

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

January 15, 2003

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Group Recruits Carefully to Boost Efficiency

Painstaking physician recruitment, organizational efficiency, and production-related compensation are the basic strategic tools a Texas multispecialty group uses to increase productivity. The group, Collom & Carney Clinic Association, in Texarkana, Texas, pays its 71 physicians 150% or more than the national average for physician wages.

"We recruit physicians who have a focus on high productivity," says Stephen B. Glenn, MD, president of the physician-owned, multisite clinic's executive committee.

Efficiency and Quality

Too often, productivity is disparaged as contradictory to quality care and good patient service, according to Walter Unger, CEO of the Stratos Institute for Healthcare Performance Inc. "Successful medical groups not only deliver quality care and superb service, they also operate highly efficiently," Unger says. His video and media education company in Laguna Niguel, Calif. (at www.stratosinstitute.com), produced a video and lesson guide about Collom & Carney.

The four most important elements of success for the practice are instituting a groupwide work ethic, maintaining a focus on quality care, aligning compensation to production goals, and increasing organizational efficiency. "Those crucial strategies establish a culture that promotes productivity," says Tom Simmons, the clinic's CEO.

Physicians need to understand those

four elements and how they relate to their compensation, Simmons explains. "We reward physicians for the value of the services they provide," he says. "We make sure they understand productivity goals and standards and how the compensation plan works. Above all, we want them to view our reimbursement procedures as fair."

A physician who is willing to emphasize productivity can increase his or her income, says Simmons. The physicians are paid based on the volume of work they do or the number of patients they see, he explains. "Our physician volume is higher than industry averages, so our reimbursement model is also higher," he notes. "Our physicians earn more because they work harder."

The emphasis on hard work requires Collom & Carney to recruit physicians who have a work ethic that parallels that of the group, Simmons says. "At the initial interview, we ask the physician candidates what is important to them, the amount of free time they need, and how they feel about filling in for other physicians. Their responses tell us almost immediately whether they will be a good fit."

Other factors the clinic considers when making a hiring decision include a physician's financial and professional goals. It also examines the scope and quality of the physician's training, as well as his or her board eligibility and certification. The group has 450 staff, including 71 physicians, in 13 locations.

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Increased Efficiency Improves Patient Care

As we begin our eighth year of publishing *Practice Options*, we have revised the mission of the newsletter. In the past, we focused on writing about strategies that physicians can use to succeed in health care. While we will continue to write about strategies for success, we are also broadening the topics we cover to include improving patient care through increased practice efficiency.

Although this change may seem subtle, it is one that we have been developing during the past few years because we believe it is important. We have found that as physicians become more adept at learning how to prosper in health care, they want and need more information on how to increase their practice efficiency while also improving patient care. To address that need, we have recently featured articles about how physicians are doing just that: increasing their efficiency and providing better patient care.

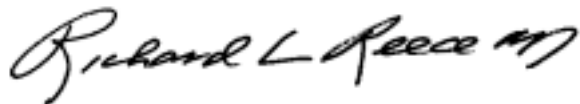
In the Sept. 15 issue of *Practice Options*, for example, Brent C. James, MD, executive director of the Institute for Health Care Delivery Research at Intermountain Health Care, in Salt Lake City, described a step-by-step approach to implementing computer systems in a medical practice in order to increase efficiency.

An example of improving patient care comes from our Oct. 15 issue, which featured Michael Good, MD, a family physician with ProHealth, in Middletown, Conn. Good described how his practice uses information systems to improve care by facilitating patient-physician communication.

In our Dec. 15 issue, Ed Fotsch, MD, CEO of Medem Inc., discussed how his company helps physicians establish secure lines of communication so that they can conduct online consultations with patients.

We also write frequently about physicians in smaller organizations who are finding new and innovative methods of solving difficult problems in their practices. The cover article in our Dec. 15 issue told the story of Gregg Omura, MD, a family physician in western Colorado who is focusing on improving efficiency in several areas in his practice. Over the past two years, his group has increased appointments by 20% and cut the number of no-shows by 17%. At the same time, charges have increased by 22%, gross revenue by 21%, and income by 20%.

By providing articles like these, we believe that our readers are learning new ways to increase their practice efficiency. In doing so, they are able to spend more time with their patients, which improves care and increases both patient and physician satisfaction.



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What Happens If Cost Control Fails?

