

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

January 15, 2001

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E-Health Plans Raise Questions for Physicians

Just when many physician group practices have figured out how to survive, if not thrive, under managed care, a new breed of health plans is emerging. Many companies are introducing next-generation plans designed to respond to discontent with managed care. The executives developing these new plans believe health care will evolve from being controlled by managed care organizations to being consumer-driven.

The companies dedicated to consumer-driven e-health care want to give consumers and physicians freedom from the restrictions common under managed care, and they want consumers to accept more responsibility for major health care decisions. In these plans, consumers themselves will control the selection of physicians and other providers and purchase health care services directly. Physicians will determine their own prices, care for patients without the burden of precertification or other external controls, decide how they will measure and document the quality of care they provide, and compete with one another for patients.

Internet-Enabled Purchasing
These new consumer-driven plans use the Internet to assemble and summarize comparative information on physicians' prices, practices, credentials, and quality. Consumers use tools on the firms' Web sites to assess, compare, and choose providers.

The basic question for physicians is

whether they believe the market is evolving away from traditional managed care and moving in the direction of the consumer-driven models. If physicians believe the market is shifting, then the next question to ask is whether they should participate in these new e-health plans.

"The market is changing and moving," says Dave Teckman, president and CEO of Vivius Inc. (www.vivius.com), a company in Minneapolis that enables consumers to contract with physicians directly. "The marketplace and the various models of e-health plans are aligning. The direction toward a consumer-driven system is beginning to emerge."

Starting early this year, Vivius will enable consumers to assemble their own panels of physicians and other providers. Consumers will use benefit contributions from their employers to purchase prepaid care from the providers they select.

"There is a substantial group of consumers who want to take control of—and responsibility for—their health care choices," says John Danaher, MD, president and chief operating officer of HealthMarket (www.healthmarket.com), a company in Wilton, Conn., that has created "The Exchange," an online service that consumers use to find physicians and other providers and to evaluate prices by medical specialty, condition, or service.

Today, many physician groups sign contracts with most of the managed

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Variety of Tools Helps Small Practices Compete

Physicians in small practices are at an administrative disadvantage when dealing with complex bureaucracies or when delivering complicated services. Physicians often describe difficulties of coping with these disadvantages as "the hassle factor."

Indeed, large group practices have administrative advantages over small groups, says Victor Fuchs, a professor of health economics at Stanford University. Large organizations have access to capital, which finances growth, he explains. Large organizations have more effective mechanisms for dealing with bureaucratic phenomena and they possess the management skills needed to organize complex technology, maximize the talent of specialists, and bring together professionals from different backgrounds to deliver services as a team. Since Fuchs first explained these advantages in an article in *Health Affairs* in 1982, three significant trends have changed the delivery of health care.

The first trend came in the mid-1980s when physicians began to use office-based computer systems. These systems were expensive, took time to learn, required staff training, demanded periodic maintenance, and mostly were used in physicians' back offices. Rarely did physicians themselves use these systems because they were not personally engaged in capturing or entering data.

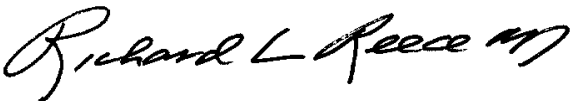
The second trend began 10 years later when physicians began to use the Internet. At first, the Web required physicians to use a keyboard to enter data into desktop or laptop computers. Those physicians who had limited typing skills or who were seeing patients in a variety of settings, found these computers to be inconvenient and therefore they had little utility at the point of care.

But by the late 1990s, came the third trend, the explosive growth of the Web and many sites that physicians developed to help meet their needs in their offices and at the point of care. Internet-savvy physicians who were practicing in clinical settings began developing applications that physicians could use to collect and review data while seeing patients.

These applications offered practical solutions to some complex administrative problems such as documenting medical histories, capturing accurate coding data, applying the right codes, and reducing the time required to see a patient. Physicians could use these applications to help increase their efficiency and productivity.

Throughout the past few months, we have written many articles that explain how physicians are using new technology to improve their performance. We will continue to do so in the months to come.

While these tools may not be making it any easier to practice medicine today, they are certainly helping to expedite many of the more arduous tasks in a physician's office and are helping physicians to compete in ways that were not possible 10 or 15 years ago.



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OIG Unveils Work Plan for 2001

By John W. McDaniel

For physician groups treating Medicare patients, a new work plan for the year from the Office of Inspector General (OIG) shows that the OIG will examine physician-billing patterns regarding patient care. The work plan from the OIG of the federal Department of Health and Human Services clearly demonstrates that it wants physicians to substantiate medical necessity through appropriate and complete documentation and to make appropriate and accurate links between diagnosis coding (ICD-9-CM) and procedural coding (CPT-4).

The work plan for 2001 released in November identifies nine areas in which it will concentrate its investigations this year. Given the OIG's intense efforts to curb what it believes are fraudulent and abusive patterns of behavior among health care providers, all medical practices should be developing and implementing medical practice compliance programs, particularly for coding and reimbursement.

In September, the OIG recommended that all physician practices establish standards for complying with federal regulations regarding Medicare reimbursement by developing a code of conduct and by writing policies and procedures to ensure compliance. In making its recommendations last year, the OIG issued guidelines to help explain many issues particularly troubling to physi-

cians. (The recommendations, *Compliance Program Guidance for Individual and Small Group Physician Practices*, are on the Internet at www.hhs.gov/oig/new.html).

Physicians should take advantage of the fact that the OIG is one of the few federal agencies that issue reports in advance of its investigative plans for the future and be mindful of these specific target areas.

In addition to listing nine areas specific to physician practices where it will concentrate its auditing and investigative efforts this year, the OIG has identified other

repayments by many teaching hospitals since prior OIG audits have found that physician services were not billed at the correct level. This area is being continued for investigation in order to verify compliance with Medicare rules.

