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IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

December 2004

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Physician Takes Steps to Get Paid on Time

As managed care companies make payments more slowly now than ever before, physicians are finding that they need to manage their accounts receivable processes more closely. One physician who has honed those processes to ensure that he receives payment promptly is Jack Cook, III, MD, an internist in Leesburg, Va.

Cook instructs his staff to check each patient's address at every visit and to verify and copy all primary and secondary insurance cards every time a patient enrolls in a new health plan. He has also instructed all providers in his office to document each patient visit, list all ICD codes to the fifth digit, set E&M codes, and indicate all ancillary services on the encounter form at every patient visit.

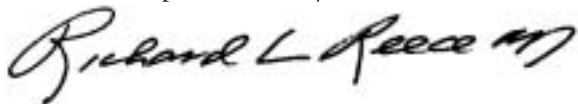
Cook tells his discharge clerks to double-check all services on the encounter form at the time of visit and to know what's covered under each patient's insurance plan. They are also instructed to explain to each patient the balance (if any) from the previous visit, how much is owed for the current visit, and to request payment in cash or with a check or credit card. Then, the clerks make a return appointment.

Cook also requires his staff to ensure that no billings are lost; they do so by submitting hospital billing and nursing home billing complete with ICD codes and the requisite level of service every day. Practice billings (including secondary billings) are submitted each day as well. Whenever a health plan discounts a line item or does not pay a bill, Cook instructs his staff to rebill immediately upon receipt of the initial payment or the explanation of denial. Also, he insists that all medical records be legible and accessible.

Cook asks his staff to review the accounts receivable by payer each quarter. He looks for payers whose accounts receivable percentage is increasing. If it is rising, he wants to know why: Is it a problem involving initial billing, timely rebilling, or a systematic payer delay? Most payers will report a physician's clean claims percentage. Cook finds this figure to be important when it is time to give raises or pay bonuses to his billing and collections staff.

While many physicians over the past few years have refused to accept Medicare patients, believing Medicare pays too little, Cook recommends that all physicians who treat adults accept some Medicare patients. "Medicare performs a valuable secondary function for any practice," he explains. "Its system checks the entire organization. If you're collecting 98% of Medicare allowable payments within 60 days, your system works."

But perhaps just as important as honing the accounts receivable processes is taking a pragmatic look at where the income is coming from. Before signing a contract with any managed care organization, Cook makes sure that he knows what he will collect. "Don't deal with any organization that pays less than 115% of Medicare—period!" he says.



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Survey Shows Growth in Services

Both practice revenues and operating costs have increased for cardiology and cardiovascular-thoracic surgery groups, according to a report on the finances of such groups. The increase in revenue and costs is due largely to more investment in ancillary services and information systems, says Frederic R. Simmons, Jr., CPA, CEO of Clearwater Cardiovascular and Interventional Consultants, an 18-physician single-specialty group in Clearwater, Fla.

"Higher costs are due, in part, to the investments groups make to bring new revenue streams into the practice," says Simmons, chairman of the survey advisory committee for the Medical Group Management Association in Englewood, Colo. MGMA conducted the survey, *Cost Survey for Cardiovascular/Thoracic Surgery and Cardiology Practices: 2003 Report Based on 2002 Data*. Cardiology practices use the survey data as a benchmark against their own data on practice revenue, costs, and other financial indicators.

Higher Revenue

Mean total medical revenue in cardiology practices surveyed rose 5.5%, from \$947,592 per full-time equivalent physician in 2001 to \$999,878 in 2002, the survey shows. At the same time, total gross charges per FTE physician rose almost 10%, from \$1,955,027 in 2001 to \$2,159,334 in 2002.

"This seems like a reasonable relationship between revenue and gross

charges, because many practices set their fee schedules at about 200% of Medicare reimbursement, and Medicare is the dominant payer for cardiovascular services," Simmons explains.

Mean total medical revenue in the cardiovascular-thoracic surgery practices surveyed grew by about 8%, from \$778,590 per FTE physician in 2001 to \$844,299 in 2002. Total gross charges per FTE physician rose from \$1,821,743 in 2001 to \$2,131,292 in 2002, a 17% increase.

Revenue growth is a positive indicator for cardiology practices. "Most of the revenue growth over the past year is likely driven by the development of new services in cardiology offices," Simmons speculates. "More groups are now providing echocardiography, nuclear medicine, and even cardiac catheterization lab services. In the past, these services have been hospital-based. But as cardiology groups grow in size, they can achieve the critical mass to support ancillary services in their offices."

Revenue is higher because cardiologists can generate a global fee for services they provide in house, Simmons explains. "In the past, cardiologists who provided these services at the hospital were generating only the professional component of the fee," he explains. "Now they can generate the global fee, which is the professional fee plus the technical component."

Many mid-sized cardiology groups have their own echocardiography departments, and some also offer out-

patient nuclear medicine scans, Simmons adds. "Even small groups can pursue this strategy," he says. "Many cardiology groups with two, three, or four cardiologists can support one echocardiography machine and one nuclear camera."

In fact, thanks in part to the incorporation of outpatient testing in cardiology practices, mean compensation per FTE physician rose 4.4% between 2001 and 2002, the survey shows. "Cardiologists can look for opportunities to develop in-house testing capabilities in order to enhance their income," Simmons says. "Careful analysis of opportunities will reveal which opportunities can be lucrative, even given the initial cost of investment."

Many cardiologists prefer single-specialty rather than multispecialty practice, because single-specialty practice allows them to retain more of the technical fee revenue stream they generate, Simmons says. "Cardiologists and other specialists who can generate technical fee revenue are generally happier and more successful in single-specialty groups than they are in multispecialty groups," he asserts. "Typically, the technical fee revenue stream in a multispecialty group is owned by the group as a whole. A portion of that revenue must be allocated to reduce group overhead, and the rest must be shared with nonproceduralists. In contrast, in a single-specialty cardiology group, the cardiologists own the technical fee revenue stream."