By Richard L. Reece, MD, editor in chief

Health policy experts are currently wrestling with this question: Is it possible to contain health costs and reform the health care system at the same time?

While the policy experts seek answers to this question, physicians are struggling to survive under constraints that are more demanding than ever. In order to seek more equitable systems that are not encumbered by low reimbursements and administrative hassles, some physicians have decided to discontinue their relationships with difficult health plans and with Medicare.

Meanwhile, politicians and health policy planners debate the merits of the current system and several alternatives to it. They face a daunting task: As Americans, we are likely to resist any attempts to reform the system, given our individualistic penchant for new technology, the fragmentation of the health care industry, the need for health care organizations to make a profit to stay in business, and our distrust of government.

There are other thorny reasons that will make it extremely difficult to reform the health care system. One is the extreme reluctance among health systems to gather and share data on quality and outcomes with consumers, competitors, regulators, and purchasers. And, since the early 1990s when former President Clinton proposed sweeping changes in the health system that were quickly dismissed as infeasible and unpopular, many of our political leaders have largely stayed away from the health reform issue.

But something must be done to contain costs: Last year, the economy grew by 2.4% while health care costs surged 15%.

Until four years ago, HMOs had

Five Reasons Costs Are Rising

As part of its annual health care cost trend survey this year, The Segal Co., benefits consultants and actuaries in New York, identified some of the reasons costs are rising. Health policy planners are correct when they say that the usual forces—such as price inflation and an aging population—are spurring the cost increases, but other factors are at work as well, Segal says. In fact, some of the new forces are creating a more resilient form of medical cost increases, Segal says, citing the following:

1. Consolidation among for-profit physician groups and other providers has enabled these larger organizations to negotiate higher reimbursement levels from health insurers and MCOs. Large hospital systems can bring leverage and sophistication to contract negotiations, meaning managed care networks are struggling to contain fees for physicians and all providers.
2. Labor shortages for nurses and pharmacists are pushing up wages in these professions at nearly double-digit annual rates.
3. Premiums for malpractice insurance for physicians and other providers are reaching alarming levels, which are ultimately passed on to health plans.
4. Modest fixed-dollar copayments (such as \$10 per visit) do little to discourage unnecessary care, thereby contributing to a rising number of office visits.
5. Fixed-dollar copayments erode in value over time, meaning that a health plan pays relatively more as participants pay relatively less. If a \$10 copayment represents 20% of the cost of a \$50 office visit and the cost of that visit rises to \$70, then the \$10 copayment represents only slightly more than 14% of the cost.

been effective at containing costs, but then they gave in to widespread criticism of the limits imposed by managed care plans and developed more flexible and more costly systems. Today, a number of factors are causing costs to rise sharply once again.

The Need for Data

Among the experts who argue that health systems need to gather and share data are Patricia Salber, MD, MBA, an internist working with General Motors Corp., and Brian Klepper, PhD, director of the Center

for Practical Health Reform, in Jacksonville, Fla. They contend that the high costs stem from a lack of comparative data and from a lack of understanding about health care processes.

Health care costs are uncontrollable because the results of the health system's processes are invisible, they say. In other words, outcomes and costs are only sometimes captured, and they are rarely shared or made publicly available, they contend. They also point out that objective comparisons of procedures, doctors and hospitals, suppliers, and insurers

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remain hard to find.

What's more, there is a lack of accountability at every level of the system, Salber and Klepper believe. According to them, health care is a sprawling, fragmented, and complex system of competing and relatively independent interests. They argue that until each participant in the health care process—including patients—is held accountable for their health care decisions and choices, controlling costs will remain an elusive ideal.

Free Markets

Some experts believe that a lack of accountability and the failure to collect data on outcomes are built into the American culture, arguing that the market itself will resolve these inherent problems. According to those who hold to this theory, the market distributes services better than any government could. In the context of health care, this theory would hold that the market allows access to medical technologies without bureaucratic intervention.

A proponent of this theory is Robert Goldberg, a senior fellow at the Manhattan Institute for Policy Research in New York. "Managed care is now organized not only to limit access to the fruits of medical progress, but to slow it down altogether," he says. "Managed care is not alone in this venture. The national health services in Britain, Germany, and Canada are similarly designed to limit medical progress." Such limits consist of price controls and restrictions on access to new medicines and new technology, Goldberg points out, adding that these limits are designed to prevent people from freely embracing the coming wave of medical innovations and to discourage the development of new treatments.

