OCCUPATIONAL MEDICINE

Disciplined Time Management Drives Your 2011 Marketing Plan

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By the time you read this, your clinic should have a 2011 marketing plan firmly in place. Even if you do, that plan is only a piece of paper (and/or an electronic file) if—as is commonly the case—it is not executed in a resolute manner.

Here is what you need to do in order to ensure your plan becomes your practice:

1. Pepper your plan with date-specific action steps and remain committed to this schedule.
2. For every marketing tactic (e.g., a monthly tip email blast), create and calendar a series of mini-steps (e.g., create a six-month "tip inventory").
3. Spread out each mini-tactic over the entire year. Make a specific day (e.g., Monday) Marketing Tactic Day and be disciplined in *never* failing to execute that week's mini-tactic.
4. Set a date to develop your 2012 marketing plan (November 2011 will do), with a full array of mini-tasks. Learn from your 2011 experience and avoid waiting until January 2012 to initiate this process.

Discipline Continues on the Sales Side

Discipline on the "sales side" involves two significant issues: *time management* and *playing the numbers game*. Time management is the essence of effective sales. It's mathematical: carve out 20% more time for sales and your numbers go up by 20% or more.

Monitor your time allocation through the maintenance of *honest* weekly time sheets. Do not drift away from this commitment; keep your timesheets going through both good times and bad, look for shortfalls on your part—then minimize or eliminate those shortfalls.

1. Do what works, not just what you enjoy doing. Mustering the discipline to carve out 10 minutes a day for brief phone messages means you could literally leave 2,500 voicemail messages during 2011, assuming a 50-week work year. That tactic represents market penetration for 10 minutes a day.

   Making such calls is certainly not as "sexy" as a face-to-face meeting, but in the aggregate may be more fruitful when measured by the hour. Get a handle on what works.
2. Learn to say no. Many occupational health professionals report to professionals in another discipline (e.g., a clinician) who view the sales professional as a utility player that is perpetually available to address any miscellaneous ad hoc activities. Guard your precious time like a hawk.

The numbers game

The "numbers game" is where the rubber hits the road. Set quotas for key tasks that will help you complete the big picture, and commit to them. Small steps taken in a disciplined fashion every day or every week increase your exposure exponentially over the course of a year. Here are some examples:

1. **Introductory letters per week.** Keep your pipeline full. If you fall behind in the pipeline game, you will invariably spend unproductive time just trying to catch up.
2. **Sales-oriented phone calls.** This varies every day, but should be fairly consistent over the course of a week. In order to keep your appointment dance card full, you need to be disciplined in making your introductory calls. Many of your peers—and competitors—are not.
3. **Live sales calls.** You should be making three or four

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If the provider had taken the time to write, "I discussed the fact that he is at risk for a heart attack and that he needs to go immediately to the emergency department for further workup and monitoring. Understanding the risk of death or serious illness, the patient, who is competent and verbalizes understanding of the risks, refuses to go to the ED, etc."

This simple paragraph would take only a few minutes to hand write (or seconds to click if you have a macro in the electronic medical record) and would have saved the practice and provider from financial ruin.

6. **Order sets.** Not having protocols or standing orders for potentially high-risk conditions, in other words. The three previous Health Law columns published in *JUCM* discuss this in detail.

   Bottom line: Good providers and urgent care staff make simple mistakes when busy or stressed. The use of standing orders has been shown to prevent medical misadventures, ultimately lower the cost of healthcare, and make the practice more efficient.

7. **Poor hiring practices.** Hiring rude or inadequately trained staff members and providers is a guaranteed inciting event for medical malpractice. The jury is still out on whether or not you can teach people to be nice. My gut tells me that kindness and compassion are probably inherited traits, and that coaching people to be more kind is akin to trying to coach someone to change their sexual orientation, so unless you make the "right hire" don't count on being able to teach them the requisite skills.

   The take-home point is this: Providers or staff that don't know the center's policies, are rude to patients and other staff members, or are negativity mongers have no business working in healthcare. Not only will they predispose your clinic to malpractice suits, they will chase off good team members who don't want to work in such a toxic environment.

8. **Documentation.** Poor, illegible, or inadequate documentation is often the final nail in the coffin when trying to defend care which may border on the standard. Many times I have seen a case rest on documentation. Poor handwriting, scant documentation, and not documenting the pertinent negatives are ultimately what the case turns upon. Spend the money to purchase an EMR system which forces your providers to be thorough, complete, and legible with their documentation. If implemented properly, I guarantee the return on investment on the EMR purchase and adoption will be significant, lasting, and lifesaving.

"It is the provider, not the business, that is reported to the National Practitioner Data Bank, so the onus is on you."

9. **Callbacks.** Performing callbacks on all patients acts as an early warning detector to identify patients who have complaints about the service, are not getting better, or have not made their follow-up visits. Patients love callbacks. They interpret this simple phone call to mean that you actually do care about them. It is the ultimate win-win-win. The patients love them, they prevent unnecessary suits, and the staff receives positive affirmation from grateful patients.

