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Online Consultation Is Growing Slowly

Consumers are slow to try online clinical consultations, according to a research report. Only 3% of adult Internet users participated in online clinical consultations with their doctors last year, even though 65% of the consumers who responded to a questionnaire in 2002 said they would welcome such a service, says Jupiter Media, a researcher in Darien, Conn. The growth of online consultations is likely to continue to be slow over the next two to three years, in part because 92% of consumers, in responding to a Jupiter survey earlier this year, said they were unwilling to pay more than \$10 for such a service.

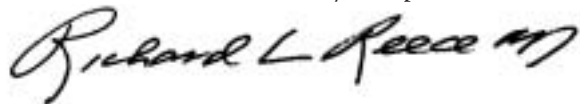
Maybe so, but some physicians are reporting anecdotally that patients who have had a preexisting relationship with them are generally willing to pay \$20 to \$25 by credit card for nonemergency advice. These patients prefer an online consultation to driving to the doctor's office, waiting to see the doctor, and having to make a copayment of \$10 or more.

Ed Fotsch, MD, CEO of Medem Inc., has developed free physician Web sites and an online consultation tool. Medem recommends that physicians conduct online consultations only with their existing patients, that they obtain an informed consent form from these patients, and that the consultations be for only nonemergency follow-up care. Medem also says fees must be clearly posted, e-mail communication must be secure, and the online consultations must be made a part of the medical record.

Medem has more than 100,000 physicians using its Web sites, and more than 10,000 doctors are doing online consultations with their patients, says Fotsch. For patients, there are several advantages to online consultations. The consultations save patients time and money, allow for frequent and complete communication and prompt replies to their questions, prevent unnecessary office visits, and improve care by making it easy for them to get reference sources and educational materials. For physicians, such consultations increase practice revenue (often by \$10,000 or so annually), decrease medical liability risk, and eliminate unnecessary office visits.

Although the Medem approach calls for payment outside of health plans, some plans are offering payment for online consultations. Beginning in August, for example, Blue Cross & Blue Shield of Massachusetts started paying primary care physicians at Beth Israel Deaconess Medical Center, Caritas Christi Health Care, and Baystate Health System \$19 for online consultations and patients will pay \$5 per consultation. Meanwhile, health plans in other parts of the country are conducting studies on the feasibility of paying for online consultations.

Online consultation is an idea whose time has come. Physicians need to get the word out to their patients that this type of physician-patient communication can save both time and money, two precious commodities in health care.



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Practice Enhances Health Plan Relationships Through Use of EMR

Many cardiologists are reluctant to adopt an electronic medical record system, citing high costs, the initial reduction in practice productivity as physicians and staff members learn the system, and the desire to wait for additional advances in technology. But one large cardiology practice reports that its adoption of an EMR system has enhanced efficiency, reduced costs, and improved relationships with payers. Furthermore, the practice saw a return on its investment within two years.

Associated Cardiovascular Consultants adopted its EMR system in 2000, six years after the practice was formed through the merger of three cardiology practices. ACC is a 31-physician practice with six locations in Southern New Jersey, and is affiliated with Virtua Health, a four-hospital health system headquartered in Marlton, N.J.

"After working together for a few years, the cardiologists realized that an EMR system could help them eliminate some of the inefficiencies and inconveniences that had arisen as a result of the merger," notes John Morris, CMPE, executive director of the practice.

Improved Access

The physicians outlined five main reasons for pursuing an EMR. First, they wanted easy access to patient records.

"The physicians found that they were often seeing a patient in one office while the patient's records were in another office," Morris says. "Now, they can view patient records from any computer that has Internet access."

"Once the groups merged, our biggest problem was getting records from one office to another," says John Saia, MD, a cardiologist and chairman of the medical records committee. "The logistics of manipulating paper charts in a practice with six offices were unbelievably difficult. Record accessibility is crucial to practice efficiency."

Such accessibility also facilitates high-quality care, says Saia, offering an example. "While I was on call one Sunday night, a patient of ours was in Florida and went to the emergency room with severe myocardial infarction," he explains. "I received a call at home from the emergency room staff. Within five minutes, I was able to access this patient's chart, including the history, medication list, and other relevant information, and fax it to the hospital in Florida. The value of that kind of information accessibility cannot be overstated when it comes to quality of care."

Second, the cardiologists wanted to improve the accuracy of coding and documentation. "Before we had the EMR system, I jotted notes on the patient chart during the visit and dictated a chart note later," Saia says.

"Because of the delay, it was hard to capture 100% of what happened during that visit. And we couldn't bill for the visit properly if the documentation wasn't complete."

"Most physicians will code defensively if they do not feel confident in their documentation," says Morris. "Such undercoding can result in a significant loss of revenue. But at the same time, inadvertent overcoding can have serious consequences in a Medicare audit. Templates developed by the practice remind physicians to include documentation components needed to support the assignment of a given code, ensuring their coding accuracy and facilitating coding compliance audits."

Third, because each of the three original practices had a different format for patient chart notes, the physicians had difficulty reading each other's notes, explains Morris. "We knew that an EMR system would allow us to have a standardized note format," he adds.

Cutting Costs

Fourth, the physicians wanted to reduce transcription costs, which had reached \$250,000 a year. "Using the EMR, physicians now can select from a list of sentences and phrases to create a note in the system," Morris explains. Transcription costs have fallen to about \$70,000 a year; some transcription is still required for notes physi-

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"The logistics of manipulating paper charts in a practice with six offices were unbelievably difficult. Record accessibility is crucial to practice efficiency."

—John Saia, MD, Associated Cardiovascular Consultants

(Continued from page 3)

cians may dictate about unusual cases.

