THE VALIDITY OF THE FIFTEEN-MINUTE OFFICE VISIT

By

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The Validity of the Fifteen-Minute Office Visit

Abstract
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Objective: To examine the adequacy of the time limit of the fifteen-minute office visit for a primary care provider who follows evidence based practice recommendations to properly assess, evaluate, and treat a complex patient. Methods: The databases of CINAHL, Medline, Economics, Business Source Complete, Business and Management practices, and AHRQ for the last ten years were reviewed including sources abroad. Results: Inadequate amounts of time to see patients seems to be a world wide phenomenon and a common complaint where patients were given office time based on diagnosis as opposed to acuity. Studies demonstrate that providers are failing to deliver all the care evidence based practice requires in the allotted 15 minutes, and that patient’s trust and satisfaction are also on the decline. Conclusions: The whole concept of how to determine how much time clinic patients need should be revisited. The focus for nurse practitioners is holistic, evidence based patient care with an emphasis on health promotion and prevention. Further research needs to be done to develop a care model where providers can effectively and cost efficiently provide holistic care to patients with complex problems and the providers need to include nurse practitioners and physician assistants in the research team. Developing an acuity-based model for outpatient settings, such as the one mandated in acute care facilities, could yield improved health care delivery for complex patients and decrease the burden on the health care system.
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The Validity of the Fifteen-Minute Office Visit

Problem Statement

The most common block of time for a standard family practice office visit is fifteen minutes. Most practitioners agree that it is an inadequate period of time to accomplish all the tasks required of a thorough practitioner who follows evidence-based practices recommendations. Ster, Svab and Kalan (2008) observed the trends of older patients with multiple morbidity issues have increased the workload of family practitioners with a shortening of consultation time and a decrease in patient satisfaction. They noted that longer consultations were linked to better care, the prescribing of fewer drugs, a higher identification of chronic diseases and psychosocial problems, and the promotion of healthier lifestyles.

Waters (2004) noted that in 1987 a 15-minute office visit for a well or sick child was for a few vaccines, some anticipatory guidance, and mostly acute or episodic care such as earache or sore throat. The practitioner performed brief history and examination, wrote a prescription for amoxicillin, and suggested follow up in two weeks. The same time frame that was adequate for that visit now must encompass chief complaints, health maintenance, growth and development with BMI calculations, anticipatory guidance, vision and hearing screening, injury prevention, violence prevention, abuse prevention, domestic violence screening, chronic disease management, lead screening, anemia screening, vaccine evaluation and update, numerous action plans for chronic conditions such as asthma, obesity, and attention deficit disorder, sex education, advice on car seats, booster seats, seat belts, air bags, bike and skateboard safety, limiting TV and computer time, cultural competence, prescriptions, not to mention the history
and physical, and labs. All of this must be documented, coded, and billed for accurate reimbursement. A 15-minute office visit is no longer adequate.

Wetterneck et al. (2002) noted that general internists' role of caring for patients with complex problems is associated with lower levels of satisfaction and recommended adjusting caseload for patient complexity, expanding time for office visits, and additional training in the care of patients with psychosocially complex problems to improve provider job satisfaction.

Scope and Significance

It would seem despite the frequent evidence-based recommendations for preventative health care that most practitioners are not managing to fulfill this mandate in the usual 15-minute visit. The Agency for Healthcare Research and Quality (AHRQ) (March 2005) found that adult vaccination rates are well below the national goals of 90 percent and that influenza and pneumonia continues to be the fifth leading cause of death among the elderly. The 27-month study showed missed opportunities to vaccinate against influenza at 38% of visits and at 47% of visits for pneumococcal disease. The missed opportunities for tetanus were 94%.

Bell & Kravitz (2008) noted that hypertensive patients were assessed on their medication adherence but counseling on hypertension and lifestyle was limited and that provider feedback on blood pressure was not provided in 36 of 61 visits despite the fact that hypertension afflicts one fourth of United States (US) adults and contributes significantly to heart disease, stroke, and kidney failure. Another study evaluating three studies done in 1995, 2000, and 2006 by Weyer, Bobiak, and Stange (2008) evaluated patients' rate of being up to date on preventative service delivery and found an increase of 29 percent to 33 percent to 38% in the time periods but a corresponding drop in patient satisfaction from 4.26% in 1995 to 3.93% in 2006. They attributed
a diminishment in the patient centered focus to an imbalance between the incentives of primary care to focus on the measurable goals of preventative service delivery over what is valued by the patients.