2. Reassignment of physician benefits. The OIG will evaluate the practice of allowing physicians to reassign their billing numbers to clinics. Clinics that employ more than one doctor may accept reassignment of the physicians' billing numbers, thus allowing the clinic to handle all billing and keep all fees for physician-

One of the few federal agencies that issue reports on its future investigative plans, the OIG has listed its specific target areas for the year.

areas of investigation as well (see sidebar). The nine areas are:

1. Physicians at teaching hospitals
2. Reassignment of physician benefits
3. Podiatrists' Medicare billings
4. Podiatry services
5. Advance beneficiary notices
6. Critical care codes
7. Bone-density screening
8. The role of nonphysician practitioners
9. Services and supplies incident to physicians' services.

1. Physicians at teaching hospitals (PATH). This initiative is designed to verify compliance with Medicare rules governing payment for physician services provided in teaching hospitals and to ensure that claims accurately reflect the level of service provided to patients. Previous OIG work in this area suggested that many providers were not in compliance with applicable Medicare reimbursement policies.

PATH audits have led to huge

provided services, usually in exchange for paying a flat fee or salary to the physicians. Known as reassignment of benefits, this practice is convenient for physicians and the clinic business office. Typically, in these instances, the physician never sees what is billed under his or her physician number. This practice shifts the accountability and liability for billing abuses away from the physician to the clinics. The OIG will examine past reassignment abuses to determine specific vulnerabilities.

The issue of reassignment has led to upcoding in some cases and can increase the potential for fraudulent claims. Physicians need to evaluate the practice of reassigning their billing numbers to clinics because the OIG is focusing on the "855 Reassignment Form," believing that it has become a document that can be used for fraud and abuse.

3. Podiatrists' Medicare billings. The OIG wants to determine the

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extent to which podiatrists improperly bill Medicare. An OIG audit of a podiatrist in one state disclosed an error rate of 99%, and the OIG believes it has anecdotal evidence that suggests that claims from other podiatrists may represent a significant problem.

By focusing on podiatrists, the OIG may be signaling that it believes there is a general lack of knowledge among this group of specialists about the appropriate use of evaluation and management codes. Obviously, the OIG would be concerned about any lack of knowledge because many physicians already have insufficient or poor documentation and often fail to provide substantiation of medical necessity. Audits of podiatry practices have found high billing error rates and upcoding in several states, and prior settlements indicate that some podiatrists have billed for medically unnecessary services or for services never provided.

4. Podiatry Services. The OIG will review a sample of podiatry claims to determine if the services have met the coverage policy of the federal Health Care Financing Administration (HCFA), which runs Medicare, and to gain a better understanding of the factors affecting what the OIG considers an extreme variation in allowed charges per thousand beneficiaries. From 1992 through 1995, for example, Medicare expenditures for nail debridement increased 46%, while Medicare expenditures for all other Part B services increased only 18%.

Earlier OIG audits have shown an apparent failure by podiatrists to meet the Medicare definition of "reasonable and customary services." Furthermore, the OIG believes podiatrists generally are not as familiar as other specialists are with the logic behind linking appropriate procedures to a specific diagnosis.

5. Advance Beneficiary Notices (ABNs). The OIG will examine the

Other Areas of Interest

In addition to the nine primary areas of interest that the Office of Inspector General (OIG) has identified in its work plan for this year, the OIG of the federal Department of Health and Human Services has outlined several other physician-related target areas that it will focus on this year. Among these areas are the following:

Clinical Laboratory Improvement Amendments (CLIA) Certifications. The OIG will determine whether laboratories are conducting tests and billing Medicare within the scope of their certifications under the CLIA.

Medicare billings for cholesterol testing. The OIG will determine whether cholesterol tests billed to Medicare are medically necessary and coded accurately. Total cholesterol testing can be used to monitor many patients, but Medicare claims show a preponderance of billing for lipid panels, which include HDL cholesterol and triglycerides also.

Rural health clinics. The OIG will follow up on its previous study of rural health clinics to determine whether its recommendations have been implemented.

Physician incentive plans. The OIG will review physician incentive plans included in contracts between physicians and managed care organizations. As part of this review, the OIG will consider clauses in these contracts that could affect the quality of care.

Medicare Part B. The most common Part B violation involves false provider claims to obtain payments. The OIG will investigate a broad range of suspected fraud and present cases for both criminal and civil prosecution.

Outpatient prospective payment system. The OIG will evaluate the effectiveness of internal controls, coding, and whether the services provided are medically necessary. Physicians should pay particular attention to coding for evaluation and management and critical care.

—JWM

use of ABNs, which physicians must give to Medicare beneficiaries prior to treatment if they provide services that they know or believe Medicare does not consider medically necessary or for which Medicare will not provide reimbursement. The OIG also will examine the financial effect of ABNs on beneficiaries and providers. OIG has evidence that the use of ABNs varies widely.

6. Critical care codes. The OIG will examine the use of two critical care codes that may be billed to Medicare only if the patient is critically ill and requires constant attention by a physician. Payment for critical care is based on the time spent with the patient. The OIG will examine

claims data to determine whether some physicians may be billing inappropriately for critical care and identify any other potential vulnerabilities.

7. Bone-density screening. The OIG will evaluate the effect of the recent standardization and expansion of Medicare coverage for bone-density screening. As the number of claims for bone-density screening increases, there are questions about the appropriateness and quality of some services.

When billing for bone-density screening, physicians should be aware that this issue relates to medical necessity since many physicians do not meet screening requirements when billing for this test. Also, it is

Practices using nurse practitioners, clinical nurse specialists, or physician assistants need to understand that the OIG's major concern involves quality of care issues.

important to link the appropriate procedure to the patient's diagnosis.

8. The role of nonphysician practitioners. The OIG will describe the scope of services that nonphysician practitioners provide to Medicare beneficiaries and identify any potential vulnerabilities that may have emerged since the Balanced Budget Act was passed in 1997.

For practices that use nurse practitioners, clinical nurse specialists, or physician assistants, it is important to identify the scope of services these individuals provide to Medicare beneficiaries and understand that the OIG's major concern involves quality of care issues. The OIG wants to determine whether physicians are improperly billing for services provided by nonphysician practitioners.