Finally, the physicians had begun a research program and wanted to be able to quickly identify patients who would be good candidates for research studies. “The EMR system allows us to prescreen patients relatively quickly to determine who might be eligible for participation,” Morris says. “Identifying potential study participants would be much more difficult and time-consuming if we had to review paper charts.”

While a number of systems had components that would have met the practice’s needs, the practice chose to purchase an EMR system from Amicore Inc. (in Andover, Mass.), which had a proven track record and offered excellent customer service, two features Morris counsels cardiologists to consider when seeking a vendor. “When we started our search for an EMR system, there were several companies that offered the same standard features, but all of them had been in business for less than three years,” Morris points out. “We were concerned about purchasing a system from a company that might not be around over the short- to medium- term.”

Implementation Steps

Physician support for and acclimation to the EMR system are important factors in implementing it. “Our system required an investment of \$800,000, so we had to get buy-in from all the physicians to make the purchase,” Morris says. After that, the speed at which they became acclimated to the EMR system varied widely. “Some cardiologists embrace an EMR system quickly, while others incorporate it into their practices more begrudgingly. It probably takes

a year or two before all the physicians in a large practice are thoroughly comfortable using a new system.”

Still, Morris notes that learning how to use the software was simple for both staff and cardiologists. “The EMR includes scheduling software and an internal messaging component, which the staff learned to use in about two days,” he says. “The physicians also picked up the concept of how to use the EMR very easily.”

The cardiologists’ biggest complaint was that using the software initially required more time than it takes to simply dictate a note. “The first time a patient was treated after EMR installation, the physicians had to enter all the diagnoses, the medications list, and the problems list,” Morris explains. “Naturally, that took longer than creating a paper note because the other information would already be in the chart. But when the patient came for a second visit, since all the information was already in the system, the physicians were much more positive about it.”

Practices adopting an EMR system may want their staff to enter patient background data before the patient arrives at the office, rather than having clinicians enter information during a patient visit, Morris suggests. “If I had to do this again, I would hire technicians or pay our nurses overtime to come in early and enter into the computer the diagnosis codes, medication lists, and past problems for that day’s patients so that the patient records would be ready for the visit,” he offers. “One of our offices paid a nurse to do just that, and the cardiologists there reported a much more positive early experience than did the physicians in the other offices.”

Replicating Patterns

Cardiologists should also look for an EMR system that will enable them to replicate their current practice patterns as closely as possible. “Before we adopted our EMR system, our cardiologists would see a patient in the examining room and then walk back to their offices to dictate their notes,” Morris observes. “We tried to mimic that pattern with the EMR: The physicians would take their jotted notes back to their offices and enter the information into the EMR, using their desktop computers.”

Within the last year, the practice purchased tablet PCs for each cardiologist. “The tablet PCs now have much bigger screens than they did originally, making them much more user-friendly,” Morris says. “The cardiologists take them into the exam rooms and enter the note right there, using a stylus to tap on templates that appear on the tablet. They can look up other information or patient records during the visit, and they can even show the patient the screen if necessary.”

The physicians hold the tablet PC on their lap just as they would hold a paper folder, explains Morris. “With tablet PCs, our cardiologists find that the analogy to the paper chart is truer today than ever before,” he adds. Still, physicians note that some patients may view the tablet as an intrusion. “Physicians using this kind of system at the point of care need to ensure that the patient feels that he or she is still the center of their attention,” counsels Saia. “I try to make my patients feel that the tablet PC is simply another tool, like the stethoscope, that I use to optimize care.”

Now that tablet PCs are used in

“It probably takes a year or two before all physicians in a large practice are thoroughly comfortable using a new system.”

—John Morris, CMPE, Associated Cardiovascular Consultants

the examination rooms, patients are aware that the practice uses an EMR system. According to Morris, patients who comment on the system approve. "Patients have remarked that our practice is really progressive," he says. In addition, they may perceive that the EMR represents an enhancement to patient safety. "When cardiologists write prescriptions using the EMR, the system flags potential contraindications and drug interactions. Furthermore, the prescriptions are printed, rather than handwritten, and the system allows us to print a sheet for patients listing all their medications and instructions for use. Our patients really love that feature."

What's more, the EMR system allows physicians to complete some of their daily work at their own convenience. "High-speed Internet access is available in most areas of the country," Morris says. "Many of our physicians leave the office at 6 pm, spend time with their families, and then log on to the system in the evenings to go through phone messages, all of which are entered into the system by the receptionists, and commit notes to the patient charts. In 45 uninterrupted minutes, they say they can accomplish the equivalent of three hours' work. In this way, the EMR has improved our cardiologists' quality of life."

Insurer Relationships

Most physicians and practice administrators expect an EMR system to reduce practice costs, but the cardiologists at Associated Cardiovascular Consultants expect their system to help them generate revenue as well. "Insurers are beginning to pay providers based on the quality of care they provide," Morris notes. "How

can a medical group prove its quality? One way is to compare actual physician practices with guideline compliance, which is easily done with an EMR."

The practice's cardiologists recently completed contract negotiations with three large insurers in which they encouraged the insurers to build into the contracts quality indicators that can be used to measure provider performance. "For example, myocardial infarction patients should be taking aspirin and beta blockers unless there is a contraindication," Morris explains. "Our contracts stipulate that the physicians will receive a higher reimbursement for each code billed if greater than a certain percentage of appropriate patients receive this treatment. It would be very, very difficult to pull these kinds of data from paper charts."

Furthermore, the group is among the first to be accepted into the National Committee on Quality Assurance's Heart/Stroke Recognition Program. As part of this program, physicians certified as high-quality providers are featured in referral directories, referred by NCQA to callers, and paid annual bonuses by large employers participating in the program each time an employee is treated. To qualify, Morris had to submit 25 charts for each physician to demonstrate that myocardial infarction patients met the following program criteria: blood pressure level below 140/90 mm Hg; cholesterol screening and control (LDL below 100 mg/dL); use of aspirin or another antithrombotic; and smoking cessation advice or treatment. "It took me only about four hours to gather this information for each doctor using the EMR," Morris says. "I cannot imagine how long it would have taken if

we still had paper charts."