(Continued on page 4)

"More groups are now providing echocardiography, nuclear medicine, and even cardiac catheterization lab services. In the past, these services have been hospital-based," says Frederic R. Simmons, Jr., CPA.

(Continued from page 3)

Investment Costs

While revenue grew, so too did practice costs, and these costs more than offset the increase in revenue, the survey shows. Mean total operating costs per FTE physician increased from \$438,219 in 2001 to \$472,744 in 2002. Thus, while mean total medical revenue increased 5.5% between 2001 and 2002, mean total operating cost increased 7.9% over the same period.

Total support staff cost per physician increased 5.5%, from \$230,565 in 2001 to \$242,644 in 2002; total general operating costs—which include items such as equipment, information technology, maintenance, insurance, supplies, and clinical laboratory expenses—increased by 11.1%, from \$207,634 per FTE physician in 2001 to \$230,100 in 2002.

A significant driver of cost increases is the investment in new services. “The investment in services that allows cardiologists to collect a technical fee along with the professional fee represents a fairly significant expense,” says Simmons. For example, radiology and imaging operating costs per FTE physician have increased by 18.7%.

If a cardiologist orders an echocardiogram for a patient and that echocardiogram is done in the hospital, the physician will read the echocardiogram in the hospital and will generate a professional fee of approximately \$100. If the physician can perform echocardiography in the office, he or she may collect a global fee of \$500.

“But the practice has purchased a machine that may cost \$150,000 and has hired an echocardiography technician with salary and benefits costing around \$50,000,” Simmons says. “Other expenses include depreciation and interest on the machine and the cost of additional office space for the echocardiography service. As long as the practice can keep the machine and the technician relatively busy, it

will make a profit on that service.”

The survey’s data on diagnostic radiology reveal the investments in new services. Mean gross charges per procedure increased from \$334.81 to \$464.08 between 2001 and 2002; in the same period, mean total costs per procedure rose from \$273.08 to \$317.82.

Per procedure charges and costs are rising as practices add more complex services. “The first wave of procedures that have been offered in the office environment included the echocardiography procedures, because they are the most straightforward,” Simmons says. “Most cardiologists

cost per procedure will rise even higher,” Simmons notes.

Ancillary Services

The survey also showed a higher level of total assets per FTE physician, which averaged \$151,800 in 2001 and \$176,934 in 2002. Again, these data reflect the fact that more cardiology services are being offered in cardiology offices, Simmons says.

“Developing ancillary services that were previously offered only in the hospital is a strong trend in cardiology,” Simmons notes. However, he advises cardiologists to analyze the effect of such a strategy on a practice

Mean total operating costs per FTE physician increased from \$438,219 in 2001 to \$472,744 in 2002.

ogy practices offer echocardiography services in-house. Echocardiography requires one machine, and that machine can be wheeled from room to room. It involves no significant injectables or supplies, and therefore the costs, as well as the charges, are not that high.”

A smaller but still significant number of practices—particularly those that are mid-sized or larger—offer nuclear medicine services, which are more involved. “The machines are larger, are fixed, require more space, are more expensive, and involve the use of radioactive isotopes,” Simmons explains. Despite the complexity, offering nuclear imaging services seems to be a strong trend, since the survey indicates that the number of groups that offer office-based nuclear imaging rose by 19%.

Finally, a small but growing number of large practices are implementing their own catheterization laboratories, which require significant investments in machinery and staff. “As more practices develop cardiac catheterization laboratories, both gross charges per procedure and total

before pursuing it. “Cardiologists want to bring in new revenue streams, but they have to carefully assess all the costs associated with the service under consideration,” he explains. “A practice must have adequate volume to achieve positive net income. Cardiologists should examine whether they can provide the service in a high-quality way, and then analyze whether they will generate enough volume to support this line of business. Therefore, careful strategic planning is crucial to ensuring that the right business decision is being made.”

Resources

Readers may purchase a copy of the *Cost Survey for Cardiovascular/Thoracic Surgery and Cardiology Practices: 2003 Report Based on 2002 Data*, from the Medical Group Management Association in Englewood, Colo. More information is available on the Web (at www.mgma.org) or by calling 877/275-6462.

The survey shows that operating cost trends have hit smaller practices the hardest, Simmons says. "In some ways, the financial strength of the medium and large practices has been less affected because these practices have been able to bring in these ancillary services that, while generating a higher overhead, are still profitable," he explains.

Rising Liability Costs

One of the fastest rising costs is for professional liability insurance for cardiologists. These costs rose from an average of \$10,704 per FTE physician in 2001 to \$13,649 in 2002—a 27.5% increase. Cardiovascular-thoracic surgery groups experienced an increase from \$23,966 per FTE physician in 2001 to \$28,335 in 2002, an 18% jump.

It is likely that surveys done after 2002 will show a much greater jump. "The full impact of the liability insurance crisis will not be revealed for another year or two," Simmons says. "Increases in premiums spurred by the Sept. 11 attacks, poor stock market performance, and higher reserve requirements for medical malpractice insurers will not be fully felt until the 2003 data are published."

While professional liability costs are rising, the increase in costs alone understates the magnitude of the crisis, because as these costs rise, many practices have reduced their insurance coverage, Simmons says. "So while we may see increases of 30% to 40% in premiums, those premiums represent lower coverage," he explains.

Information Technology

Another component of operating cost is investment in information technology. Mean information technology costs per FTE physician was \$15,528 in 2001, and it rose to \$17,387 in 2002, an increase of about 12%. "More cardiology groups are beginning to adopt electronic medical records and otherwise upgrade their information systems," Simmons

Survey Facilitates Practice Benchmarking

For the annual *Cost Survey for Cardiovascular/Thoracic Surgery and Cardiology Practices: 2003 Report Based on 2002 Data*, the Medical Group Management Association compiled information from 116 cardiology and cardiovascular-thoracic surgery practices in the United States. Data were provided from all survey respondents, and were organized by number of FTE physicians, type of practice, and presence of capitation revenue.