But many who promote the free-market theory are ignoring the fact that more than 44 million Americans lack health insurance,

Physicians Rejecting Medicare

The number of physicians providing charity care and treating Medicaid patients declined between 1997 and 2001, according to a recent study released by the Center for Studying Health System Change (HSC), a research organization in Washington, D.C.

The proportion of physicians providing charity care declined by nearly five percentage points, from 76.3% in 1997 to 71.5% in 2001, the study shows. At the same time, the percentage of physicians whose practices treat any Medicaid patients declined from 87.1% to 85.4%.

"The decline in physicians providing charity care and treating Medicaid patients is a sign of the financial pressures facing physicians," says HSC President Paul B. Ginsburg, PhD. "With substantial pressure on payment rates from private insurers, physicians may place a lower priority on treating the uninsured and Medicaid patients."

The study also examined access to care for uninsured and Medicaid patients. The percentage of uninsured patients with a usual source of care—already far lower than that for insured Americans—dropped more than four percentage points, from 68.6% in 1997, to 64.2% in 2001, HSC says. At the same time, the proportion of uninsured people who saw a physician in the last year dropped from 51.5% to 46.6%. The report, *HSC Tracking Report—Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001*, is available online (at www.hschange.com).

and the number is rising every year. Some argue that this situation should not be tolerated in a civilized society, in part because society not only has a responsibility to provide care for all citizens, but also because the uninsured drive up costs for all Americans when they are forced to seek emergency care in the most expensive settings: hospital emergency rooms.

One health care expert has suggested that government should make it illegal to be uninsured by passing and enforcing an individual insurance mandate similar to that required for people who own cars. Kenneth S. Abramowitz, a health care analyst with Sanford C. Bernstein & Co., in New York, contends that insurers should be able to offer stripped-down policies that provide modest benefits at a low cost, and that tax deductions and tax credits would help make such insurance available widely.

Controlling Costs

Given that the uninsured are part of the reason costs are rising, the government clearly must find a way to provide care for this growing segment of society. If costs continue to rise at double-digit rates, the businesses and corporations that pay for much of the care provided to America's working families may soon find that such cost increases are unsustainable.

There is no question that cost control is necessary, but it will not be easy to implement. Even so, a number of incremental steps have been taken to keep costs under control. In some markets, for example, employers are offering consumer-driven health plans, which offer a combination of high deductibles and savings accounts and let workers and families choose their own physicians and other providers. Employers have also increased deductibles and copayments

Experts say that until each participant in the health care process is held accountable for their choices, controlling costs will be elusive.

in an effort shift more costs to workers.

Health plans and other payers have introduced tiered payments for high-cost drugs, hospitals, and specialist care. Health care consumers who want the best and most expensive treatment will have to pay for it under these plans. For patients with chronic conditions, disease management programs are helping to increase the quality of care while also helping to limit cost increases.

Introducing tiered health plans is one way health care purchasers are seeking to make workers and family members more savvy consumers. Another way is to give them information on quality and outcomes. Robert Galvin, MD, director of corporate health care for General Electric, and Arnold Milstein, MD, MPH, a consultant for the Pacific Business Group on Health, wrote last fall in *NEJM* that employers believe consumer pressure is a powerful, underused lever for improving quality and efficiency. Employers believe that higher quality and lower cost will result if consumers have more responsibility for their health care expenditures and if physicians and other providers respond by improving the care they deliver. For this strategy to succeed, consumers will have to be motivated to seek more efficient, higher quality care, and physicians will have to be rewarded for delivering it.

Looking Ahead

Seeking to become more aggressive in their efforts to control costs, employers will foster the idea that workers and their families should use consumer-driven health plans. To do so, employers and other purchasers are shifting more out-of-pocket costs to consumers.

At the same time, physicians and health plans will realize that customized centers of excellence can offer comprehensive care centered around a specific procedure (such as orthopedic surgery) or a condition (such as diabetes). Consumers seeking expert care and having the ability to choose their own physicians likely will want to choose doctors in these centers of excellence.

Similarly, health plans and employers are turning to chronic care management for major common diseases, such as asthma. These disease management approaches have taught us that working to improve the health of populations is just as important as caring for individuals.