The EMR system also has strengthened the group's position with at least one other payer. "During a semi-annual review of the practice by a large insurer, the insurer's representatives told us their data indicated that we could do a much better job of prescribing beta blockers and aspirin for our myocardial infarction patients," says Morris. "Their data indicated that we were about 70% compliant. When I asked how many of our charts they had sampled to get this statistic, they answered 59. I offered to use the EMR to run an analysis of 3,000 patients. That analysis indicated that we were 94% compliant."

Furthermore, the analysis showed that other patients—for example, those at risk of gastrointestinal bleeding—were not candidates for that therapy. "From the insurance company's perspective, those were patients who had had an MI but were not on aspirin; our analysis demonstrated that these patients were not on aspirin because there was a contraindication," Morris explains.

"This information changed the whole tenor of the conversation," Morris continues. "Now, the insurer's representatives want to look at our data rather than provide their own, and they want our physicians to be on some of their advisory boards. Our ability to provide data through the EMR improved the relationship. We gained their respect by providing accurate data demonstrating our ability to provide thorough preventive medicine. This story truly represents the value of the EMR."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

"Now the insurer's representatives want to look at our data rather than provide their own," Morris says.

Plan Seeks Help From Physicians in Its Predictive Modeling Efforts

Predictive modeling is the new buzzword in health care. A tool adopted earlier by other industries, predictive modeling is just now coming to health plans that are learning how to use it for improving care and cutting costs. But many in health care who are adopting this tool are finding that it is not simply a matter of dumping data into a software program which spews out results that quickly lead to better outcomes and lower costs. In fact, some who have implemented predictive modeling, while enthused about its potential, are still learning about the best way to make it work.

Dennis Angellis, MD, is among those who is both encouraged and challenged by the potential benefits of predictive modeling (PM). The tool was implemented in April 2003 at Presbyterian Health Plan in Albuquerque, N.M., where Angellis is chief medical officer and vice president of medical affairs. PHP, which is part of the Presbyterian Healthcare Services integrated delivery system, is a 300,000-member, provider-owned health plan that offers four products: commercial (100,000 members), administrative services only (ASO) (50,000 members), Medicare (15,000 members), and Medicaid (135,000 members).

Risk Stratification

PHP's goal in implementing predictive modeling is to identify potential high-risk members and to intervene

before their health status deteriorates. But one problem with the strategy, Angellis has discovered, is finding a way of contacting the targeted hard-to-reach members so that these interventions can occur. One option PHP is considering to address this problem involves physicians.

Angellis spoke about PHP's experiences with predictive modeling at the 16th annual National Managed Health Care Congress held in May in Washington D.C. In a session entitled "Predictive Modeling: Lessons Learned for Successful Implementation," Angellis discussed PHP's experience with implementing predictive modeling, including the difficulties encountered and the challenges ahead.

Learning to Use PM

As it is with almost any tool, you have to know how to use it well to derive benefits from it, Angellis noted in his opening remarks. Predictive modeling, he said, is that kind of tool. Among the most important lessons PHP has learned in adopting predictive modeling is that having an effective implementation strategy is crucial.

Part of that implementation strategy involves choosing the appropriate predictive modeling software, Angellis said. PHP chose impactPro to meet its needs, but Angellis noted that all health plans have different needs and different patient populations and those factors should be

considered when selecting the PM software.

In addition to meeting its software needs, PHP's implementation strategy included

- Redesigning case management processes (by, for instance, decreasing concurrent review from all members to only members who met certain defined criteria)
- Helping staff adopt new ways of thinking about case management (from reacting after "trigger" episodes have occurred that cause members to be referred for case management, to attempting to intervene before the trigger episodes happen)
- Developing "motivational interviewing" techniques to encourage PM-targeted members to participate in the intervention.

Just 13 months after PHP implemented predictive modeling, Angellis had reason to be encouraged. In a plan in which 10% of the members account for about 60% to 70% of the costs, PHP had achieved \$1.8 million in savings (the total savings for all PHP products). It is still too early to obtain data on how predictive modeling has specifically affected outcomes, but Angellis says that is the next level of analysis.

Even so, in analyzing the data, Angellis realized that the results could be much better if at least one aspect of the tool's implementation could be improved: the process for contacting high-risk members identi-

Presbyterian Health Plan's goal in implementing predictive modeling is to identify potential high-risk members and to intervene before their health status deteriorates.

fied by the model who could not be reached by telephone.

Cold Calling

After potential high-risk members at PHP have been identified through predictive modeling, case managers telephone them to encourage their participation in case management. Some case managers who were accustomed to dealing with a member's "real" condition (as opposed to the potential high-risk one identified by PM) had difficulty adapting to this "cold calling" way of communicating with patients and decided to quit, Angellis said. "Calling a member who has coronary artery disease to engage that member, who hasn't yet had a heart attack or other major clinical event, was difficult for case managers who were used to dealing with a member about a defined significant clinical event," Angellis noted.

When case managers do connect by telephone with PHP's targeted members, the members are sometimes suspicious about the true purpose of the call. Some are fearful, thinking the case managers are calling to reduce their benefits, Angellis said. Others, he noted, think the caller is a telemarketer and hang up. To address these calling problems requires that case managers have carefully worded calling scripts, as well as training in motivational interviewing techniques, Angellis pointed out.

But it was not the targeted members whom case managers were able to contact that caught Angellis' attention; rather it was the targeted members they couldn't reach. The

PM call data from April to December 2003 showed that 21% of the targeted members did not answer the telephone and 9% were unreachable because of disconnected telephone numbers.