9. Services and supplies incident to physicians' services. The OIG will evaluate the conditions under which physicians bill "incident-to" services and supplies. Physicians may bill for the services provided by allied health professionals, such as nurses, technicians, and therapists, as incident to their professional services. Incident-to services, which are paid at 100% of the Medicare physician fee schedule, must be provided by an employee of the physician and under the physician's direct supervision. Because little information is available on the types of services being billed, questions persist about the quality and appropriateness of these billings.

"Incident to" billing and the issues involving "physician direct supervision" have been a concern for the OIG for some time. Physicians should evaluate the appropriateness and quality of these billings since the OIG's focus is on whether physicians are on the premises to supervise these medical services properly.

As with any matter involving Medicare and the OIG, it is extremely important that physicians first understand all of the issues. Then, physicians must review their practices to ensure that they are in compliance. The best way to ensure compliance is for physicians to follow the OIG's recommendations to develop and implement a medical practice compliance program for coding and reimbursement. Having such a program may be the only way to help prevent an audit and avoid a penalty. ■

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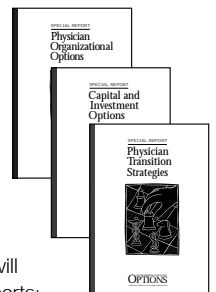
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Five Principles of Organizing Practices

By Thomas M. Gorey, JD

Since starting this column two years ago, much has changed about physicians' organizational options, yet much remains the same. It is still true, for example, that there are no guarantees of success.

Among the other issues that have remained unchanged in the past few years are some fundamental principles and strategies that all physician organizations should incorporate into their planning processes. When physicians take a disciplined, informed approach to organizational planning and development, they increase the likelihood of a positive outcome. In addition to planning well, physicians need to have sound, reliable data on both the local market and their own practices. They need to monitor patient satisfaction closely and regularly, and they need to implement effective contracting strategies that rely on accurate data. Finally, they need adequate information systems to meet the practice's contracting, management, and quality-related needs.

Physicians can increase their chances of success if they apply the following five principles:

1. Know your competition.
2. Recognize that strategy development factors have remained unchanged.
3. Collect and use the right data.
4. Keep patients satisfied.

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5. Develop an effective contracting strategy.

1. Know your competition. Looking at the health care environment broadly, the level of competition remains high. Whether at the individual physician level, the physician-organization level, the physician-hospital organization level, the health-system level, or at the health-plan level, there is intense competition that did not exist a decade ago. Practicing in such an environment makes it critical for physicians to reassess their practice options carefully and periodically to ensure that they have positioned their practice optimally in the market.

For those physicians in markets with significant managed care enroll-

ment, there is the added pressure of determining how to work with managed care plans. The number of options available can seem overwhelming at times, but by taking a rational approach to analyzing the competitive market and your options, the most appropriate practice organizational strategy should emerge.

Therefore, it is important for physicians to do some self-analysis when starting any organizational planning.

The fourth consideration is the current managed care climate in the community. Developing a practice development strategy without having a keen understanding of the dynamics of the local market has been the demise of many physician organizations. Ensure that whatever strategy is implemented will match the prevailing environment and be marketable to payers.

The last consideration is market competition. In preparing a practice development strategy, it is important to have an understanding of the provider base in the community and the supply and demand for primary and specialty services.

The first consideration is the physician's long-term goals. Having a vision of the ideal type of practice can be a motivating force to take action to make that vision a reality.

The second is the physician's

career stage. Age is simply one factor that often influences the types of career choices physicians make. A mid-career physician and those who are just establishing their practices may consider it important to assess carefully the future of the market for physician services and to plan accordingly. In some cases, bolder strategies may be warranted.

Physicians should reassess their practice options periodically to ensure that they are well positioned in the market.

3. Collect and use the right data.

Groups succeed when they compile data on physician referral and utilization patterns and use the data to modify behavior.

The characteristics of the market are a significant consideration when developing a practice organizational strategy. Therefore, it is important to conduct a market analysis prior to settling on a practice development strategy. Frequently, this is a service health care consultants will provide.

A market analysis will provide detailed, current, and projected demographic information on the population and data on the number, location, specialty, and age of physicians providing medical services in the primary and secondary service areas. The analysis also will provide information on managed care organizations in the market.

It is also critically important to have detailed internal data on the practice. With key information on the physician's patient demographics and practice characteristics, it is possible to assess the practice's strengths and weaknesses and practice alternatives.

Examples of the type of information physicians should collect include the

- Number of active patients and average number of patient visits per week
- Number of annual visits and percentage distribution by age
- Number of new patients and patients who leave the practice per year
- Number of referrals and referral sources
- Number of in-office ancillary procedures per patient per year
- Payer mix
- Services provided by CPT code
- Most common principal diagnoses
- Practice expenses and overhead

Having detailed, reliable data of this type allows physicians to negotiate from strength.

4. Keep patients satisfied. One fact that has never changed is the

importance of building and maintaining a patient-centered practice. Given the recent increased emphasis on quality, it is more essential than ever to monitor patient satisfaction regularly and make improvements as needed.

Information to be gathered should include patient feedback on waiting time in the office, length of visit, information provided by the physician, nursing service, scheduling of services, availability of appointments, and referrals.

5. Develop an effective contracting strategy. Among the many reasons to form a physician organization are gaining economies of scale, enhancing one's market clout, and providing better patient care through closer professional collaboration. But often the driving factor is that physicians are interested in positioning themselves more effectively for contracting with payers. Almost without fail, this goal emerges as a prime consideration during organizational planning. After forming a new physician group or network, it is not uncommon for physicians to encounter unexpected problems along the road toward accomplishing this goal, however.

Among the most common obstacles that thwart physicians' efforts is a lack of information or naivete regarding payers. The adage, "Build it and they will come" unfortunately is an apt characterization of many physician organizational-planning efforts in recent years. If a critical goal in forming a new physician group is enhanced managed care contracting, it is important to gather as much information as possible about all payers.