Of course, any forward-looking scenario must include a prediction about technology, which is changing medicine and the quick delivery of medical information. The Health Insurance Portability and Accountability Act is helping to foster the use of the Internet and information systems that facilitate physician billing and payment, monitoring of patients, and storage of medical records, among other myriad improvements.

What to Expect

For physicians, changes in how consumers use the health care system could create a substantial amount of upheaval. Fortunately, physicians have several options to consider.

Specialists, for example, who do most of their procedures on an inpatient basis, may want to consider investing in specialist-owned hospitals offering comprehensive but customized care to certain patients.

For specialists who perform mostly outpatient procedures, ambulatory surgery centers offer them a way to

improve care, control costs, and retain a portion of the income that results from these procedures.

For primary care physicians, the future is more complex. In many markets, PCPs are asking patients to pay an annual fee and the PCPs then provide care without contracting with an insurer or a health plan. Other physicians are choosing to simplify their practices. A company called SimpleCare in Renton, Wash., gives a discount of 30% to 50% for patients who pay cash, thereby eliminating claims processing and billing overhead. A number of independent physicians in California have formed INDOCs, an organization in Torrance, that allows them to practice what they call unmanaged care free of HMO restrictions.

Yet another approach is to go solo, have a small staff to minimize overhead, and spend more time with patients. Some doctors are specializing in procedures they do well in order to minimize paperwork and the overhead associated with general care.

Over the next 10 years, physicians will need new and innovative ways to practice, and they will need more sophisticated information systems and the Internet to compete effectively. New methods of practice and new systems will allow physicians to see more patients each day, to document details of the encounter quickly and easily, to satisfy demanding patients, and to produce data to make outcome measurement, disease tracking, and superior patient education possible. We all hope that these new systems increase efficiency so that physicians will have more time to treat patients.

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

Privacy Rules Made Simple

By Michael "Bill" Carbrej

Thirty-three years ago, young nursing assistants working at Memorial Hospital in Gulfport, Miss., learned from the director of nursing, a retired lieutenant colonel, all they needed to know about patient privacy. Typically, they would hear the following on their first day at work: "What you hear here and see here, stays here."

This advice given in the late 1960s is appropriate today as physicians prepare to comply with relatively new federal regulations regarding patient privacy. The good news about complying with the new regulations is that doing so should not be an onerous task for most physicians. The bad news is that compliance is mandatory.

The Need for Regulation

The nursing director's instructions were given in a time long before physicians and other providers used personal digital assistants to collect and store diagnosis and treatment information, long before they sent patient and claims data electronically, and long before patient records could be copied and faxed with ease.

Indeed, it was a time long before a patient's medical history and information needed to be safeguarded. It was a long time before patient medical records and billing information were being transmitted over the Internet, a system that has proven to be less secure than health policy and security experts would prefer. It

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Five Myths About HIPAA

A number of myths have been circulating among physicians regarding the Health Insurance Portability and Accountability Act. Here are five and the truth about each one.

1. Small practices do not have to worry. Yes, they do; anyone can file a complaint with federal officials.
2. I cannot use sign-in sheets. Yes, you can, but they cannot contain any information regarding a patient's diagnosis or chief complaint.
3. I need to soundproof my office. No, you don't, but you need to be aware that other people may be listening and that you may need to lower your voice.
4. I can't use a fax machine. Yes, you can, but if you are sending and receiving protected health information (PHI), make sure the information is going to the right place, and that the fax machine is not open to the public.
5. I have to put locks on all my filing cabinets. Not necessarily, but the records need to be secured from people who should not have access to PHI. —MC

was a time before landfills became the final resting place for medical records, and long before anyone bought a retiring physician's charts in order to sell them to the physician's patients.

Recognizing the vulnerability of patient data, Congress enacted the Health Insurance Portability and Accountability Act of 1996 and set compliance dates. HIPAA covers a number of issues, including health insurance protection for workers, health care fraud and abuse, electronic submission of bills, computer security, and the privacy of the individual's health information.

Who Is Covered?

The privacy regulations will affect physicians almost immediately. With

respect to the privacy regulations, most medical practices are concerned with whether they need to comply and the steps they need to take to do so. These concerns can be addressed easily: The regulations state that all covered entities must comply by April 14. An entity is covered by HIPAA if it transmits electronically any individually identifiable health information, including billing information. In other words, if a physician or the physician's office electronically sends any health information that can be identified as that of a particular patient electronically, the physician is a covered entity.