PHP claims data showed that, for the plan's commercial population, the average actual cost per case of those "no call contact" members was more than \$21,000 for the "no answer" group, and \$14,000 for the "bad phone number" group. The members of these groups were more costly than the members of other groups: no needs (\$10,000 per case), case management referral (\$12,500 per case), and refused intervention (\$4,000 per case). To Angellis, these data show that case managers were unable to reach the members most likely to benefit from intervention.

Calling on Doctors

Currently, PHP's strategy for contacting PM-targeted members is by telephone only, and case managers make three attempts to reach them. Complying with the patients' rights regulations under the Health Insurance Portability and Accountability Act is only one hurdle hampering PHP's calling efforts. Since the plan doesn't sign up its members, it must rely on others, such as employers, for member information (telephone numbers, for example), Angellis said. In an attempt to address this problem, PHP is seeking help from physicians.

PHP plans to start a pilot study involving physicians in its predictive modeling effort, Angellis noted in a telephone interview. That pilot study will begin with informal luncheon

meetings with physicians to educate them about what predictive modeling is, as well as how the tool can benefit both them and their patients. "In informal conversations with physicians about predictive modeling, I discovered none of them knew much or anything about it, and many had never even heard the term," Angellis said.

Ultimately, Angellis hopes that after bringing the physicians on board, PHP will be able to send them a list of their patients targeted by the predictive modeling software as having risk factors that could lead to a potential adverse clinical event within the next year or so. The physician can then contact these patients, suggesting that they visit the doctor's office to discuss their condition and any interventions that might be appropriate. "This effort won't increase the physician's workload," Angellis noted, "since it will likely involve only five to seven patients per year even in the largest practices."

To critics who argue that such efforts as PHP's to enlist physicians in its predictive modeling implementation efforts are an intrusion on the doctors' clinical autonomy, Angellis pointed out that the tool will actually benefit both physicians and their patients. "As a clinician, I would welcome such information," he said. "It's another way to help me improve the quality of care I deliver to my patients and improve their outcomes."

—Reported and written by Paula Grant in Lincoln, Va. More information on physician practice strategies is available on our Web site (see page 16).

"As a clinician, I would welcome such information. It's another way to help me improve the quality of care I deliver to my patients and improve their outcomes."

—Dennis Angellis, MD, CMO, Presbyterian Health Plan

Harvard Professor Says Health System Should Pay More for Quality Care



*David Cutler, PhD, is dean of the faculty of Arts and Sciences for Social Sciences at Harvard University. Previously, Cutler served on the Council of Economic Advisers and the National Economic Council during the Clinton administration. Currently, he is a research associate at the National Bureau of Economic Research and a member of the Institute of Medicine. He is associate editor of the Journal of Public Economics and the Journal of Economic Perspectives. His book, *Your Money or Your Life: Strong Medicine for America's Health Care System*, was published this year by Oxford University Press.*

Q: What prompted you to write *Your Money or Your Life*?

A: I have spent a lot of time thinking about what is wrong with our health care system. Survey data indicate that no more than one in five Americans claims to be happy with the medical care system. That seems like an awfully small number of people who are happy with something that is so important in their lives.

Q: One of the principal points in your book involves preventive care. Why is that?

A: We ought to spend more money on appropriate care, and in particular on preventive care, which is a good investment because it will obviate the need for spending even more money on the treatment of acute conditions in the future. But there are two other important points as well.

One is that we need universal coverage of some sort. All individuals must be insured if the health care sys-

tem is to work efficiently. The other is that we need to measure the quality and value of care, so that we can be sure we are spending health care dollars appropriately. I believe we should implement quality-based bonus payments for physicians. This will encourage physicians to maintain their focus on quality of care and invest in technologies that will help them to provide this care.

Q: What do you think is the best method of achieving universal coverage?

A: We should allow the general public to purchase insurance the way that government employees do. In other words, I am an advocate of expanding the present Federal

Employee Health Benefits Program. This program is a tested model and has worked successfully for federal employees. It allows enrollees a good deal of choice. Participants have reported that they are satisfied with the program.

When insurance is purchased by large groups, administrative costs are much lower, choices are more numerous, satisfaction with the process improves, and there is more control over insurer pricing practices. The federal government is one such large group. It is buying health care for millions of federal workers, and peo-

ple outside of the federal government should be able to take advantage of this plan as well.

Q: When you talk about the FEHBP, you point out that one of its deficits is that it does not pay for quality. Is that true?

A: Yes, that is true. However, it is important to remember that this is true for the medical system as a whole.

Q: Why is it important to pay physicians based on quality?

A: It is simply logical that people who do a better job should be paid at a higher rate. Health care is one of the few industries in which people who perform better do not receive higher payment. Public edu-

“We should implement quality-based bonus payments to physicians. This will encourage physicians to maintain their focus on quality of care and invest in technologies that will help them provide this care.”

cation is another example that comes to mind. Medicare reimbursement fees are the same for all doctors, regardless of skill, experience, or outcomes. As a result, physicians have no financial incentive to “go the extra mile” in ensuring the highest quality of care and the most appropriate care possible for each patient.

Under the current system, physicians receive the message that the most important thing is saving money. This message is conveyed by the current incentives that underlie the reimbursement of care. We need some major reform of these incen-

“Suppose doctors got paid more when patients got the right diagnosis and prescription, and followed up with patients to ensure that their blood pressure was under control. These doctors would be prompted to set up systems, such as outreach programs, to ensure that their patients were getting the care they needed.”

tives if we want high-quality, appropriate care. We can't just plead with doctors to improve their quality. We must actually change the system so that physicians receive the proper financial incentives to offer high-quality care.