The goal of the survey was to provide a comprehensive financial census of cardiology and cardiovascular surgery practices, says Frederic R. Simmons, Jr., CPA, CEO for Clearwater Cardiovascular and Interventional Consultants, an 18-physician single-specialty group in Clearwater, Fla. Simmons is chairman of MGMA's 2003-2004 survey advisory committee.

The survey data can help cardiology practices assess their own financial performance, Simmons says. "The survey establishes good benchmarks that allow cardiology and cardiac surgery practices to compare themselves to others in the industry," he says. "Groups can compare themselves to practices of their own size and in their own region. Furthermore, information about services that cardiology practices provide (such as nuclear medicine, echocardiography, and cardiac catheterization) enables comparisons based on service volume."

The 2002 report showed that cardiology practice staff and operating costs had increased significantly over the previous year, but that practice revenues had also grown. That trend is evident in the 2003 report, which was released earlier this year. —DJN

says, adding that these groups also are investing in digital imaging systems.

Cardiovascular-thoracic surgery groups surveyed reported a per FTE physician information technology cost of \$11,042 in 2002, an increase of almost 20% over 2001 (\$9,227).

Investments in information technology have probably contributed to another trend in the data: The reduction of days in accounts receivable have gone down. The survey indicates that cardiology groups experienced a decrease of six days in accounts receivable, to about 47 days in 2002, meaning cardiologists are collecting the money they are owed for services at a faster rate.

"Gross fee-for-service charges in accounts receivable have fallen about 12%, largely because of the adoption of electronic medical records and

enhancements in practice management systems," Simmons observes. "For example, before we implemented an EMR, it took three or four days for charge data to be gathered from paper documents, entered into the computer, and billed. Now, charges are posted almost automatically and services provided on a given day are billed that night. Our practice has experienced a reduction in our days in accounts receivable partially due to the fact that we are getting the charges in more quickly."

By helping to increase cash flow, information technology can help practices lower their operating costs, Simmons adds.

—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).

Steering Clear of Malpractice

Malpractice is a word that physicians do not like to hear. A study published by the congressional General Accounting Office last year found that inflation-adjusted malpractice insurance premiums rose 8.2% between 1998 and 2001 in the seven states included in the GAO survey. This increase was due, at least in part, to an 18% rise in losses after adjusting for inflation during the same timeframe.

"Seventy-five percent of malpractice lawsuits filed are found to be without merit," says Jeff Driver, chief risk management officer at the Stanford University Medical Center. "These are often angry people who don't get the information they need from their doctor and run to a lawyer."

Talking Face-to-Face

While it is impossible to completely suit-proof a medical practice, experts agree that there are steps physicians can take to decrease the likelihood that a patient will sue. Perhaps more important, there are initiatives doctors can take to make their defense easier if they face a malpractice suit.

"We know that certain physicians collect lawsuits," says Stephen Tharp, MD, a staff physician at St. Vincent Hospital in Frankfurt, Ind. "Physicians are more likely to be sued if their attitude is disagreeable or if they give the patient a reason to feel disrespected."

Studies back this up. For an article in the *Archives of Internal Medicine*, researchers reviewed transcripts of depositions seeking an answer to the question, "Why did you decide to sue?" Four themes emerged from the

sample: deserting the patient, devaluing the family's or the patient's views, delivering information poorly, and failing to understand the family's or the patient's perspective.

"The single best way to avoid malpractice is to talk person to person," comments Richard Amdur, JD, a malpractice defense attorney with Amdur, Maggs, and McGann in Eatontown, N.J. "Physicians should give the patient their time and attention."

It is important for physicians to give each patient the idea that they care about the patient and are trying to do what is in each patient's best interest. In a study of malpractice suits in the United Kingdom that was published in *Lancet*, researchers found that those taking legal action expressed a desire for greater honesty, an appreciation of the trauma they had suffered, and assurances that lessons had been learned so that the same problems would not reoccur.

Setting Expectations

Setting realistic expectations for outcomes is an important first step. The consent process is the time to outline what is supposed to happen and to let patients know the downside of any action or procedure.

"I advise my physicians to highlight to their patients what they are going to do and the possible outcomes," says Driver. "Patients need to know both the usual and unusual complications that can occur. If that isn't done thoroughly, a patient may not be able to distinguish between malpractice and complications."

Being impersonal and aloof can

help change a small disagreement into a big lawsuit. Physicians should not give the impression that they are too busy to give each patient the time he or she deserves, experts say. Returning phone calls quickly can be one way that physicians can personalize themselves to their patients. Such feelings can be engendered in a patient by staff as well as by the doctor.

"Physicians should look at the processes in their offices to see if they tend to run behind all the time," says Tharp. "When a patient phones or comes in, is the patient greeted in a friendly manner?" Tharp suggests using the equivalent of what retailers call secret shoppers: having a friend call the office and ask the receptionist or telephone operator questions about the practice. Physicians may be able to correct problems with reception if they ask patients about any problems they may have had getting an appointment.

An often overlooked risk management opportunity is the overdue bill. For some patients, withholding payment may be an attempt to express displeasure. It may be in the legal best interests of the physician to have someone in the office speak directly to the patient if payment is not made after two or three bills have been sent. If there is a problem, physicians should make sure that someone of authority looks into the matter and follows up with the patient.

Documenting Steps

Although these steps lessen the chances of being sued, they do not guarantee that some patient will not

"The single best way to avoid malpractice is to talk person to person," comments Richard Amdur, JD, of Amdur, Maggs, and McGann. "Physicians should give the patient their time and attention."

Resources

For more information on how to avoid a malpractice suit, physicians can talk with their insurers about practice evaluation programs. In these programs, risk managers work with physicians to find problem areas. Hospitals also have peer review systems and risk managers who can offer useful advice. The American Society for Healthcare Risk Management (at www.ashrm.org) has published monographs on the topic that are available at little or no cost on its Web site. —KU

bring an action. “Unfortunately, every patient is a potential plaintiff,” says Amdur. When that happens, the best defense is good record keeping. “Documentation should always be preventive,” Amdur adds.