Such information is known as protected health information (or PHI). PHI includes any patient

If a physician or physician's staff electronically sends any health information that can be identified as the information of a particular patient, they are a covered entity under HIPAA and need to comply with the privacy regulations.

information relating to the past, present, or future physical or mental health of an individual, as well as information related to the provision of health care or the payment for health care services for an individual. Also, PHI extends the definition of "normal medical record" to include personal notes or billing information.

The regulations define "electronic transmission" as including the use of magnetic tape, disks, and CDs; Internet and intranet transmissions; and the transfer of information from one place to another if done electronically. Transmitting information by fax is not considered an electronic transmission, but the information on the fax is considered PHI.

Beyond the Basics

Once physicians have answers to the six basic questions about HIPAA (see sidebar), many also want to know what the chances are that they will face fines or penalties if they fail to comply. Physicians need not worry about having to face a federal HIPAA compliance regulator because the regulations do not provide funding for active field representatives.

The Office of Civil Rights of the federal Department of Justice will respond to complaints about HIPAA violations, however. In other words, complaints from a patient or a lawyer representing a patient could be worrisome. Some consultants envision the possibility of a new legal practice centered on suits brought on behalf of patients whose privacy has been violated. Of course, a whistle-blower in a physician's practice can result in a

Six Questions to Answer

Physicians are asking themselves a number of questions about the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among them are the following:

1. Am I covered? You are covered under the regulations and must comply if you transmit any patient information electronically. Most practices file their bills to Medicare electronically, meaning they must comply with HIPAA.
2. What is covered under HIPAA? All protected health information (PHI) is covered.
3. How does the law affect me? For most practices, the regulations require physicians to take specific steps, but generally, it will change the way physicians act regarding PHI.
4. What do I need to do? The regulations say some certain requirements must be met. Physicians must provide notice to their patients stating how they plan to authorize and consent to release PHI, initiate safeguards, provide employee training, designate a privacy officer, make certain accounting disclosures, and make agreements to safeguard PHI with certain business associates.
5. What does it cost to comply? As with all health care regulations, the price of compliance ranges from the affordable to the overpriced. Typically, a complete compliance program installed by the physician can cost under \$500, and formal training would cost \$40 to \$50 per employee. Some additional attorney's fees may be required because a lawyer would need to review the contracts the physicians has with his or her business associates.
6. What if I do not comply? The regulations call for fines and penalties, both civil and criminal, ranging from \$100 to \$250,000. Also, the regulations allow for prison terms ranging from one year to 10 years if the criminal penalties are enforced.

—MC

complaint as well.

Clearly, the HIPAA privacy regulations involve more than buying and reading a new how-to manual. Instead, physicians and staff will need to remember that others may overhear conversations about a patient, or read files left unattend-

ed or unsecured. So, the admonition of more than three decades ago holds true even in a physician's office today: "What you hear here and see here, stays here."

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

Vendors Can Ensure Compliance

The first portion of the Health Insurance Portability and Accountability Act of 1996 went into effect in October 2002, and physicians face another deadline for compliance by April 14, 2003. HIPAA has significant implications for all physicians, including rheumatologists, who must ensure that their practices comply with the act so that they can receive payment on claims and avoid penalties for noncompliance with the provisions of the act.

Even though many physicians may be able to shift some of the most onerous issues involved with HIPAA compliance to systems and other vendors, most physicians and

Bysinger, principal of WGB Advisory, consultants in Poulsbo, Wash. (at www.wgbadvisory.com). "Hospitals are complying, insurers are complying, but physician practices are not complying," he says.

"Physicians can meet HIPAA requirements without excessively burdening their practice either from a time or financial standpoint," says Bysinger, who consults on HIPAA, e-health, and technology for physicians and other health care providers.

Congress enacted HIPAA with the idea that the law would streamline health care transactions and protect patient privacy, Weintrub explains. The act sets standards in three areas:

tronically," Bysinger continues, "and that electronic portion must comply with HIPAA." There is no specification for how practices should file paper claims, except that the information must be kept confidential. Practices that do not file claims electronically do not need to comply with the rules," he says regarding electronic transmission this year, but they will need to be in compliance with all other requirements of HIPAA, experts say.

Another set of HIPAA regulations addresses privacy and confidentiality of protected health information (which the act calls PHI). "The privacy regulations require practices to

"Hospitals are complying, insurers are complying, but physician practices are not complying."