If the health care system structure is changed such that we pay more money to physicians who can demonstrate a better quality record, physicians will have a financial incentive to adopt electronic medical records and other technologies that enable them to track and improve their performance.

Q: *In your book, you note that large multispecialty practices have been measuring outcomes and rewarding doctors accordingly. Can this experience be replicated, given that most physicians practice in small to midsized groups?*

A: The structure and means for rewarding physicians based on quality of care will likely be different in different parts of the country. The health care structure in some areas, like Minneapolis, has developed in a way that facilitates payment based on quality. Other parts of the country have very strong physician groups, so the likely scenario is that the physicians will come together to negotiate with insurers based on quality. And in some parts of the country, the gov-

ernment will have to play a bigger role, because the insurers and doctors just can't seem to develop collaborative working relationships.

We have to create a situation in which people want health care incentives to be based on quality, and then they can determine the best way to make this happen. For example, suppose the federal Centers for Medicare & Medicaid Services reported that it will change its fee structure and will now reimburse physicians based on quality. Under that scenario, the physicians in each area would say, "How can we improve quality? Should we work with the government to do it? Should we work among ourselves? Should we work with the insurers?" Each region may come up with a different solution.

To be successful, however, in all cases this change will have to be driven by physicians. I also think it will be important to get the professional societies on board, so that the doctors do not view payment for quality as a bad, rather than a good, thing.

Q: *In your book, you often mention the great geographic variation in health care provision, which often translates into the misuse, overuse, or underuse of health care services. How can care be standardized?*

A: Because we do not pay providers based on quality, many providers reasonably follow the incentives that are embedded in our system, meaning those that dictate cost savings. This is what causes geographic variation in care. Health care providers should be able to learn what works well and what doesn't work well and always follow the path that leads to the best outcomes. In many areas, clinical guidelines outline the optimal treatment path. However, providers are not rewarded for following that path. The focus is rather on financial results, given the incentives of the system.

For example, the hypertension of only one quarter of the individuals with that condition in the United States is successfully controlled, even though hypertension medications have been around since the 1950s. Why is that? People have a hard time getting to the doctor regularly; they have a hard time filling medications; the doctor does not always prescribe the right medicine. There are a host of reasons. How can we do better? Suppose doctors got paid more when patients got the right diagnosis and prescription, and followed up with patients to ensure that their blood pressure was under control. These doctors would be prompted to set up systems, such as outreach programs,

(Continued on page 10)

“Doing things that will ensure that clinicians take advantage of information to the maximum extent possible so that people are helped to the maximum extent possible will offer a very high return.”

INTERVIEW

(Continued from page 9)

to ensure that their patients were getting the care they needed.

The payer community must reimburse providers in ways that will encourage these changes. We must pay more for the best care. Doing so will encourage all providers to reach the standard.

Here's one possible structural change that could occur. Suppose that the government added funds to the current Medicare program such that reimbursement would be increased by 10%. The program would not increase payments across the board by 10%; rather, that money would be put into a quality improvement fund. That fund would dispense money to doctors on the basis of how well their practice met clinical guidelines. Every time a patient came in, the physician would see what, if any, clinical guidelines could be applied to that patient's care. Has this patient been referred for a mammogram? Has this patient received hypertension medication? Every time a patient is treated according to clinical guidelines, the doctor would earn points. At the end of the year, those points would be translated into a financial bonus, paid from the fund.

Q: Will this change require that physicians have a computer at the point of care so that clinical reminders can prompt the right care?

A: That would be optimal. The cost of both hardware and the software is dropping precipitously. Groups such as the Leapfrog Group and the Institute of Medicine are preaching safety. More physicians are realizing that computer systems enhance their practice efficiency, productivity, and profitability. But if

we ask doctors why don't they invest in these systems, they say they do not have the money to invest.

Health care information systems represent an extremely high productivity investment. Doing things that will ensure that clinicians take advantage of information to the maximum extent possible so that people are helped to the maximum extent possible will offer a very high return.

Of course, doctors need the money to invest in that infrastructure and need to be trained to use it. We must change the health care system to a structure that will hold providers accountable for quality, but this system must embody incentives for good care and provide the resources that will prompt quality improvements. This might require a government investment or it might necessitate an investment by private insurers or groups of physicians. The government pays for about 40% of medical care and the private insurers pay for another 40%. If we are really going to change the system, both of those constituencies must work together.

Q: You seem to be a bit dismissive of consumer-driven health plans because they require individuals to be more informed buyers. Is that correct?

A: For some people, consumer-driven health care is the right solution. Some people feel comfortable being in the driver's seat. But many other people need more help navigating through the health care system and making the best health care decisions.

Consumer-driven health care is a fad, just like all the other fads that we have tried. The whole structure of the industry has to change in a fundamen-

tal way. The idea that consumers on their own—without any changes on the supply side or any changes on the reimbursement side—will be able to change the system just isn't very likely. The system won't change significantly just because people have to pay more and make their own decisions.

A significant pitfall to avoid is a situation in which there is no flexibility. Consumer-driven health care will not work for everyone, just like not everyone is comfortable with managed care. We need a system that is more pluralistic, where some people can get insurance in one way but others can get it differently.

Q: What do you think about the Medicare reform bill that was recently passed?

A: The Medicare act was a big waste of opportunity. The drug benefit is really kind of silly. The cost sharing is such that while the government shares in the costs below about \$3,000, people are responsible for all of the drug costs they incur between \$3,000 and \$5,000. Then, government payment starts again. The act provides drug coverage to some people, which is good, but the coverage is not nearly as broad as it should be. While many extra provisions are packaged in that act, there is nothing that really addresses how the quality of the Medicare system is going to be improved. Overall, the package is much, much weaker than it should have been, and the act does not really address the central problems with the current Medicare system.

—Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

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Antifraud Efforts Yield Savings

The Blue Cross and Blue Shield Association in Washington, D.C., reported this summer that antifraud measures yielded about \$240 million in recoveries and savings last year, an increase of more than 52% from what the BCBSA association saved in 2002.

"Americans spent more than \$1.7 trillion on health care in 2003, and the overwhelming majority of individuals who work in the health care system are honest," says BCBSA National Antifraud Director Byron Hollis. "But, according to experts, as much as 5% of that, about \$85 billion, was lost to fraud."

Fraud affects every health care consumer and practitioner because the amount lost to fraud could have been spent on treatment, to support federal health care programs, or for private health insurance for consumers. "Every dollar stolen by health care fraud perpetrators is a dollar not available for necessary life-saving treatments, drugs, research, or emergency services," Hollis explains.

While recognizing that fraud exists, some experts note that investigators sometimes view mistakes as fraud. "The large majority of coding errors are just that, coding errors, and not fraud, although at first it may appear that way to insurance companies," says Neil Baum, MD, a urologist and member of the clinical faculty at Tulane University and the Louisiana State University School of Medicine in New Orleans. Baum has studied physician marketing and business practices for many years.

"I have a problem believing that actual fraud is as high as 5%," Baum comments. "The billing system is currently so cumbersome that physicians make those mistakes all the time and sometimes the first thing a plan thinks is that the mistake is on purpose even though there's no real attempt to deceive."

Indeed, not all cases of suspected fraud are found to be intentional upon investigation, Hollis concedes. BCBSA members reported more than 20,000 cases of suspected health care fraud last year, and 606 of those cases were referred to law enforcement agencies. Among those 606 cases, 206 resulted in criminal convictions. In addition, nine civil actions were filed, and 475 cases were referred to regulatory agencies. The rest of the cases are still being investigated or no action was taken.

Last year, many of the 20,000 cases began when individual health plans that are part of the Blue Cross Blue Shield system received 66,117 telephone calls to its Antifraud Hotline. In addition, law enforcement agencies referred 941 cases and BCBS plan internal staff referred 13,232 cases to internal fraud units. An additional 3,886 cases came from external referrals from other public and private investigating agencies.

Types of Fraud

The most common types of fraud include performing unnecessary medical procedures, improperly prescribing drugs, impersonating a health professional, and billing for a more

expensive service than the one performed, according to BCBSA officials.

"False or altered billing codes, forged documents, and computer technology are powerful tools used to illegitimately collect billions of dollars every year from unsuspecting consumers and their health insurers," says Baum.

"That's how most fraud or alleged fraud is uncovered," says John McDaniel, president of Peak Performance Physicians, physician practice management consultants in New Orleans. "Plans carefully examine billing records to determine a pattern, and to determine which physicians are exceeding benchmarks. When they see that physicians are exceeding benchmarks, they investigate. It doesn't always mean fraud, of course."

The aggregate \$240 million BCBS plans recovered or saved represents money recovered from those who had submitted fraudulent claims and money saved because fraud was exposed before payment, Hollis explains. But the BCBSA report said that health insurance fraud cost BCBS plans, which insure more than 88 million people, about \$162 million in lost revenue in 2003 even after the \$240 million recovery. That reflects an increase of 66% from \$98 million in lost revenue in 2002. The increase may result in part from a more aggressive coordinated approach by the association, says Hollis.

But increases in health care fraud trends also reflect current health care

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"The large majority of coding errors are just that, coding errors, not fraud, although at first it may appear that way to insurance companies."

—Neil Baum, MD, Tulane University

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market conditions, Hollis adds. For example, prescription drugs represent a larger portion of total health care expenditures than they did years ago, so pharmaceutical fraud has increased. Specifically, there has been a rise in the number of cases in which pharmaceuticals are diverted for illegal use or street sales, according to Hollis.

Another trend involves an increase in cases that pose opportunities for potential patient harm, say BCBSA officials. In these cases, patients actually undergo unnecessary medical procedures, including invasive surgery. In the past, such activity was rare and the apparent increase in occurrence represents a growing danger to the public, says Hollis, although why an increase in unnecessary surgeries is occurring remains unclear. "Sometimes a physician will perform one procedure but bill for a more expensive procedure," says Hollis.

John Morris, manager of special investigations for Blue Cross and Blue Shield of Florida, says that some physicians use what he calls "rent-a-patient" schemes in which physicians recruit patients to undergo procedures they do not need and then share the reimbursement with them.

Other types of fraud committed by physicians that were uncovered by the association and its 41 members

include the following:

- Phantom billing—adding charges for services never performed or fabricating claims
- Upcoding—charging for a more expensive service, such as a visit to a specialist when the patient actually saw a nurse or an intern
- Misrepresenting services—performing uncovered services but billing insurance companies for different services that are covered
- Unbundling—charging separately for procedures that are actually part of a single procedure.

Fraud committed by consumers were primarily of two types:

- Identity theft—using another person's health insurance card or identification to obtain health care or other services or to impersonate that individual.
- Doctor shopping—going from one physician to another to obtain multiple prescriptions for controlled substances.

BCBSA officials said they will continue to pursue suspected fraud aggressively and have started a new national fraud telephone contact number and Web site (www.bcbs.com/antifraud), designed to increase the number of investigations by providing consumers with a central place to report alleged fraud. "This will help us identify national patterns and work with the

separate plans to coordinate the investigation of plan reports," says Hollis. "In order to keep up with an increased volume of information, Blue plans have invested in advanced computer software to uncover complex fraud schemes."

And in order to bolster individual plan efforts in fighting fraud, the association members have created the BCBS Antifraud Strike Force, consisting of investigators from 11 plans and designed to enhance the coordination of antifraud activities among members.