The socially disadvantaged and people with multiple morbidities who would benefit from longer visits do not receive the longer time as billing coding is based primarily on chart documentation rather than the needs of the patient. Longer visits are under coded and time for paper work, such as documentation for social services, follow up on abnormal tests, and out of visit medication management, is not reimbursed (Fiscella & Epstein, 2008). Moreover, health plans have increased cost shifting on to patients through higher co-payments and reduced coverage so a greater frequency of visits is also not feasible (Inglehart as cited by Fiscella & Epstein, 2008, p.1845).

There are also several studies indicating additional provider time beyond a fifteen-minute time frame is needed to adequately prescribe new medicines, perform the appropriate counseling, and to provide counseling and screening required by evidence based practices guidelines (Bell & Kravitz, 2008; Chen, Farwell & Jha; 2010, Tarn et al. 2008.). The effect on patient satisfaction is also noted by Lin et al (2010). Their review of several studies, along with their own study, indicated that longer ambulatory visits have been directly related to increased patient satisfaction.

The AHRQ (HS08841, 2001) reviewed two studies that seem to demonstrate with the push for primary care provider (PCP) to be more productive by seeing more patients per hour and keeping costs down, that patient trust in the their PCP's has been eroded. The studies reviewed by the AHRQ showed a decline in both access to care and the relationship quality between providers and patients, as measured by communication, interpersonal treatment,
provider’s knowledge of patients, and patient trust. The AHRQ drew the conclusion that though patients put a high priority to being given timely and convenient access to their providers’ s office, there was a higher priority given to what provider they saw and the quality of their connection to the provider.

The AHRQ also reported from the Medical Expenditure Panel Survey significant growth in visits for specific medical conditions between 1996 and 2006. The growth for high cholesterol visits were up 300 percent, kidney disease visits grew 112 percent, thyroid disease visits grew 96 percent, diabetes visits grew 96 percent, gall bladder, pancreatic and liver disease visits grew 94 percent, and upper gastrointestinal disorders visits such as acid reflux grew 76 percent so PCP providers are seeing a higher volume of sicker patients, but do not have more time to see them.

The purpose of this paper is to demonstrate the need to change the criteria used to determine how much time is needed for an office visit from being based on patient diagnosis to being based on patient acuity.

Review of Literature

The databases of CINAHL, Medline, Economics, Business Source Complete, Business and Management practices, and AHRQ for the last ten years were reviewed including sources abroad. Inadequate amounts of time to see patients seems to be a world wide phenomenon, as demonstrated by a classic study from Slovenia (Ster, Svab, & Kalan (2008)), as well as numerous studies from the United States (US), Europe, and Canada (Konrad et al., 2010). Numerous studies were found focusing on the paucity of time for a complete and comprehensive visit that is fully reimbursed and encompasses all the necessary evidence based recommendations in the literature (Chen, Farwell & Jha, 2010, Tarn et al. 2008. Bell & Kravitz, 2008). Most
studies mainly dealt with physicians, and not nurse practitioners (NP) or physician’s assistants (PA). Many of the articles dealt with how to manage adequate patient care in this time frame as if it were a disease to be cured. The solutions for this disease of time management mostly dealt with other people assuming some of the assessment and care of the patient, and improving efficiency through teamwork and coordination of care (AHRQ, 2010; Fiscella & Epstein 2008).

The business, health technology, and economic literature mainly dealt with how offices could streamline their practices to be more efficient and use telehealth systems and electronic medical records to help bridge some of the gaps not covered in a standard 15-minute office visit. They also dealt with the impact of decreased reimbursement for counseling; out of visit documentation, billing and follow-up. There was also a mention of the impact of minute clinics such as those offered by drugstores and large chains such as Wal-Mart and their impact on primary care by offering generic but quick and cost effective care (AHRQ, 2007, 2010).

The search conducted did not discover where the 15-minute time frame for the office visit originated, and why this is considered the “normal” time frame for an office visit. There are numerous methods detailed to help with a time shortage including how to deal with difficult or complex patients through improved communication, team work or an increase in integrated medical groups (AHRQ, 2010; Rodriguez, Glahn, Rogers, & Safran, 2009), alternative payment methods such as fee for service, and a patient centered medical home approach (Fiscella & Epstein, 2008).