The chart should reflect the thought processes that went into deciding what course of treatment to take. Included in the documentation should be symptoms present, how the pieces were put together to make decisions on treatment, why one course of treatment was chosen over another, and which risks were discussed. Alternative treatments, including doing nothing, are often missed. In addition to helping justify treatment decisions, this record reconstructs what happened if the incident ever comes to trial.

“We all make mistakes,” comments Tharp. “Having a record showing that the physician thought about the problem is much more effective in court than one that shows the physician did not even care enough to write down what was going on. This is very important to establish the physician’s credibility.”

When charting, physicians should never alter a record after it is completed. If corrections need to be made, most experts suggest making a single line through the mistake along with the physician’s initials, the date, time, and the notation “error” next to the words crossed out. If words are added, physicians should note the change by adding the date and time as a new note using “addendum” or similar wording.

Experts advise physicians always to

be objective. They should choose language that is descriptive, logical, and respectful while still getting needed information into the record. Physicians should document as though the patient is going to read the chart, because if it gets to court, the patient most likely will read it.

Physicians who use handwritten charts should ensure that their writing is legible. When viewed by a jury, sloppy writing may indicate sloppy care. Physicians should remember that the case may not go to trial for several years, and there are few things more embarrassing on the witness stand than not being able to read one’s own handwriting.

“What I don’t want to find in the record is a lot of finger pointing and blame,” says Driver. “The chart is a record of care.”

Admitting Mistakes

One controversial area of malpractice involves whether a physician should admit a mistake to a patient. New standards set by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Village, Ill., require patient and family notification in some settings.

“We used to think we should never admit to doing something wrong,” says Tharp. “Patients want to know what happened and what the physician is going to do to correct it. Otherwise, it looks like the physician is hiding something.”

The literature tends to agree that honesty is the best policy. A study pub-

lished in JAMA found that 24% of mothers who had sued following perinatal injury or death of their babies were motivated by what they recognized as a cover-up.

When reviewing the issues involved in a malpractice case with a patient, physicians should not speculate about why a mistake occurred or how the patient’s care might have been managed differently, Tharp says. Physicians should ensure that they carefully differentiate between what is known and not known, and what is being done to answer any outstanding questions. Physicians should stress that bad outcomes are not always malpractice.

“Physicians should say they are sorry without saying that they caused the error,” stresses Tharp. “We all can express sympathy when something bad happens, but that does not mean we are taking responsibility for everything that went wrong.”

Driver suggests that physicians contact their risk managers and insurers for advice about what to say and how to say it. They should never lie to the patient or the patient’s family, however. If a case goes to court, a jury is likely to view a physician in a negative light if the physician has lied to a patient already in distress. As Driver observes, “Angry juries tend to throw money (at the plaintiff).”

Whenever possible, physicians should explain to patients and family members what is being done to make sure the mistake will not be repeated, experts advise. Research shows that protecting others from harm or trying to ensure that a similar incident does not occur were important to large percentages of the families in research studies.

“We all make mistakes over the course of a career,” notes Tharp. “What prevents problems is how we handle them.”

—Reported and written by Kurt Ullman, RN, MHA, in Carmel, Ind. More information on physician practice strategies is available on our Web site (see page 16).

3 Find Ways to Renew Love of Medicine

By Robert F. Priddy, MSM, and David Nissen Kahn, MD

Many physicians who call career placement companies are seeking to leave the practice of medicine. In fact, the most familiar refrain we hear is, "I'm not sure I want to, but I guess I could work for a big company." Typically, our response is, "Let's not discuss what you think you could be doing, but rather let's find out what you should be doing with your career."

The best career placement companies endeavor to determine not only what each physician client is good at, but also what career path makes each client happy. After gathering this information, these career placement companies can help create a "best fit" workplace option for the physician.

Finding a Match

Many physician clients of career placement companies should in fact do what they set out to do many years ago: Be physicians. Caring for patients is what they're best equipped to do and it's what makes them joyful. The passion in their lives is delivering the best medical care possible to interested, appreciative patients in a happy team environment.

In our business over the past several years, we have seen physicians make significant changes in how they practice medicine. One general surgeon was typical of the physicians we saw. Frustrated by the administrative hassles and rising malpractice premiums that are common today, he decided to open an endoscopy center

that allowed him to control his practice style and hours and decrease his malpractice exposure at the same time. Now he runs his own practice, instead of the practice running him.

For some physicians, making changes in their practice involves first identifying what needs to be changed. Because the changes they are considering are so significant, they often begin to think about going into a new line of work that is outside of patient care. The three physicians we profile in this article were doing just that: thinking of leaving the practice of medicine. But after identifying and making the changes that were needed, each one is continuing in medicine and is much more satisfied and fulfilled by doing so. All three have reignited the passion they had when they entered medicine, showing that positive change is possible and quite achievable despite the circumstances.

Back to Basics

Many physicians struggling under the constraints of managed care have forgotten that patient care is their passion. Some may wonder if there even are any appreciative patients or if a

has never been easy, and it is particularly difficult today. However, as experts in physician careers, we have seen that practicing medicine need not be as difficult as it now is for many physicians.

The first step in this career assessment involves identifying the variables linked to the most significant problems in a medical practice. Although individual situations vary, the following variables would apply to most practices:

- Patients
- Staff
- Location
- Specialty
- Partners
- Income

As the following anecdotes show, it is possible to change any one of these variables.

Making Choices

David Steiner, MD, PhD, is an obstetrician/gynecologist in Chicago. When we met him, he was in the second practice of his three-year career. Although he enjoyed the intellectual challenge of medicine, the relationships he had with his patients, staff, and partners were not rewarding. He

By identifying the variables in his career that had been affecting his happiness, Steiner learned that understanding those variables gave him the power to change them so that they worked for him not against him.

happy, contented care team environment even exists in this cost-conscious, efficiency-focused health care world. Finding the perfect practice

found the focus to be too heavy on production, believed he was not supported in his practice growth, and had noncompliant patients. Like

Robert F. Priddy, MSM, is executive director of The PhysicianCareerNetwork in Englewood, Colo. (at www.physiciancareernetwork.com). David Nissen Kahn, MD, a former nephrologist, is a medical and health care writer for CareerLab, parent company of PhysicianCareerNetwork.