Another common obstacle is inadequate information systems. It is extremely important for physician

groups to have an organizational infrastructure that can support contracting efforts.

For many physician practices—especially those that are new to managed care—a typical obstacle is seeking short-term gains rather than a long-term relationship with payers. Often, physicians consider payers to be "the enemy" in contracting situations, but if a new physician group or network is to contract successfully, physicians should view payers as "the customer." Building long-term relationships with payers can be in the best interests of physicians, payers, and patients.

One of the most difficult obstacles to overcome is inadequate or inequitable physician compensation systems. Groups formed in anticipation of enhanced contracting opportunities often overlook the fact that no amount of contracting success will overcome an inequitable compensation scheme. While achieving true equity in physician compensation plans is probably unattainable, a physician organization nonetheless must find a common ground around which all of its members can be reasonably content.

Another difficult obstacle is nonexistent or underdeveloped medical management processes. These processes play a key role in the group's ability to succeed in managed care contracting. Groups succeed when they compile data on physician referral and utilization patterns, share that data with member physicians, and have the group's medical director use the data to encourage appropriate modifications in behavior. Unless a medical group or network can achieve clinical and administrative efficiencies—and improved outcomes—it is not likely to be successful in managing contract risk. ■

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care plans that operate in their markets. Should physicians also sign up with all new e-health plans? Lee N. Newcomer, MD, the executive vice president and chief medical officer of Vivius, suggests assembling a diversified portfolio.

"Physicians need to affiliate with

established managed care organizations," Newcomer explains. "They are like blue chip stocks. Physicians also should experiment with some e-health plans, which are like growth stocks that may take off."

Park Nicollet, a large, multispecialty group practice in Minneapolis, is

participating in Vivius and Definity Health (www.definityhealth.com), a company in Minneapolis that, like Vivius, relies on a defined contribution benefit from employers. Under a defined contribution approach, an employer would pay each covered employee a fixed annual amount for

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E-Health Plans Roll Out Offerings

One of the most basic issues about e-health plans involves how they work. Three e-health plans—HealthMarket, in Wilton, Conn., and Vivius and Definity Health, both in Minneapolis—illustrate how consumer-driven health plans function.

HealthMarket (www.healthmarket.com) has created what it calls "The Exchange," an online service that consumers use to find physicians and other providers and evaluate prices by medical specialty, condition, or service. Physicians, group practices, and health systems formulate and submit prospective prices for 105 different episodes of care, sets of services, and procedures that form a package of care for various conditions. John Danaher, MD, HealthMarket's president and chief operating officer, explains that episodes enable consumers to pay for care in the way they actually experience care—in an episodic fashion. His company is devising its own episodes of care based on detailed analysis of medical claims.

HealthMarket is making The Exchange available to insurers and managed care organizations. In addition, the company offers its own insurance coverage underwritten by Centre Insurance, part of Zurich Financial Services Group of Zurich, Switzerland.

Definity Health (www.definityhealth.com) relies on a defined benefit contribution from the employer and has three core components. First, it provides health insurance with deductibles, coinsurance rates, and annual out-of-pocket limits determined by the employer. Second, an employer-funded personal care account functions like a medical checking account that consumers use to pay for medical care, prescription drugs, or other health-related products or services. Third, a personal health advocate is a set of online resources for consumers, such as customized home pages with appointment and drug refill reminders, personal health records, and condition-specific health education.

Vivius (www.vivius.com) also bases what it calls a personalized health system on a defined benefit con-

tribution from the employer along with an insurance plan and personal spending account.

"We are not sure that consumers want to shop for specific services and procedures in a spot market," says Lee Newcomer, MD, executive vice president and chief medical officer of Vivius. "We are convinced that consumers desire greater freedom and that the freedom they want is the ability to pick health care professionals they know and trust, whose values match their own, and with whom they want to build an ongoing patient-doctor relationship."

Consequently, in the Vivius e-health plan, consumers build their own provider networks. Vivius has developed 23 categories across medical specialties, such as primary care, orthopedics, general surgery, and mental health. Physicians, group practices, and other providers select the categories they want to price and then establish their own monthly prepaid fees by groups of patients categorized by age and sex. Unlike capitated plans, physicians set their own prices. Also, in the Vivius model, there is no pooling of risk across large groups of physicians, and the physicians' monthly fees do not cover hospital or pharmacy costs. In sum, the prepaid fees represent the monthly amounts physicians decide to charge for their own services within the Vivius categories.

Employer groups offering the Vivius personalized health plans provide insurance and a set monthly amount for each employee's personal account. Consumers start by choosing a personal physician, who may then help them complete their provider panels. As the consumer picks providers among all 23 categories, a calculator on the Vivius Web site shows a running total of the monthly cost of their panel versus their account budgets provided by their employers. So, as they assess the fee differences among competing physicians, they have a financial incentive to use the practice, credentialing, and quality information on the Vivius site to compare providers and shop for the best value.

—DA

(Continued from page 8)

health care based on the employee's age and sex. An employee seeking care could use all or part of his or her contribution to pay for the costs of care. Few companies currently offer defined contribution plans.

"When assessing new e-health plans, group practices should look carefully at the same basic issues that they examine with their managed care contracts," advises William Telleen, vice president of payer relations for Park Nicollet. It is particularly important to understand exactly how the plans work, including payment requirements, policies, procedures and the financial risks, he adds.

Danaher of HealthMarket agrees. "Physicians must be able to price their services intelligently under e-health plans' various models and understand precisely who gets paid for what, by whom, when, and how," Danaher says.

Intensifying Competition

Another important issue for physicians involves quality of care. The e-health plans intend to give consumers comparative information on the quality of care physicians and other providers offer. Tom Valdivia, MD, chief medical information officer of Definity Health, says, "To be successful, physicians will have to focus on information that consumers want to know."