"This will provide a springboard for plans' efforts by enabling them to work together on complex, multi-jurisdictional cases," says Gregory Anderson, co-chair of the antifraud strike force and vice president for corporate and financial investigations for Blue Cross Blue Shield of Michigan. "We will help facilitate the sharing of best practices and improved detection of emerging trends across the country, and have a greater ability to respond quickly and forcefully when fraud is identified. We are also engaging consumers in fighting health care fraud."

In addition, the association works with the Federal Bureau of Investigation to eliminate such crime. "That's where the money is," said Tim Delaney, supervisor of the FBI health care fraud unit when asked why the FBI places an emphasis on health care fraud. The agency has 500 agents working on 2,000 health fraud cases open at any given time, he adds.

But McDaniel's take on where the money is differs from Delaney's: "If 5% of claims are found to be based on fraud, then 95% are completely legitimate," he points out. "The truth is most physicians are honest and are honestly trying to do a good job within a difficult reimbursement system."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice strategies is available on our Web site (see page 16).

Who Investigates Fraud?

In addition to health plans, such as those represented by the Blue Cross Blue Shield Association in Washington, D.C., and the Federal Bureau of Investigation, a number of public entities investigate purported cases of health care fraud:

- City, county, and state law enforcement agencies
- U.S. Department of Justice through the U.S. Attorney General's Office
- Postal inspectors
- U.S. Food and Drug Administration (FDA)
- Offices of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS)

—MS

Physician Tells How He Beat Addiction Brought on by Pressures of Practice

By Richard L. Reece, MD, editor in chief

Cardiologist Steven Farber offers an intimate and revealing view of the physical, emotional, and social pressures physicians face in his book, *Behind the White Coat: Intimate Reflections on Being a Doctor in Today's World* (www.booklocker.com 2001). Part memoir and part medical expose, Farber writes about his entire career, from his days as a nervous medical student to his work in large institutional settings and to the establishment of his own private practice.

The book is particularly instructive for physicians who are feeling burned out from long hours and feel they have little satisfaction from practicing medicine in a health care system dominated by managed care, one that offers little control and lots of pressure to work many hours each day and week. Farber built a successful solo cardiology practice over two decades, but the pressures inherent in the practice of medicine today exacted a high price. He became addicted to a powerful anti-anxiety medication and was divorced four times.

Among many of Farber's patients, the book has struck a nerve. They say they have gained an understanding of physicians as human beings. And physicians benefit as well because they may come to realize they are not

alone in experiencing the exhilaration, tension, and fear that is built into the practice of medicine in the early 21st century.

Farber, who beat his addiction, is currently happily married, has three young children, and practices in The Woodlands, Texas, outside of Houston.

"Writing the book was a labor of love," says Farber. "Over the 20 years of my medical practice I have had many successes, but I have also made a lot of mistakes along the way. When I went to medical school, I was not taught the realities of what the life of a doctor would involve. I was poorly prepared for the pressures I faced when I went into practice. Through my book, I hope to help other physicians avoid these mistakes, or at least realize that they are not alone in their problems."

The Emotional Toll

The book addresses the tremendous emotional pressure on doctors and the problems that flow from that pressure, including addiction and suicide. Farber himself has had four physician friends who committed suicide.

The problem of depression among physicians is well known. Last year, JAMA devoted an entire issue (June

18, 2003) to depression; in that issue, experts from the American Foundation for Suicide Prevention issued a consensus statement asserting that the medical profession must place a higher emphasis on clinician mental health in order to address the number of untreated mood disorders and reduce the number of suicides among medical professionals.

Research into the psychology of physician practice has shown that doctors can easily become isolated, a factor that leads to depression. Physicians give their time, energy, and care, but do not get much emotional gratification in return, and they are often deeply disturbed or depressed. "Going through medical school and the subsequent training can be a very isolating experience," Farber says. "It can be an extremely brutal process at times. During my internship at Baylor University, I never had a day off. At that time, interns were required to actually live at the hospital, and spouses would come in for conjugal visits. I am sure to many residents, this felt like a physical and psychological prison. The intense work schedules physicians and physicians-in-training face serve to isolate them from their family and friends, such that they cannot have a normal social or family life."

(Continued on page 14)

"When I went to medical school, I was not taught the realities of what the life of a doctor would involve," Farber says. "I was poorly prepared for the pressures I faced when I went into practice. Through my book, I hope to help other physicians avoid these mistakes, or at least realize that they are not alone in their problems."

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Heavy schedules continue after training and take a heavy toll. "For example, I typically work a 60- to 70-hour week, at least," he says. "My average day includes about 12 hours spent at the hospital and in the office, but obviously medicine is really a 24/7 profession because our patients may need us at any given moment. Physicians often go two, three, or four weeks without a day off. This schedule is very wearing on physicians, especially as they get older and have more family obligations."

Furthermore, a confluence of forces in today's practice environment exacerbates the pressures inherent in the job. Many doctors say that four main tensions in their lives are the fear of being sued for malpractice, the administrative hassles with insurers, inadequate reimbursement, and the complications of living in a society that is increasingly hostile to doctors. These issues resonate with Farber.

"These and other issues have made it harder and harder to practice medicine in the current environment," Farber comments. "For example, the 5% of physicians who are responsible for the majority of malpractice suits are the ones we read about in the newspaper. But we don't hear much about the 95% who are very, very good physicians. As a result, the profession has gotten a bad name."

At the same time, patient expectations about what they can expect from a physician are often unreasonable. "In the book, I point out that physicians are expected to have the competitive fire of Michael Jordan, the courage and heart of Lance Armstrong, the 'true grit' of John Wayne, the confidence of

Mohammed Ali, the ability to communicate like Dale Carnegie, the patience of Job, and the intelligence of Albert Einstein," Farber says. "The pressure of these expectations is astounding."