Three Practice Scenarios

For many physicians who are dissatisfied with the practice of medicine, it is likely that one of the following three scenarios applies:

1. You are in the right practice but simply need to make some changes so that it works smoothly for you.
2. The practice has problems that you cannot fix, so it might be best to find a new line of work. Fortunately, there are many opportunities for physicians today; it's simply a matter of choosing the next opportunity wisely.
3. You are not suited to the setting you're in or you may be in the wrong specialty, but you should continue to work as a practicing physician.

Because it is often difficult for a physician to determine which of the three scenarios applies in his or her case—and to determine what changes to make once the right scenario has been identified—physician career consultants can help the physician clarify the appropriate career path.

—RP and KND

many of the physicians we see regularly, he believed he needed to leave the practice of medicine, possibly for a career in community health, his doctoral field.

Based on the fundamental principle that any of the variables can be changed, we made a plan for him to leave his current practice. In making arrangements for him to leave, we suggested that he identify the areas of work that he most wanted and needed, as well as the areas that he wanted to avoid in any new setting. Once he had identified those areas, he could look knowledgeably and productively for opportunities in clinical medicine and in community health that would not reproduce the frictions he had experienced in the past.

Working closely with Steiner and his lawyer, we crafted an acceptable separation agreement, connected him with a number of physician recruiters, and suggested he call other professionals with whom he had worked in the past who could help him find his next career opportunity. As a result of these suggestions, he began calling people to find opportunities in ob-gyn practices and in community health settings. By the end of the second month of his job hunt, mostly through directed networking, Steiner

was entertaining two intriguing opportunities: one in a thriving practice near Chicago, the other in a public health position that required both his MD and PhD degrees.

As Steiner considered both options, he realized that what he wanted and needed was to continue working as a practicing physician. By identifying the variables in his career that had been affecting his happiness, job-placement testing and assessments had revealed a need for deliberate thinking and action, for strong interpersonal relationships, and the ability to direct his own work activities. His work environment was demanding fast action and decision-making, offered an absence of close relationships with staff and colleagues and the focus on his production left him feeling controlled. Steiner learned that understanding these issues gave him the power to change them so that they worked for him not against him.

Not surprisingly, Steiner found he could stay in clinical practice, where he feels he belongs. Today he has both an active clinical practice with an established patient base and is involved in issues of health planning and developing programs to address the health needs of the clinic's patients.

Improving Conditions

Steiner had to leave his former practice to find the right career match, but we have found that it is possible for many dissatisfied physicians to remain in their current situations if they are willing to make the necessary changes to improve their working conditions.

Corinne Dawson-Taylor, MD, was like many physicians who say that while their incomes are acceptable, they have to work too hard and too long for it. She felt that her income didn't match the effort she was expending for it and therefore wanted to leave her practice.

To resolve Dawson-Taylor's dilemma, we examined her books and found that her gross charges were in the 95th percentile. This level was higher than we would expect in her situation, a pediatrics practice in Denver with a high percentage of Medicaid patients. At the same time, what her staff collected was below the 50th percentile. Dawson-Taylor's frustration was appropriate: She was working harder and getting paid less than her colleagues.

After examining her books, we found that her billing and collection processes were inefficient. We helped her find the holes in her systems and recommended more rigorous processes and procedures to plug the leaks. Within two months, she had collected most of her "old dollars," and her collection rate was much more appropriate to her effort. She added \$250,000 to her annual income. As a result of these efforts, a good clinical doctor decided to continue caring for sick people.

Before undertaking these efforts, Dawson-Taylor hadn't disliked practicing medicine—even in the current managed care environment—but she hated running on a treadmill. When we examined the variables together, she found that the principle is right: Any of them can be changed.

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Facing Trials

Making a number of significant changes in one's practice may seem daunting at first, but once the process has begun, the effort—and the corresponding results—can be highly rewarding. This was the lesson Stacy Childs, MD, learned, after 25 years of practice as a urologist in Cheyenne, Wyo.

By almost any measure, Childs was successful. Yet, over the previous two years, he had lost his passion for practicing medicine. Clinical research, an exciting and lucrative part of his urology practice for 24 years, had become less rewarding because reimbursement had declined while the paperwork requirements were increasing. What's more, although he was honored to be appointed to the Wyoming Governor's Health Care Commission, he found the appointment to be time consuming and frustrating.

"It was also an eye-opener to the myriad problems in the health care system, not only in Wyoming but in all states," Childs says of his experience on the commission. "I became more and more disappointed in the lack of access to care for the uninsured and underinsured. And, I realized that all doctors are constantly in the crosshairs of trial attorneys—just waiting for an honest mistake to be called negligence."

Renewed Interest

Childs' exposure to health policy piqued his interest in medical liability problems. He took courses in medical malpractice and the law and began to serve as an expert witness in court cases. Soon, he became so involved that he started teaching seminars on malpractice and on testifying skills. "I thought my new career was born," he says.

While the work was challenging, practicing medicine while building a seminar business was extremely stressful. Being uncertain about how to proceed, Childs consulted a career spe-

cialist and learned that making a career change that would make his life less stressful was not only possible, but inevitable, he says. Through his work with a career consultant, Childs met a urologist in Steamboat Springs, Colo., who invited Childs to join his practice. Although continuing to practice medicine had not been his first choice, Childs reasoned that joining the urologist's practice would reduce his stress and provide cash flow while he started his seminar business. Also, the practice was convenient to his new home in Steamboat Springs, where he and his wife planned to retire.

In his new practice, Childs went from seeing 40 patients a day to seeing just 15, affording him more time for his other interests, he says. "In my new practice, I have been able to spend as

and cash flow to continue building his seminar business.