—Bill Bysinger, WGB Advisory

rheumatologists need to be involved with that compliance, experts say.

"HIPAA compliance is required," says James Weintrub, MD, "and physicians need to have some understanding of what is involved. They need to implement changes in their practices from policy, procedure, and technological standpoints. Then, on an ongoing basis, they need to train employees on the various aspects of HIPAA." Weintrub, a practicing plastic and reconstructive surgeon in Providence, R.I., is founder and CEO of Digital Physicians Network, an information technology firm that specializes in compliance. DPN (at www.dpnx.com) has developed *Getting Your Practice Ready for HIPAA*, a CD-Rom being distributed to 10,000 doctors by Blue Cross & Blue Shield of Rhode Island.

Fewer than 30% of practices are ready for HIPAA, according to Bill

health care transactions, patient privacy, and security of health information. Transaction standards involve how health care claims are submitted. "For example, one transaction standard involves a new format for health care claims," Weintrub says.

Electronic Transactions

The transaction regulations stipulate that claims must be sent to the payer in the proper electronic format so that payers can pay claims properly, Bysinger says. "The regulations also require that information be kept confidential when it is being transmitted, and that it be transmitted in ANSII format, a national electronic standard for transmitting information," he adds.

Practices that file claims electronically are covered under the transaction regulations. "In most practices, a portion of claims is generated elec-

tronically," Bysinger continues, "and that electronic portion must comply with HIPAA." There is no specification for how practices should file paper claims, except that the information must be kept confidential. Practices that do not file claims electronically do not need to comply with the rules," he says regarding electronic transmission this year, but they will need to be in compliance with all other requirements of HIPAA, experts say.

To comply, physician practices need to have a privacy officer, says Weintrub. "They also need to put in place policies and procedures to protect patients' health information from unintended or illicit disclosure, and they need to post and distribute a Notice of Privacy Practices in order to communicate privacy-oriented policies and procedures to their patients," he adds.

The security provisions dovetail with the privacy provisions, Weintrub continues. "The security provisions involve how physicians handle patient information, meaning how they store it, protect it, and distribute it," he says. "Security regulations

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cover electronic medical records, computerized information, and health data within paper records.”

For physicians, the security regulations stipulate that all electronic health information should be secured so that it cannot be exposed inadvertently to anyone who does not have the right to see that information or the training to see it and use it properly, Bysinger explains.

Physicians—including rheumatologists—need to be aware of several deadlines for HIPAA compliance. “The deadline for compliance with the transaction standards, Oct. 15, 2002, has passed, but practices were granted a one-year extension if they filed a model compliance plan,” Weintrub explains. “The deadline for compliance with HIPAA privacy regulations is April 14. As yet, there is no compliance deadline for the security standards.”

The penalty for noncompliance can be severe, particularly with regard to privacy regulations. “The fines for breaching patient confidentiality will start at \$100 per infraction and rise up to \$250,000 and 10 years in prison if it is proven to be done with intent or for personal gain,” Bysinger notes. Most doctors, he adds, don’t take these penalties seriously.

If a physician practice fails to comply with the transaction regulations, the penalty is not receiving payment for both Medicare and commercial insurer claims. “As a result, the need to comply with HIPAA transaction regulations is fundamental to the success of a physician practice,” Weintrub points out.

What’s more, physicians who do not comply with HIPAA are risking a lawsuit. “A patient may accuse a physician of breaching his or her PHI and take the physician to court,” Bysinger says. “There is no malpractice insurance for HIPAA yet, so physicians are exposed if they are not complying with the act.”

Two Important HIPAA Compliance Steps

Complying with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 involves two distinctly different projects, says James Weintrub, MD, a surgeon and CEO of Digital Physicians Network, in Providence, R.I.

1. The first step involves setting office policies and procedures that meet the HIPAA requirements for privacy and security, according to Weintrub. “This project can be accomplished internally using a variety of available resources,” he says.
2. The second step involves ensuring that the practice management system is HIPAA compliant. The HIPAA transaction standards are complicated because they involve electronic standards, requiring practices to depend on practice management system vendors for compliance.

“If the vendors are not forthcoming with information and are not doing the proper systems development, a practice would need to pursue an alternative means of submitting claims and receiving payment,” Weintrub says. “In that unusual circumstance, the use of a clearinghouse or the adoption of a new practice management system would be required.”