Trying to defend the urgent care practice or act as the "expert" on these particular issues can prove to be somewhat challenging, inasmuch as in every instance the defendant-provider or owner had to come up with some reasonable answer as to why they did not have adequate controls in place to prevent the ultimate delta uniform (or, in the case of x-ray over-reads, the rational basis for why other films would be chosen over what was ultimately the culprit x-ray for radiology over-read).

I would venture to say, if an urgent care organization thoroughly addressed each and every one of these areas, the amount of malpractice in our industry would be negligible.

Frankly, as a provider, I would not work for an urgent care practice that did not have these areas adequately addressed, particularly since at the end of the day, no matter the reason, you will forever own and have to defend the resultant delta uniform on every new hire application, hospital or health plan credentialing form, and state licensure submission.

Remember, it is the provider, not the business, that is reported to the National Practitioner Data Bank, so the onus is on you to ensure that adequate safeguards are in place before you start working. It is simply not worth it in the long run to subject your professional career and the lives of your patients to lax business practices.

In aviation terms, malpractice reduction is all about preventing the *delta uniform* so that you don't go *tango uniform* (I'll let you figure that one out for yourself!). ■

CODING Q & A

Many payors may not reimburse for this code. Some payors may reimburse for this code, but only if the payor has the practice you envision enrolled as a true urgent care center.

It is important to note that your practice would not accept walk-in patients during all hours of operation. Thus, this practice does not meet the UCAOA criteria of a true urgent care center. ■

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ABSTRACTS IN URGENT CARE

Delaying Appendectomy May Not Be Harmful for Adults with Acute Appendicitis

Key point: Findings validate the practice of treating acute appendicitis urgently rather than emergently.

Citation: Ingraham AM, Cohen ME, Bilimoria KY, et al. Effect of delay to operation on outcomes in adults with acute appendicitis. *Arch Surg*. 2010;145(9):886-892.

The goal of the study was to determine the impact of delay from surgical admission for acute appendicitis to induction of anesthesia on outcomes after appendectomy in adults, using data from 32,782 patients submitted to the American College of Surgeons National Surgical Quality Improvement Program.

The principal exposure was time to operation, and primary study endpoints were 30-day overall morbidity and serious morbidity or mortality.

Appendectomy was performed within six hours of surgical admission in 24,647 patients (75.2%), from more than six through 12 hours in 4934 patients (15.1%), and more than 12 hours after surgical admission in 3,201 patients (9.8%).

Although there were statistically significant differences in operative duration (51, 50, and 55 minutes, respectively; p<.001), these were not clinically meaningful. Similarly, the difference in length of postoperative stay (2.2 days for the >12-hour group versus 1.8 days for the remaining groups; p<.001) was not clinically meaningful.

In regression models, duration from surgical admission to induction of anesthesia did not predict overall morbidity or serious morbidity or mortality. There were no significant differences in adjusted overall morbidity (5.5%, 5.4%, and 6.1%, respectively; p=.33) or serious morbidity or mortality (3%, 3.6%, and 3%, respectively; p=.17).

In an accompanying invited critique, it is noted that these findings validate the practice of treating acute appendicitis urgently rather than emergently. ■

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sales calls every day. Given five days per week (minus holidays) over a 50-week work year, that is *900* live sales calls a year. How can you fail?! Manage your face time well; cluster your travel, map out the routes to your destinations, and keep meetings brief and to the point.

4. **Emails.** Dedicate an hour at the end of your day (e.g., 4:00 to 5:00 p.m.) to sending an email to virtually everyone you dealt with that day (in order to review and document your interaction). Send confirmation emails concerning your next day's activities, as well.
5. **Clinic tours.** Carefully planned clinic tours for prime prospects should be an integral part of every program's marketing plans. Schedule at least *three* clinic tours each week. That's 150 tours every year, during which prospects can see firsthand what you've been talking to them about on the phone, via email, and in face-to-face meetings.

Discipline is not easy and is not much fun. I am convinced, however, that discipline is the lifeblood of success. If you really want big numbers in 2011, commit to being laser focused on what is best for your sales output each and every hour of each and every day. You may be surprised at how it all adds up. ■

A Disciplined Plan for 2011	
Daily	• Complete *10* telephonic sales calls (both introductory and follow-up). • Complete three or four "live" sales calls. • Carve out an email hour including reviews, reminders of the next day's meeting, email responses, and internal briefings. • Fine-tune your time management plan for the following day. • Document your day's activity on your weekly time sheet. • Leave *five* after-hours voicemail messages for clients and/or prospects.
Weekly	• Execute the marketing tactic listed for that week. • Review the previous week's timesheet; compare to year-to-date time allocation; adjust as necessary. • Send out at least *10* introductory letters. • Ensure that you complete at least *three* clinic tours.
Annually	• Develop the following year's marketing plan by November.