Managing Change

As these three physicians learned, making changes can be a challenge. But doing nothing might have been a mistake. Change can hurt when it's done to you; it's less painful, and perhaps even pleasant, when you make the changes.

Physicians who make changes in their careers find that they control all of the variables. Physicians who don't make changes when factors beyond their control are affecting them negatively soon learn that these factors could result in changes they may not like.

If practicing medicine seems like an obstacle not a challenge, if you feel

"Although my life was filled with stress and hard work, I assumed that I had to change occupations rather than locations."

—Stacy Childs, MD

much as an hour with difficult patients," he comments. "Some days I can have breakfast or lunch with my wife, and start work an hour later than in the past. And, the big plus: My new partner's office manager has trimmed overhead to about 60% of that of my former practice; my take-home pay has gone up rather than down."

Like many physicians, Childs had assumed that changing his work situation would be difficult if not impossible. "Although my life was filled with stress and hard work, I assumed that I had to change occupations rather than locations," Childs says. "I am now a urologist in a full-time practice that feels like part time. I feel that I can continue in this location and role until retirement age. Then, I'll revisit a career change into the seminar business." Meanwhile, Childs says that he will have the time

threatened, unhappy, or frustrated in your career, and if you like practicing medicine but hate the way you have to do it, then you are experiencing some of the symptoms that these three physicians once experienced.

As any physician knows, patients experiencing certain symptoms recognize that something is wrong, and the more intense the symptoms, usually the more threatening the disease. It's foolish and risky for them to ignore their symptoms or delay finding out what they mean; the sensible thing to do is to seek treatment. Likewise for physicians who are unhappy in their career: Consulting an expert who can offer good advice about what to do is often the most sensible thing to do.

—More information on physician practice strategies is available on our Web site (see page 16).

New Traditions Needed in Health Care

By John W. McDaniel

Since health care is one of the most traditional industries in the United States, it is imperative that the health care industry establish new benchmarks and break old barriers in order to make substantive progress in the future.

While almost everyone enjoys tradition in a variety of circumstances, people also develop new traditions over the years. For example, most people have pleasant memories involving traditions surrounding the holidays when they were children, but these traditions are usually modified or new ones are developed after they get married and have children of their own. The field of sports is an excellent example of breaking barriers through extraordinary human achievement and believing that “anything is possible.” The stock market is yet another example of barriers being broken: When the stock market index exceeded 10,000 several years ago, a barrier was broken that was previously thought to be impenetrable.

Achieving Superior Results

It is clear that those in the health care industry who continue to do the same old things in the same old ways will achieve the same old results. The

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challenge is determining how to raise the bar in order to achieve superior clinical and operational performance.

The five areas in which to leverage performance improvement in health care are reimbursement systems, billing and collection processes, accounts receivable management, operations improvement, and practice growth.

In the area of reimbursement systems, physicians continue to undercode (as well as underdocument) with respect to procedural coding. It is essential that physicians improve in this area, since coding and documenting properly usually lead to improved reimbursement and reduce the likelihood of payer audits. Physicians should keep in mind that one third of the areas in the work plan from the Office of Inspector General of the U.S. Department of Health and Human Services deal specifically with coding.

Furthermore, physicians must become more conscientious in their managed care contracting and refuse to accept any fee schedule that does not allow them to make a profit on every contract. While most physicians are reluctant to refuse to participate with managed care companies when they find the fee schedules to be unacceptable, they must have confidence in both their patients and their referral sources that their business will not appreciably suffer if they choose not to participate with certain managed care companies.

Managing Revenue

Perhaps one of the most important areas of establishing new traditions in health care deals with revenue cycle management, which includes billing, collections, and accounts receivable management. While most practices have finally accepted the fact that they must request copayments at the time of service (since these copayments are required by third-party payers), practices must also be more diligent in verifying and collecting patient deductibles at the time of service, as well as collecting for noncovered services and outstanding balances.

Even though most health care providers do not enjoy the higher levels of reimbursement and prompt payment turnaround they had experienced in the past, it is essential that practices manage all processes closely—from the treatment of patients to the collection of fees for services rendered. This scrutiny extends to ensuring prompt turnaround with respect to claim denials and rejections, ensuring payer contract compliance, and continually monitoring other critical areas of cash flow management.

In fact, accounts receivable management should be the number one priority among all medical practices, exceeding even physician compensation as their major concern. Historically, medical practices have sent patient statements sporadically and have been lax in making appropriate determinations for writing off patient accounts or sending the accounts for third-party collection.

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Accounts receivable management should be the number one priority among all medical practices, exceeding even physician compensation as the major concern among physician practices.

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Making Improvements

Peak performing medical practices send patient statements monthly. In fact, some practices alpha-sort their patient accounts receivable balances and send patient statements weekly in order to facilitate cash flow and reduce the number of telephone calls that their staff must make to collect overdue balances. Some practices use a variety of techniques to encourage prompt payment, such as allowing patients to make payment arrangements and issuing promissory notes.

Peak performing practices also send a final demand letter after 90 days in order to seek payment in full or to ask patients to make payment plan arrangements. If patients fail to comply, these practices refer the accounts to a third-party collection agency. While many practices use

ty of consolidating or centralizing services both within the practice and among practices of similar specialties.

Some practices also consider increasing the use of ancillary services for both patient convenience and as alternative sources of revenue. Many practices evaluate the cost and benefits of improving information technology for both clinical and practice enhancement.

Ensuring Satisfaction

In the past, physicians could always depend on their patients returning to them for their care; today, it is clear that patients have become more consumer savvy. Physicians in peak performing practices recognize that they need to implement various customer relation services to ensure the satisfaction of their patients.

Veterinarians and dentists have done an outstanding job of reminding patients about the need for semi-annual or annual visits, but primary care practices historically have done a very poor job in this most basic area of practice growth.

collection agencies, some practices use other alternatives, such as local credit bureaus, small claims courts, and patient financing companies. Some practices even use IRS Form 1099-C if they choose to write off as uncollectible an account that is more than \$600, since the money owed to the practice may be deemed income to the patient.