"Physicians should consider collecting and documenting information on patient satisfaction and patient-centered outcomes," says Kevin Kearney, CEO of Point-of-View Survey Systems Inc., a company in Denver that specializes in patient-reported data management solutions for physicians and health care organizations. "By demonstrating quality from the consumer perspective, physicians will strengthen their ability to compete in a consumer-focused market."

Given the importance of the Internet in e-health, physicians must understand the comparative information and online resources that e-

health plans will give to consumers. And, it is critical for physician groups to build and maintain their own Web sites, insist upon having links from the e-health plans' sites to their own, and ensure accuracy and consistency in the information presented about their practices.

Moreover, according to Newcomer, physicians should begin considering enabling patients to schedule appointments directly via the Internet. "This convenience will be highly prized by online consumers and will be a clear competitive advantage," he says.

Recognizing the potential for growth, Park Nicollet wants to contract with e-health plans.

Telleen agrees. "If you cannot satisfy consumer expectations for access, they will go elsewhere," he cautions. "The dynamics of e-health will intensify competition in a consumer-driven market."

Group practices also should assess what types of consumers are most likely to be among the first to use e-health plans to shop for health care online. These consumers are likely to be informed, engaged patients who use the Internet to educate themselves so that they can take an active role in their own health care, Telleen says. Physicians will have to treat these patients as partners in the process of patient care and consider using the Internet to provide them with regular updates on relevant, diagnosis-specific information, he adds.

Questions To Answer

Physicians seeking to position their practices for success in e-health plans want to know what it will take to be successful, if the market becomes more consumer-driven as e-health plans envision. Given that these plans are so new, it may not be possible to get definitive answers right away.

Definity Health, for example, is

taking an incremental approach to pricing the services of physicians and other providers. It is asking physicians and other providers to supply information on their usual and customary fees plus the percentage discounts they are willing to offer to consumers covered by Definity Health, Valdivia says. During the next 12 to 18 months, the company will formulate an approach that fits between pricing for individual procedure codes and comprehensive episodes of care.

Despite the progress these and other companies are making, the

question that remains unanswered is whether e-health plans will replace managed care. For these plans to be successful, consumers will need to accept much more responsibility for managing their own health and health care decisions, and they will have to pay for those decisions.

"It remains to be seen if consumers are sufficiently discontent to declare independence from managed care and get more rights and real responsibility for their health, selection of providers, and the costs of their decisions," Miller says.

Recognizing the potential for growth, Park Nicollet wants to be involved from the beginning. "We support these new ventures because they have the potential to change the dynamics of pricing and help us forge direct relationships with patients," Telleen explains. "Physicians should get involved in e-health early, before the new plans really start to grow. Low initial volume reduces the risk of experimenting and learning how to be successful."

—Reported and written by David Aquilina, a consultant and health care writer in Minneapolis. More information on practice strategies is available on our Web site (see page 16).

Working With Alternative Providers

Neil Baum, MD

Alternative medicine is here to stay. Over the past few years, the number of patients turning to alternative medicine for the treatment of their illnesses and conditions has been rising steadily. Physicians who treat patients have seen dozens of consumers who self-treat with saw palmetto for benign prostatic hyperplasia, yohimbine for erectile dysfunction, St. John's wort for depression, and Chinese herbal medicines for prostate cancer. While alternative medicine may be anathema to many mainstream physicians, there are ways to make your practice more attractive to patients who also are seeking care and advice from alternative health care providers.

Alternative or complementary medicine can be defined as any non-traditional health care treatment used by providers to replace the popularly accepted and practiced treatments. These alternatives usually are not taught in medical schools or practiced by conventional allopathic physicians. Examples of alternative medicine include acupuncture, hypnotherapy, massage therapy, chiropractic medicine, herbal and nutritional supplements, homeopathy, and even prayer.

Out-of-Pocket Payments

Research shows that many Americans have sought treatment from nontraditional physicians and

other providers. In 1997, for example, 40% of Americans sought a complementary or alternative medicine for an illness or pain-related complaint. They paid out-of-pocket an estimated \$27 billion for these services. What's more, the number of visits to alternative practitioners increased by 50% between 1990 and 1997. Patients made 700 million visits to these providers in 1999, while making only 340 million visits to conventional physicians.

While these patients are willing to pay out-of-pocket for alternative

key to patient satisfaction.

- Guide patients to the best alternative medical sites on the Web.
- Generate referrals from alternative providers.

Make alternative medicine an ally not an adversary. Physicians who view unconventional therapies as an opportunity can incorporate alternative medical options into their conventional medical practices. Many use nontraditional treatments to complement traditional therapy. Using conventional medicine as the primary method, physicians allow the other forms of thera-

Since alternative medicine is attracting hundreds of thousands of Americans, perhaps we can do more to meet our patients' needs.

medicine, some insurers are now paying for certain kinds of alternative medicine.

Physicians who understand why patients use alternative therapy can adapt their practices to meet the needs of these patients. Many patients believe that conventional therapy does not offer sufficient relief from their symptoms and that alternative therapies are more cost-effective and have fewer side effects. Using this knowledge, physicians can be more successful at attracting patients who might otherwise seek care from a nontraditional practitioner by taking the following steps:

- Make alternative medicine an ally not an adversary
- Revise your patient questionnaire to include queries about alternative therapies, herbal medications, and over-the-counter drugs.
- Remember that comfort is the

py to support their treatment. The most popular integrative approaches include physical therapies such as yoga, massage, chiropractic services, and acupressure. Mind-body techniques such as biofeedback, hypnotherapy, and meditation also supplement traditional therapy.

Years ago, traditional physicians discouraged patients from using alternative therapies. But today, patients may not accept doctors who belittle or frown upon alternative solutions. If the physician is insensitive or resists the use of alternative therapies, patients may be reluctant to discuss their treatment with alternative providers and may seek care from another physician.