There were also suggestions of shorter office visits and more complex patients contributing to both a decrease in patient satisfaction and to provider burnout (An et al., 2009). One study (Meddings & McMahon, 2008) recommended scoring health care quality based on individualized patient risk reduction rather than one size fits all treatment goals using calculated
risk assessments when possible. The study also advised refocusing pay for performance on quality improvement through risk reduction so patients with complex health care needs do not become financial liabilities to providers (Meddings & McMahon, 2008).

The National Committee for Quality Assurance (NCQA) has proposed a new payment model to help insurers and employers identify top physicians and pay them for their increased quality of healthcare. The new model calls for physicians to be reimbursed for spending longer times with patients during office visits, for helping patients to manage chronic disease, and for telephone and e-mail consults during non office hours (NCQA, 2007). Unfortunately the plan specifies physicians and does not seem to include nurse practitioners or other primary care providers.

Implications for Nursing Practice

The focus for nurse practitioners is holistic, evidence based patient care with an emphasis on health promotion and prevention. It is difficult to find any specific published literature dealing with how nurse practitioners manage the time of office visits in family practice, perhaps because there is such a wide variance in the role of nurse practitioners throughout the country. Numerous articles seemed to focus on how the work of nurse practitioners affected the workload of family physicians and how the patient care by physician assistants and nurse practitioners varied from that provided by physicians. The 2006 Nurse Practitioner Salary and Practice survey showed nurse practitioners are often salaried and not given any bonuses or pay incentives for seeing more patients. This seems to lead to nurse practitioners seeing more complex and demanding patients with longer times slotted for visits than physicians who receive higher salaries plus bonuses for seeing more patients (Newland, 2006; NCQA, 2007).
Nurse practitioners need to provide patient care based on the needs of the patient as opposed to an arbitrary amount of time allocated for a particular diagnoses. In order for this to be effective, a model similar to the one proposed by Meddings and McMahon (2008) is needed. Risk assessments for patients are calculated specifically for each patient and take into consideration factors such as socioeconomic status, co morbidities, resources available to the patient, and the success or failure of previous care and treatment plans. A model needs to be developed that allows for the care of the more complex patient, otherwise these patients will continue to receive sub optimal or no care, as providers will not be able to spend the necessary time to treat them without incurring significant financial liability. The office visit time would then be calculated on the acuity of the patient, rather than his or her diagnosis. In this way, an older diabetic with hypertension on Medicaid with an A1C of 10 would get more time in a visit than a younger diabetic with good health and an A1C of six.

Further Research

More research needs to be done specifically on how providers can effectively provide care to patients with complex problems and the providers need to include nurse practitioners and physician assistants. Developing an acuity based model for patient visits and testing it in a wide variety of outpatient settings could yield much needed data on how to improve health care delivery to complex patients to stop them becoming a burden on the health care system.

Such an acuity model would also give providers more time to develop a holistic comprehensive plan of care, which should improve patient satisfaction and health care outcomes. It would be interesting to see also how it would affect the workload and job satisfaction of
primary care providers if they were compensated for the actual care they provide, as opposed to only a portion of it.

Conclusions

The arbitrary setting of a time limit on patient care would seem to defy the concept of patient centered care. How can anyone determine what the needs of a patient are before the patient has been assessed. Given the high co-pays and time constraints most patients suffer, it does not seem fair to ask patients to schedule another visit when 15 minutes seems to be inadequate. Also studies show providers are failing to deliver all the care evidence based practice requires in the allotted 15 minutes, and that patient’s trust and satisfaction are also on the decline.

The whole concept of how to determine how much time a patient needs should be revisited. A significant amount of provider time and attention is spent in non patient care duties such as documentation, phone calls, emails and faxes to and from other providers, lab and test follow-ups, and coding. The 15 minute office visit can generate two hours of follow up work that is unseen and often not reimbursed but eats away at the productivity of the provider, allowing him or her even less time to see patients. An acuity-based model has been mandated in acute care facilities for years. Now is the time for providers to demand that it should be developed in outpatient settings as well.
References


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