Areas for operational improvement involve finding ways to do more with less. For example, some practices review the mix of staff (such as the number of registered nurses, licensed practical nurses, nurse practitioners, and physician assistants) and consider the possibili-

One step to ensure patient satisfaction for primary care practices involves recalling patients who have not been seen by the primary care doctor in a year or more. Doing so reflects a commitment to quality of care and helps to ensure the perpetuation of patient appointments. Indeed, veterinarians and dentists have done an outstanding job of reminding patients about the need for semi-annual or annual visits, but primary care practices historically have done a very poor job in this most basic area of practice growth.

Many physicians are finding that they need to operate their practices

as a business that, like a retail business, must compete with other similar businesses to attract consumers. So, over the past several years, many physicians have opened urgent care clinics and offices in strip malls to attract more patients. In some areas, physicians have established clinics within grocery stores and in department stores. This trend is reflected in *Money* magazine, which has reported that consumers are beginning to shop for health care.

Finally, it is important for specialists to monitor both the volume and the quality of referrals from other physicians, since specialists should view physicians as their primary customer and seek ways to improve patient care as well as increase volume.

Developing New Traditions

Although there are many other strategies a practice may use to promote practice growth (such as determining the number and type of patients from various Zip codes), medical practices must develop new traditions to foster and implement strategic initiatives that will ensure their growth.

In light of today's reimbursement environment and patient expectations, it is clear that the traditional business techniques currently being used are antiquated. Furthermore, there remains a glaring absence of formality with respect to written policies and procedures for financial operations and quality assurance processes.

The bottom line is that medical practices must find ways to retool their clinical and business processes. By establishing new expectations for physicians, staff, and patients, they will be creating the new traditions that are necessary for future practice performance.

—More information on physician practice strategies is available on our Web site (see page 16).

What Physicians Can Expect From Consumer-Directed Health Plans



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helps insurance agents and brokers arrange group insurance coverage for employer groups; it also provides consultative strategies and administrative sales and marketing support for insurers. It specializes in fully insured employee benefits for small and midsize firms. In this interview, Hogan discusses the movement toward consumer-directed health plans with Richard L. Reece, MD, editor in chief.

Q: Is it true, as some observers believe, that health savings accounts and the evolution of the consumer-driven health plans will change the way health care is delivered?

A: Yes, I would say that is a fairly accurate characterization. The full consumer-directed marketplace is only three years old. But basically the same sort of perfect storm that occurred in the late 1980s and caused managed care to come about is happening again; namely, health care costs are rising out of control and cost-sharing responsibilities for employers and employees are increasing. The confluence of these trends is causing changes to occur in our marketplace.

Three years ago, the Internal Revenue Service interpreted Section

105 of the tax code to enable health reimbursement accounts (or HRAs), whereby an employer can set aside a sum of money for each employee. That sum of money can be used to take care of unreimbursed medical expenses (such as a doctor's bill), an over-the-counter medication, insurance coverage, or what have you.

That occurrence started a fairly vigorous discussion, which caused politicians to consider changing the traditional roles and responsibilities of the players in health care—employers, employees, and providers, as well as health plans—to generate some sense of price and quality transparency. The belief was quite simple: that if, in fact, employees and employers had more of a stake in the system, they would be more responsible in their spending habits, would spend better, would become more educated, and would seek adequate and appropriate information to make better spending decisions.

In turn, the Medicare Prescription Drug Improvement and Modernization Act of 2003 enabled HSAs to occur whereby we could combine a high-deductible health plan with a financial vehicle that was the responsibility of the individual employee. And it has spawned a kind of a feeding frenzy, if you will, with big health plans.

Speed-to-market development of these types of plans is causing the big health plans to spend millions of dol-

lars to get integrated products into the marketplace as quickly as possible to replace traditional homogeneous HMOs and point-of-service plans in which stakeholders don't have much responsibility. This big revolution is causing all the roles and responsibilities of all the players to change, perhaps most markedly those involving providers. To date, insurers and health plans have not necessarily focused on providers, but downstream providers probably will be among those most affected by this burgeoning marketplace.

Q: When you explain this new form of insurance to physicians, what do you say?

A: Basically, I've been talking about the new roles and responsibilities they will have. I'd say the primary reaction that I'm getting is one of shock: first, that it's coming so quickly, and second that the providers have not fully thought out this new relationship seriously and in depth.

The basic relationship between a patient and his or her provider will not necessarily be thrown aside, but employees will have more information than they have had in the past. Whether it's correct information or better information is not yet known. But employees will have more information and their expectations will be significantly higher than what they are right now relative to the adequacy of the service and the recommen-

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“To date, insurers and health plans have not necessarily focused on providers, but downstream providers probably will be among those most affected by this burgeoning marketplace.”

INTERVIEW

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dations that providers are offering to them.

Q: *One characteristic of consumer-driven health plans is information provided over the Internet that helps to make the features of all of these plans and the quality of care patients can expect to be somewhat transparent. How do these Web sites work?*

A: These Web sites are designed to be the primary portal or entrance for users of the health care system and to make employees educated consumers. Health plans have various tools that they provide over the Internet so that employees can make decisions.

The most popular tool and the first baseline tool that most users of health care navigate to is a prescription cost calculator tool. Since many employees have a number of prescriptions that they're required to take each month, this tool is the first level of consumerism for most employees coming into the consumer-directed health plan model.

Prescription cost calculator tools give employees a sense of the cost of the medications they're taking, and some contextual sense for the cost of a particular medication in relation to other medications that might be similar, but perhaps less costly. These tools may also give consumers a list of contraindications and other information related to the prescription. So, for example, an employee taking a cholesterol-lowering medication each month can ask his or her physician if there is a more appropriate or less expensive medication that would function the same as the one the employee is currently taking.