To help ease the compliance burden, a practice that files claims electronically should ensure that its software vendors or billing service bureau is complying with HIPAA, says Bill Bysinger, a principal with WGB Advisory, technology consultants in Poulsbo, Wash. “The responsibility for compliance lies with whoever is supplying the electronic method by which claim transactions occur,” he says. “Rheumatologists should contact their vendors and request verification of HIPAA compliance in writing.”

—DJN

Ensuring Compliance

While less than a third of practices are on schedule to comply with HIPAA by the deadline, most are well aware that compliance is mandatory and that the government is pushing them to streamline health care claims processing, Weintrub says. To comply, rheumatologists—and all physicians—need to examine how they handle confidential patient information and develop and publish specific policies and procedures regarding how privacy is maintained, Bysinger says.

In addition, HIPAA calls for contractual agreements with all business

associates whose employees may have access to identifiable PHI. These agreements must stipulate that PHI will remain private.

Several cost-effective strategies for achieving and demonstrating HIPAA compliance are available. “Some material on the Internet is free, and several professional organizations are providing guidance, much of which is also free,” says Weintrub. But even after using all available free options, practices will need some form of outside assistance in complying with HIPAA, Weintrub believes.

Many Web sites offer sample forms. “The AMA has sample forms for the

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Success Factors

In addition to recruiting carefully, Collom & Carney physicians believe success derives from effective production, efficient use of its physical plant capacity, and contributions from support staff. In other words, the physicians work to match resources to production requirements, Simmons says.

One of the most significant keys to productivity is the physician compensation formula. Approximately 80% of this formula is based on work units, or the amount of collected revenue each physician generates. The remaining 20% is determined by an even split of department profits after subtracting expenses.

Also, the group considers ancillary revenue from laboratory and radiology services as a production credit and accounts for malpractice insurance as a general expense, not as a departmental expense. Malpractice insurance payments can be contentious in a multispecialty group because the rates can vary widely among specialties.

"Most medical groups consider the issue of who pays whose mal-

practice insurance to be controversial," Simmons explains. "Collom & Carney believes that sharing the costs of malpractice insurance across the entire organization helps hold us together as an organization."

Monitoring Productivity

To measure productivity each month, the group produces a revenue and usage report for each physician that is based on net collectible billing per physician. The report provides details on each CPT code billed, the number of patient contacts or procedures by each physician, and total charges for each physician. Also included in the report are income from ancillary services and collection adjustments related to Medicare, Medicaid, managed care, and other third-party payers.

Once it has data on each physician, the group uses internal and external data to compare its results against those of multispecialty and single-specialty clinics, says Glenn. The primary source of external data comes from the Medical Group Management Association, in Englewood, Colo. Each year,

MGMA collects data on productivity and compensation from physicians nationwide. In addition to MGMA's physician productivity data, the group asks physician recruiting firms what recruits are looking for and how many hours a week they want to work, Glenn says.

At Collom & Carney, physicians who fail to reach their goals meet with an administrator to discuss the monthly reports, the goals, and the actions the physicians could take to improve their results, Simmons explains.

Each January, the executive committee reviews the formulas used for profit distribution and makes adjustments as necessary. Such adjustments help prevent substantial income variations from year to year. "We quickly learned that physicians, like everyone else, have an aversion to large swings in income," Simmons says.

Staff Retention

Retaining staff is one way to avoid large swings in income, according to Simmons. Because staff retention is an important element of maintaining high production and quality care, the clinic's compensation plan is designed to help the group retain staff over time, he notes.

"All physicians are employed with the hope that they will retire in the organization," Simmons says. "If that is not achieved, the clinic feels both parties have failed to meet their goal." After 20 years, a physician will be vested in the company's stock ownership and pension benefit plans, and each can be significant. The clinic's attrition rate among physicians is only about 5% a year.

Attrition among midlevel staff, including nurses, is also low, partly because their compensation is related to productivity and is therefore higher than industry norms, Simmons says. "The key to our

Above-Average Rates

Compensation at Collom & Carney Clinic Association in Texarkana, Texas, annually exceeds the norms determined through surveys by the Medical Group Management Association in Englewood, Colo. Here's how the range of its physicians' 2001 income compared to national norms:

Specialty	Collom & Carney	National Average
Family Practice	\$180,000 to \$230,000	\$149,009
Internal Medicine	\$175,000 to \$275,000	\$149,700
Pediatrics	\$240,000 to \$400,000	\$150,222
General Surgery	\$250,000 to \$450,000	\$257,509

Source: Collom & Carney; and *Physician Compensation and Production Survey, 2002 Report Based on 2001 Data*, MGMA, Englewood, Colo.