Revise your patient questionnaire. Include queries about alternative therapies, herbal and over-the-counter medications. An effective questionnaire should give

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patients a chance to report their participation in alternative health care modalities. Be careful in your questionnaire, however, not to single out alternative medicine as if you disapprove. Instead, include questions about alternative medicine with the overall medical history. You might ask each patient to name his or her primary care physician, specialists, and any alternative health care providers the patient has used previously. You also might ask what type of medications the patient is taking, including prescription and over-the-counter drugs, and herbal therapies.

The answers to these questions will help you qualify the patients' interest in alternative health care so you can incorporate appropriate alternative therapies to meet your patients needs.

An estimated 15 million Americans who take herbal medication have the potential for a dangerous interaction between their prescribed medicines and OTC drugs or herbal medicines. Because herbal supplements are not technically considered drugs, the federal Food and Drug Administration cannot force the herbal industry to provide scientific data on the ingredients.

Remember that comfort is the key to patient satisfaction. Make every effort to provide a positive experience for your patients. You may offer soothing music through headphones or invest in a machine that makes natural sounds. Herbal teas, bottled water, and other healthy food and liquids may calm patients and keep them feeling comfortable. Your reception area should be pleasant and have an array of magazines and journals that demonstrate your comfort level with alternative and complementary medicine, such as *Prevention Magazine* and *Vegetarian Times*.

Guide your patients to the best alternative medical sites on the

Web. Many studies have shown that patients learn about alternative therapies from the Internet. You can show your acceptance and knowledge of this subject by having articles and information on your Web site and links to reliable alternative medical resources. Also, offer a pamphlet or a brochure that lists Web sites you have visited and trust. Make sure to provide Web sites that are truthful, unbiased, informative, and relatively easy to use. Try to lead patients to sites that are strictly for information, rather than trying to sell a product. Often the sites that try to sell products do not mention potential side effects of these products. Information sites are more comprehensive and offer an unbiased approach. It is also advisable to check any sites you recommend every month or so to make sure they are still operating and offering the same reliable information you found previously.

Generate referrals from alternative providers. Traditionally, physi-

cians have looked to other physicians as the primary source of patient referrals. But alternative health care providers can serve as excellent sources of new patients as well. A successful practice will identify the alternative providers who have the potential to refer patients.

Alternative medicine is attracting hundreds of thousands of Americans. Perhaps physicians have to do some soul searching to recognize that we are not meeting the needs of our patients fully and they are turning to alternative providers for help and assistance. We can turn this trend in our favor by making an effort to incorporate certain aspects of alternative therapies into conventional medicine. Those physicians who have been successful at embracing alternative medicine and integrating it in their practices such as Andrew Weil, MD, and Deepak Chopra, MD, have viewed alternative medicine to be an opportunity not an obstacle. ■

Reaching Out Produces Results

As a practicing urologist, I have some interest in the urologic complications, such as impotence and incontinence, in men with back pain. Therefore, a few years ago I asked a chiropractor who has referred patients to me if I could address his professional organization.

Since chiropractors see many patients with chronic back pain, I suggested a talk on urologic complications associated with back pain among men. In my presentation, I emphasized the basic philosophy that the two specialties have in common: that our fundamental purpose is to ease pain and make patients feel better. I showed slides from both medical and chiropractic texts, pointing out the common areas of education.

Finally, I ended the presentation with a discussion of current treatments of urologic problems, including new surgical and nonsurgical treatments. I also handed out recent articles on the subject, patient brochures, and an algorithm for evaluating impotence and incontinence. Additionally, I reviewed indications for urologic referral.

After the meeting, I sent a letter to all attendees thanking them for the opportunity to address them and inviting them to my office if they were in the area. As a result of this presentation, I have received two to three referrals a month from chiropractors, and two chiropractors have become patients. Also, I've been asked to address a meeting of the Louisiana Chiropractic Society.

—NB

Medical Groups Need Professional Management, Physician-Executive Says



Michael Guthrie, MD, MBA, is executive vice president of Premier Practice Management, a division of Premier Inc., a health care alliance

in San Diego. He is responsible for the development and medical management of physician practice services. A physician executive since 1979, Guthrie has served as CEO of the Good Samaritan Health System in San Jose, Calif. He was formerly chief operating officer for the Penrose-St. Francis Healthcare System in Colorado Springs, Colorado. He is board certified by the American Board of Psychiatry and Neurology and was in private practice prior to becoming a physician executive. He is a frequent speaker for national organizations on health care issues including physician leadership, physician organizations, and marketing. He also is a member of the editorial Advisory Board of Practice Options. Readers may contact Guthrie by phone at 858/509-6800 or by e-mail at michael_guthrie@premierinc.com. Richard L. Reece, MD, editor-in-chief, conducted this interview.

Q. What services does Premier Inc. offer?

A. Premier Inc. is a national health care alliance based in San Diego that comprises approximately 900 owned hospitals and 800 affiliated hospitals around the country. About five years ago, Premier executives noted that many Premier hospitals either had financial problems or were about to experience financial problems following their rush to acquire physician practices. As a result, Premier Inc. created Premier Practice Management, a division that could

assist hospitals with activities related to integration and offer models for physician-hospital partnerships that did not require hospital ownership of medical practices.

Since that time, Premier Practice Management has become an operating company that provides five levels of services to hospitals and physicians. One such service is transition management, in which we provide plans for transitioning practices from hospital ownership back into private practice.

Second, we provide management services that hospitals can offer to physician groups.

The third service we offer is IPA and network management. This service has been particularly relevant in California, where medical groups are having a tough time succeeding in the market.

Fourth, we maintain a broad and active consulting practice called HPENPlus. Premier has joined forces with a well-known group of consultants called Healthcare Practice Enhancement Network, in Los Angeles. Through this team, we provide soup-to-nuts consulting services—anything that hospitals need on a specific project basis. We also have begun to offer these services to prominent physician groups that are not hospital-based.

Fifth, we provide project management for hospital-owned and independent physician groups that have a specific, usually time-limited problem, such as the installation of a new information system or a restructuring of a billing office.