In fact, one health plan published data recently showing that these pre-

scription calculators had a distinct behavior modification effect, which is a primary goal of consumer-directed health plans. This behavior modification has caused the health care cost trend factor to go down. If people use generic drugs more than they use brand-name or formulary drugs, then the trend factor goes down significantly.

Drugs tend to be the entry level for these Internet tools. From there, consumers start to get more sophisticated. For example, most of these sites have glossaries of information or databases that the employee or the patient can use to learn about medical procedures, alternative treatment standards, state-of-the-art information on particular procedures, and clinical practice guidelines. Some of these sites actually go so far as to say what is the best practice for the treatment of a hip fracture or a certain type of cancer.

These sites enable employees to gather information so that when they go back to their provider, they can ask questions and have a sense of alternative remedies that might be appropriate for their situation.

There are also features on these Web sites that provide information on the providers so that users can report on how long it takes to get an appointment with the provider, how long the wait times were, and how pleasant the customer experience was in the waiting room, among other features. This is subjective information that gets posted on the Web site. And then there is information related to hospital outcomes, morbidity, and mortality. In general, this information is not terribly sophisticated even from the larger health plans, simply

because it's generally Medicare-reported information. There hasn't been good reporting on other types of information. But that situation is certainly changing.

The key to these Web sites and to these consumer tools is that they're changing rapidly. In health care, there's an information vacuum, and as users become consumers they demand more sophistication in these tools as they learn to navigate better so that they have more information with which to make decisions.

Q: *If a consumer needs a hip replacement, can that patient find the relative outcomes for this procedure in his or her region, for their hospitals, and for the orthopedic surgeons?*

A: Most of these tools have not yet gained the sophistication to get down to a provider level. But as these tools evolve and become more popular and as demand increases, consumer expectations will rise as well. Then, it is quite possible that individual providers will be graded based on their outcomes and experiences. The notion is that the consumer will be able to find the provider who is best suited to a particular procedure or condition and who has the best outcomes, and perhaps meets the best practice guidelines for that particular procedure.

Q: *When you meet with physicians, what questions do they ask about these plans?*

A: Providers have many fears and the biggest fear is that they will be forced to operate more as business persons and more like retail establishments. The idea behind consumer-directed health plans is that the consumer will be in a high-deductible health plan, meaning, in

"There are features on these Web sites so that users can report on how long it takes to get an appointment with the provider and how long the wait times were."

fact, that providers have to worry about whether the employee or the patient has adequate funds in that account to take care of the service.

That's a fear right out of the gate: Employees are responsible for as much as \$2,600 annually in some of these high-deductible plans, or as much as \$5,150 in a family plan at the high end of the deductible range. At the low end, the consumer is responsible for about \$1,100 for individual coverage and \$2,200 for family coverage, and all of this is before the insurer pays anything. That excludes preventive care, which is covered at 100% under most of these plans.

To be honest, providers are afraid of many things because consumer-directed health plans have turned health care upside down. If an employee is spending out of his or her own tax-free account, then the employee is likely to have a higher level of expectation that the service being provided or recommended by the provider is the best, is adequate, and is appropriate. Consumers may expect their provider to spend more time with them if they've been empowered with more information and if they're paying out of their own pocket.

Whether or not the information the consumer has is correct is another matter. That's a problem, since the National Committee for Quality Assurance has not come out with standards for these Internet sites for quality control and the adequacy of the information they provide. It is left to the provider to revise the information that the consumer is getting when necessary.

For a patient who has taken the provider's word on faith in the past, these plans could change fairly dramatically the nature of the relation-

ship between an employee and a provider. Now, consumers could challenge providers to prove that what they're recommending is correct. Consumers will know more about their ailments and these procedures and the interaction with their provider will become less faith-based and more knowledge-based.

Q: *In other words, a consumer might ask, 'Is this procedure you're recommending considered best practice?'*

A: Correct. Consumers are going to hold providers to a higher standard than they perhaps would have in the past.

Q: *Is it true that about 1% of the market is currently in consumer-driven health plans, and how are employers shifting going forward?*

A: About 90% of our new business for insurance programs that will be effective on Jan. 1 will be for consumer-directed health plans. In other words, employers are shifting to these plans and are looking at consumer-directed health plan strategies for one reason. Traditionally, the pricing band for HMOs and point-of-service plans has been very narrow. Namely, from the lowest copay, highest hospital deductible scenario, you'd have maybe a 10% or 12% difference in premiums.

The key to these new consumer-directed health plans is that the premiums can be as much as 40% less than the traditional HMO and point-of-service premiums. And virtually every employer wants to talk about consumer-directed health plans. The problem is that employees cannot have the image that they're being tossed off a cliff.

The art form, if you will, is in establishing strategies that will

encourage employees to participate or to provide financial incentives for employees to participate in consumer-directed health plans without having them think that they're getting tossed aside. The new health savings account product is ideally suited to such a strategy because employees can get residual benefits from using HSAs to participate in a consumer-directed health plan.

Under an HSA, if an employee doesn't use the money from his or her tax-free savings account, the employee can carry it forward from year to year, just as one would with a pension or a 401K plan. And the employee can use it much like an IRA upon retirement.

On top of that, employees are allowed to pay for a whole host of eligible expenses that might not necessarily even be covered under most health plans today. Simply stated, the strategy of taking employees from a traditional HMO or point-of-service plan to a high-deductible health plan is not that difficult if it's done in an incremental way. Doing it incrementally means not using a really high-deductible health plan in the first year.

What's more, a plan with an annual deductible of \$1,100 to \$1,200 can cost 20% less than the traditional HMO or point-of-service plan. Employers can agree to pay a higher percentage of the premium cost on these plans as a way to get employees into the plans. This is a simple strategy, and employees seem to like this idea of getting into consumer-directed health plans incrementally and of getting an additional potential retirement benefit.

—More information on physician practice strategies is available on our Web site (see page 16).

“Providers have many fears (about consumer-directed plans) and the biggest fear is that they will be forced to operate more as business persons and more like retail establishments.”

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