to better monitor and communicate wait times.

Patients in the waiting room are waiting for the

Table 2. Five Suggestions for Improving Patient Perceptions of Wait Time

1. Triage and "fast track" patients. Fast tracking means moving patients presenting for routine testing or low-acuity injuries or illness more quickly through the process. By triaging patients immediately after registration, the medical staff can determine the patient's priority for seeing the provider. Low-acuity cases or re-checks may be seen by a mid-level provider or given precedence over a procedure that may tie a physician up for 20 or 30 minutes. When fast tracking is integrated into the provider workflow, the result should be faster average turnaround times for all patients than "first come, first served."

2. Communicate wait times up front and provide frequent updates. Setting expectations for wait time at sign-in puts patients in control and allows them to evaluate their options, including returning at an off-peak time. If expected wait time changes at any time during the patient's wait (for either better or worse), promptly informing patients of the change can reduce their anxiety. Likewise, informing patients at regular intervals (every 15 to 20 minutes) of where they stand in line shows the staff cares about the patient and reduces the possibility the patient will walk out prior to treatment.

3. Let patients choose where to wait. If the wait time from sign-in to seeing a provider exceeds 45 minutes, offer to write down the patient's cell phone or pager number and call the patient within 15 minutes of when the provider will be available. Running errands, shopping, working or even sitting at home is often interpreted by patients as "zero wait time" since the time waiting is spent on the patient's own terms. This practice also reduces crowding in the waiting room.

4. Keep patients comfortable and engaged. Patient attitudes about wait times can be improved if the waiting room is a comfortable, engaging environment. A waiting room should have ample seating, a wide selection of magazines (timely and relevant to the patient base), large-screen television showing talk shows or other "light but entertaining" programming, activities for children such as coloring books or game consoles, refreshments such as water, coffee, or soda, and an easily accessible restroom.

5. Survey patients and act upon suggestions. The best way to understand how to improve the patient experience is to ask patients for advice. Consider implementing a short survey on the comfort of your waiting room, the selection of magazines available, or patient preferences for television channels. Patients not only appreciate being asked for their feedback, but there is no better view into the patient's mind than his or her own words. Such surveys should be administered frequently, whenever there is a question that can benefit from patient input.

next step in a process—to move to the clinical area for treatment. Thus, they are less likely to attribute the cause of their wait to the provider than to factors they can see, such as heavy volume or complicated cases.

By comparison, patients waiting in exam rooms are focused on the arrival of one person—the provider—who they hold responsible for their wait. In an isolated exam room, a patient cannot see other activities that may be the cause of his or her wait.

Regardless, there will still be some wait in the exam room. To reduce feelings of anxiety, many centers have added television with remote control, magazine racks, and windows with blinds that can be opened to the outside. For many visits—particularly involving children—it may also be appropriate to let a family member accompany the patient to the exam room if the patient so desires. The visitor will keep the patient company and when a spouse or parent hears a treatment plan, generally compliance (and thus, medical outcomes) is improved. An extra chair should be available in the exam room for visitors.

Understanding that a provider's capacity will determine initial wait time, some urgent care operators have found ways to shift inevitable waits outside of their centers.

For example, Internet pre-registration and call-ahead scheduling add patients to the workflow when they would normally sign-in. The front desk calls within 15 minutes of when the provider will be ready to see them. The wait time isn't eliminated, but patient perceptions of the wait significantly improve.

One patient who was summoned to the clinic two hours after registering online raved about a "five-minute wait" upon arrival. The actual two-hour, five-minute wait was perceived as minimal because the patient spent that time at home.

Avoid Setting False Expectations

Some urgent care centers advertise "visits in under an hour" or "see a doctor within 15 minutes." While such

promotions may draw attention to a start-up center that is building volume, they also set an expectation for turnaround that, if not met, will disappoint and dissatisfy patients.

Even if turnaround times are not advertised as a guarantee, their presence in an ad will be interpreted as a guarantee by consumers. It is advisable to avoid marketing specific turnaround times; instead, emphasize the core benefits of urgent care: extended hours, walk-in service, no appointments necessary, and faster turnaround than the emergency room.

If patients ask about wait times, be honest—even if it means some patients will balk. Telling a patient who calls ahead there is a "short wait" will lead to disappointment if that patient waits 60 minutes upon arrival. The better solution is to let the patient know if there is an extended wait, then provide options, including returning at an off-peak time or taking the patient's cell phone number and calling when the provider is ready to see them.

Conclusion

Although urgent care centers seek to provide immediate attention to all patients, there are times when it's necessary for patients to wait. Taking a process approach, an urgent care operator can identify the causes of patient wait and seek solutions to improve operational efficiency. When patient waits simply cannot be reduced, the urgent care operator should strive to make the wait as pleasant as possible in order to reduce negative perceptions that may carry over to other elements of the patient experience. ■