Q. How has the health care environment affected physicians?

A. Physicians who are experiencing this market turbulence are

not just those whose practices are owned by hospitals, but include those who are in private practice. All of these physicians are realizing that they are moving into a different era that is requiring them to pay a great deal more attention to issues they never learned about or that never before held their interest, such as compliance, information technology, contract assessment, organizational affiliations, and sources of patient volume. All of those issues fall under the business side of medical practice—and the business of medicine is not easy. In fact, it is difficult for practice managers—and nearly impossible for physicians—to stay abreast of all the changes and the implications of those changes for medical practice.

Let's consider the Health Insurance Portability and Accountability Act (HIPAA), also known as the Kennedy-Kassebaum Act. An important section of the act relates to the privacy and security of personal health information and the transmission of health information for billing, referral authorization, quality improvement, and other purposes to third parties other than the practitioner and the patient. What does HIPAA mean for the average physician practice in terms of the management of practice records and other operational considerations? Physicians will have to think through how they handle the security of both electronic and paper patient records, and how to follow the act's explicit rules concerning privacy and confidentiality.

Physicians also will have to ensure that all entities with which they do business comply with these regulations. In addition, the transmission of records will eventually have to be in a standardized elec-

“Internet technologies offer the opportunity for small practices to stay small and independent while at the same time acting like a larger business.”

tronic format that potentially will have an effect on office systems, requiring information system upgrades and ensuring connectivity with third parties. Those are just some of the general areas of this one act. Every practice will have to learn to meet HIPAA guidelines or risk federal penalties.

These are the kinds of issues that physicians must face when managing the business of a medical practice. On top of all the market changes and declines in compensation in many markets, these issues have physicians feeling overwhelmed.

Q. *What value does Premier bring to clients?*

A. Physicians and health care administrators need guidance regarding strategies that can work. Some strategies will not work, despite the conventional wisdom. We have the expertise to say, “We’ve seen 100 organizations try this strategy and it has never worked.” We can help organizations choose a different strategy and offer some do’s and don’ts based on our expertise. When we’re consulting, we amass a significant amount of knowledge, information, and statistical data that we use to benchmark. As a result, we can provide informed advice. We also go at risk for the success of our performance. We expect to share the business risk with physician groups or our client hospitals.

Q. *What determines whether a strategy will work in a given situation?*

A. First, demographic context is important. What works in California may not work in Jackson, Miss. Size is important as well. What works in a 15-physician group will definitely not work in a 50-physician group. Specialty focus is important too. There are important differences in operations among specialty groups

and between primary care and multi-specialty groups. Finally, group culture and strategy are important. Does the group want to grow? How does it want to grow? How does it want to affect its community? The answers to these questions will drive strategy.

Q. *Have you noticed significant regional trends away from capitation and toward fee-for-service?*

A. Any trend away from capitation is different in California than it would be in other parts of the country. In California, there’s an infrastructure and a long history that led us to where we are today in terms of capitation, the development of medical groups that assume risks, and all the struggles that contributed to physicians’ learning to manage risk. Despite practice failures in California, there is an expectation around capitation that’s quite different from other markets where capitation started incrementally and where now there’s wholesale retreat, such as in Memphis or Boston. In these areas, a change in the expectation about the use of capitation is occurring where there has not been an entrenched belief that capitation is the essential tool in managing population health.

Q. *What trends have you seen in divestiture of hospital-owned physician practices?*

A. We have probably been in touch with more than 150 health systems in 24 months, and I personally visited with administrators in about half of those systems for a day or more. At this point, we’re finding that approximately one-third of the hospitals we visited are looking to divest their practices entirely.

Q. *In the second half of the 1990s, hospitals acquired roughly 5,000 practices. For the most part, these acquisitions have been disappointing. Analysis has shown that about 95% of these*

acquired practices are losing about \$100,000 per physician per year. Is divestiture of physician practices driven by similar financial concerns across hospital systems?

A. In fact, financial drivers of divestiture can be arrived at via two different pathways. First, hospitals may have owned practices for five years and are still losing money after working hard to make the practices break even. Eventually, the hospital administrators become exhausted by the effort. They say they can’t manage the practices effectively and the relationship is simply not working financially. In addition, their market is changing and with the retreat from capitation in many markets, the rationale for having these practices under the health system’s umbrella is not as clear a strategy as it once was.

A second pathway to divestiture comes from acute hospital financial difficulty. When a health system runs into economic trouble—because of the Balanced Budget Act’s changes in hospital reimbursement, for example—it reviews profit and loss numbers, and the biggest driver of losses frequently can be the physician practices. That’s when we get an urgent call from an administrator, telling us that he or she wants to do something quickly to get the practices off the books. We’re seeing more of that circumstance in certain communities, where the effect of the BBA is felt most deeply.

Q. *Experts say that one of the saviors of independently owned physician group practices, including newly divested ones, could be the use of information technology for various operational necessities, such as coding. Do you help doctors identify appropriate Internet technologies to help them manage their practices?*

(Continued on page 14)

(Continued from page 13)

A. Yes, we do. We help practices find and use effective technologies with the size and scope that are appropriate for an independent private practice. Usually the medical practices that hospitals have purchased have inherited or had to install sophisticated hospital information systems that have been more complex than was required for a physician practice and often at a much higher cost than necessary. Practices often need help getting back to a rational infrastructure for information technology.

Technologies, particularly Internet technologies, offer the opportunity for small practices to stay small and independent while at the same time acting like a larger business. This trend mirrors what has occurred in

Q. *Have you noticed a generational divide among physicians?*

A. Generational differences are eventually an issue in any given practice. Older physicians have one set of preoccupations and a certain style of practice, while physicians in their 30s have a different set of preoccupations and styles. There's a tragic loss of some of the mentoring that used to go on in practices between the older physicians and the younger physicians. This mentoring would help fill the gaps in practical practice knowledge of younger physicians. Physicians coming out of residency have big holes in what they don't know about how to practice in the real world. In the past, the older physicians filled that gap, but now for many different reasons older physi-

A. Many physicians are feeling a bit helpless in using business approaches to deal with health plans and some are moving toward political approaches. To be successful, medical groups will need to learn to use professional business managers. They have to balance the gain to the practice in income versus the cost of the management. There are a number of steps physicians can take to make their practice more sophisticated and more likely to succeed. Effectively using professional management from outside is not the tradition in medical practice in America. It's been a do-it-yourself kind of small business. But that will be a financially risky strategy to continue in the future.