A Great Irony

All the many pressures of practice can lead to a great irony: While physicians are helping their patients achieve and maintain good health, they often ignore their own well-being. "I had a partner in the late 1980s who died about a year into our partnership," Farber says. "He was only 40 years old, but he was an asthmatic who needed to use his inhaler quite a bit during the day. I often told him that he should see a pulmonologist, but he never did. He just worked 12- to 14-hour days and never took the time to go. One day, we were seeing patients in the office and he had a fatal asthma attack. We found him on the bathroom floor. His face was blue and I performed CPR on him for about four hours, but he could not be revived."

"Writing the book was an act of bravery on Farber's part, as it is highly personal and required him to relive many painful experiences. At one time, he developed an addiction to an anti-anxiety medication, which alleviated his tension and conferred a pleasing, calm feeling, one he sought repeatedly throughout the day. While self-prescribing the medication, he also took the free samples that his office received.

"The fact is, many physicians need a crutch to get through the pressures of the job," he says. "It is well known that people who are depressed tend to self-medicate." And, Farber notes, it is very easy for physicians to

become addicted to alcohol or drugs because of their easy access to medications.

After some time, Farber and his friends realized that he had a problem. "Luckily, it didn't affect my patient care, but it could have," he says. "Eventually, the medication became something I felt I could not do without, and this in itself was very disturbing to me. In addition, my friends noticed and intervened. I knew my problem was bad, and I would need help to beat it. I went through counseling to help me overcome my addiction."

Farber has also been through four painful divorces. "Many physicians are workaholics by nature, and in fact the profession rewards workaholics," he observes. "That situation can weaken a marriage and lead to divorce. Ultimately, my work schedule probably hurt my marriages more than my drug addition did. In my book, I state that doctors deserve second chances as much as everybody else."

Managing Pressure

To weather practice pressures successfully, Farber advocates that physicians develop themselves spiritually. "I had a lot of difficulty accepting my mistakes when I went into practice," he says now. "The exhilaration when we save a patient's life is phenomenal, but we despair when we fail. I truly punished myself when I made a mistake, probably more than anybody else would. I took my mistakes very personally. But all human beings are fallible. I think if I had developed a closer relationship with God, that relationship would have helped me tremendously in negotiating life's difficulties."

"Unfortunately, it is very easy for physicians to become addicted to alcohol or drugs, especially due to the accessibility of medications."

—Steven Farber, MD

At a Glance

Steven H. Farber, MD, FACC, graduated Phi Beta Kappa with honors in English from Rutgers College before attending medical school at Hahnemann Medical College and Hospital in Philadelphia. After receiving his medical degree with honors in 1977, he became an intern and resident at Baylor College of Medicine in Houston where he completed a cardiology fellowship. Board certified in Internal Medicine and Cardiovascular Disease, Farber has twice served as chairman of the Department of Cardiology at Conroe Regional Medical Center. A fellow of the American College of Cardiology, he has a private practice outside Houston.

Intellectual development is also critical to having a balanced life, says Farber, who calls for a more broad-based liberal arts education for doctors. Physicians often attend medical school after being strongly science-focused. While they may have superb grades in biological sciences and pre-medical courses, physicians also can be stunted intellectually about the world at large, particularly about the arts and literature. Realizing this fact, Farber has tried to develop his intellectual creativity by becoming a fan of Shakespeare. He also started writing poetry, and includes some in his book. Physicians should also learn ways they can help themselves manage stress and recognize signs of burn out.

In each state, the board of medical examiners of the state medical association offers services for impaired physicians who want such help. For example, the Indiana State Medical Association's Physician Assistance Program addresses the needs of physicians impaired by chemical dependence, psychiatric disorders, and disability (www.ismanet.org). Farber's Web site, www.behindthewhitecoat.com, also offers a number of links that can help

physicians understand the challenges of the job and recognize signs of depression.

Sharing Online

On Farber's Web site, physicians can participate in the "Physician's Forum Bulletin Board," a mechanism by which physicians can share their feelings and personal experiences, vent frustrations, offer opinions, and ask the opinions of other physicians regarding how to address certain problems. All of these features are available anonymously. "This forum can help physicians learn from the experiences of others and allows them to take comfort that other physicians are facing similar problems," Farber says.

Often, other physicians provide suggestions that make a difference. "For example, I learned that I need to take the time to research things before I just jump into them," Farber adds. "I was relatively naïve when I graduated from medical school and other people, including patients, took advantage of me. Younger physicians need to learn this lesson early. I know now that there is the potential to

work very, very hard for 40 years and have very little to show for it financially."

Certainly, business support for physicians is crucial. Because many medical school programs focus solely on clinical information, new physicians do not know how to run a practice from a business standpoint. Gaining such understanding can make practice challenges more manageable. "Coming out of medical school, I had no training in how to run a business," Farber notes. Business courses—such as human resources management, accounting, strategic planning, and finance—geared toward physicians could help them manage their practices more optimally, he explains.

Ultimately, Farber hopes that his book will help physicians and their patients develop a stronger relationship. "Patients have come to me and said, 'Dr. Farber, now I understand what you're all about, the pressures you are under on a day-to-day basis,'" he says. "One of the intentions of the book is to strengthen the doctor-patient relationship, which has weakened over the years, in part due to shorter visit times."

Farber also hopes to offer comfort and a sense of community. "I want physicians who may have an addiction problem to know they can find the courage to seek help," he says. "Physicians are not alone in the pressures that they feel, and talking about these pressures with colleagues and family can help physicians manage their negative feelings."

—Edited by Deborah J. Neveleff, in *North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

"One of the intentions of the book is to strengthen the doctor-patient relationship, which has weakened over the years, in part due to shorter visit times."

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