Even with professional practice management, however, a practice will not be effective unless the physician is intimately involved in the business side of the enterprise. Physicians need to be intimately involved in the business aspects of their medical practice, even if they have professional management to solve a lot of the problems. The hospitals that have fallen farthest behind a break-even objective in owning physician practices are the ones in which the physicians have been insulated from the market and the economic consequences of changes in their practice.

Professional practice management is a requirement in today's turbulent health care environment. For years, we've heard that small medical practices are doomed, and yet we've still got lots of small practices and even solo practitioners out there. The issue is not that being in independent practice is necessarily bad; rather, it's that if physicians are going to be in independent practice and all they know is medicine, and they manage their practices as a hobby, then they will be putting their practices in economic jeopardy.

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

“Using professional management from outside is not the tradition in medical practice. It's been a do-it-yourself small business. But that will be a financially risky strategy to continue in the future.”

the last 10 years with the proliferation of many successful small businesses in other sectors of the economy. These small businesses have been supported by small business service information technologies that have helped them grow. This growth has been a vital part of the economic boom in the United States over the last five years. I see a parallel path for physician practices in the next few years.

Our company is examining a number of potential partnerships that would allow us to adapt Internet-enabled information technologies that are applicable to medical practices and to assist the medical staffs in the practices in which we have partnerships and in the communities in which we have affiliated hospitals. Over the next two years this area will become a centerpiece of our business.

cians are not mentoring younger colleagues in the same way.

Q. *Has working as a physician executive in practice management been satisfying for you personally?*

A. Definitely. It's been a fascinating business to put together from scratch. Many physicians and certainly many hospitals that have physician practices need practice management. Hospitals need to know how to exit practice management gracefully or to bring more structure to the practice relationship so that they can get past the finger pointing. I do what I guess is best characterized as “missionary work” with hospitals and physicians, and it's very satisfying.

Q. *What advice would you give physicians who are reluctant to hire professional practice managers?*

Practices Will Continue To Control Care

By Richard L. Reece, MD, editor-in-chief

Managed care has undoubtedly made significant changes in how health care is delivered, and some of these changes have had a negative effect on physicians and patients. In many markets, managed care plans have attempted to wrest some degree of decisionmaking about patient care from physicians. Despite these attempts, however, physicians remain the driving force behind helping patients make the right health care decisions, says Leif Beck, a lawyer and former practice management consultant. Beck founded and subsequently retired from The Healthcare Group, a practice management firm in Plymouth Meeting, Pa. Today, he publishes a monthly newsletter for physicians, *The Physician's Advisory*, which aims to help physicians manage their practices more effectively and more efficiently.

Indeed, managed care has failed to control or supervise medical care, Beck says. Also, hospitals and physician practice management companies have fallen short of managing how consumers use health care services. Therefore, he explains, physicians likely will continue to be responsible for individual's health care, meaning those private practices that are run well and managed for profitability will have a strong role in the evolution of the nation's health care system.

Managed Care Failures

"While most physicians may not have been trained in business management, they truly control people's health care," he says. "I don't mean 'control' in the sense of telling patients what they must do, but they're the ones patients respond to. They are a driving force for medicine, and this fact has proven to be true several times. Just in the past few

years, managed care and its efforts to control medical care have been pushed back somewhat as consumers have demonstrated a preference for physician-driven care."

The failure of these large organizations to manage physician practices created an opportunity for physicians seeking to practice efficiently in relatively smaller organizations. One important lesson from these failures is that physicians seeking to develop efficient practice management systems need strong physician leadership, Beck explains. Physician leaders need a deep and abiding interest in running the medical practice as a

says. "Electronic medical records have so much usefulness in terms of quality, but also in terms of efficient production of care that any other industry would have grabbed onto this and moved forward," he says. "The participants would have adapted to it very easily." But to date, many physicians have not accepted EMRs, he adds.

Many physicians also have been reluctant to use e-mail to communicate with patients, Beck says. "Recently, I wanted to ask a question of my family doctor," he explains. "I asked if I could send a question by e-mail, and the receptionist said, 'Oh, no, not at all.' But I could send a fax.

"The opportunity for well run, well conceived medical practices with sensible physicians at the helm is unlimited."

—Leif Beck, *The Physician's Advisory*

successful business. In fact, practices that will do well are those that are managed well by physician-owners, he adds. To be profitable, a practice must operate efficiently, work to improve productivity whenever possible, and it must continue to adapt to market changes.

"The opportunity for well run, well conceived medical practices with sensible physicians at the helm is unlimited," Beck says.

To be successful today physician practices also need effective and capable information systems, Beck adds. These systems must be able to collect data on utilization and outcomes and they must be able to handle electronic medical records (EMRs). Until now, physicians have generally reacted negatively toward sensible, technological improvements. For example, many have objected to EMRs, he

I still haven't gotten an answer, and I think the problem is that e-mail is outside of the normal pattern. Physicians fear that opening up e-mail to patients would be a disaster in terms of their time each day. It doesn't have to be like that."

Beck concludes that practices aiming to succeed should use all available tools—including EMRs, the Internet, and e-mail with patients—to help build patient volume. By using these tools and having strong physician leadership, practices will wrest control of the delivery of care from health plans and other large organizations, he says.

—Readers may contact Beck by phone at 888/941-4488 or by e-mail at fordocs@aol.com. More information on practice management is available from *The Physician's Advisory*, at www.smartpracticemanagement.com and on our Web site (see page 16).

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