Report Says Staff Size Matters

The financial success or failure of any medical group is determined simply enough by subtracting operating expenses from revenue. "In a medical group organized as a partnership or professional corporation, this is typically the amount available to the practice's physician owners and shareholders as compensation and fringe benefits," explains David Gans, director of practice management resources for the Medical Group Management Association in Englewood, Colo.

One significant operating expense is staff salaries. Hiring the correct number of staff to maximize profitability is critical to the bottom line, says Gans. In an MGMA report, *Performance and Practices of Successful Medical Groups*, Gans describes how staffing affects profitability.

"In general, the highest levels of profitable revenue per full-time physician occur when there are higher levels of staffing, but not at the highest ratio," says Gans. An MGMA review of support staff and physician compensation shows that increasing staff for primary care physicians in single-specialty practices increases individual physician compensation. But in multispecialty groups, increasing support staff by one or two workers per full-time physician can decrease profitability.

To determine the correct staffing level for profitability and to maximize compensation, Gans recommends that medical groups take four steps:

1. Perform a benchmarking analysis to compare a practice's staffing and productivity performance with acceptable industry standards, thereby determining opportunities for change.
2. Analyze productivity to determine whether staff is working at expected production levels and whether more or less staff is needed to meet those levels and to determine a physical plant's staff capacity. Determine if patient volume is too large for the number of available nurses on a specific work shift.
3. Do a work process analysis to determine whether administrative and clerical procedures improve. Determine if hiring additional staff for appointment scheduling would reduce no shows.
4. Take action to hire or reduce staff.

—MS

highly productive corporate culture is that we develop compensation incentives that benefit all our employees, not just doctors," he adds. Such incentives are based on productivity increases and departmental profitability.

Midlevel providers not only boost physician productivity, they also improve patient satisfaction, according to Simmons. "Initially, our physicians were negative on employing midlevel providers," he says. "They felt that midlevel providers would hurt, not help, their practice. However, once they brought in these providers and figured out how to best use their skills, the entire organization benefited."

Midlevel staff help leverage a physician's time by providing front-line health services, such as giving physical exams and diagnosing and

treating common acute illnesses.

What's more, having the proper number of staff is critical to any medical group's success, says David Gans, director of practice management resources for MGMA. "In the best possible case, a medical practice will have the right number of staff doing the right things," he says. "To understand the right size for its staff, a practice must first understand the objective it wants to achieve."

For Collom & Carney, increasing production is a basic objective, says Simmons. Physicians have the option, for example, of hiring a second nurse to help increase their productivity, he says. The clinic absorbs the cost of one nurse, but the cost of the second nurse is deducted from the individual physician's earnings.

The clinic has found that whenever one of its physicians hires an additional nurse, the physician's productivity increases, says Simmons. "That seems somewhat counterintuitive, and MGMA studies have shown that increased staffing can increase costs without increasing revenue, but our highest earners make the decision on their own, and invariably, their income goes up," he says.

It is no coincidence that the clinic's patient volume is higher than that of MGMA's average for multispecialty groups, and so is its compensation. "With an emphasis on productivity, increased compensation falls into place, and with that comes lower attrition, more efficient service, and better medicine," says Simmons.

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

Since the penalty for failing to comply with HIPAA could result in not receiving payment, the need to comply is fundamental to the success of a physician practice, says James Weintrub, MD, CEO of Digital Physicians Network.

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Notice of Privacy Practices and for authorizations,” says Weintrub. “The American Health Information Management Association has a job description for a privacy officer. Other such resources are available, but they are scattered across the Internet.”

Also, rheumatologists can purchase books, CDs, and other materials from various sources. For example, to simplify HIPAA compliance for physicians, Bysinger has developed a set of documents that form the templates of HIPAA documentation.

Other options, including consulting services, can be more costly. “Many HIPAA consultants can help practices complete their HIPAA project,” Weintrub says. “Health care attorneys offer forms and other kinds of legal guidance. Technology consultants look after the security aspects and the transaction standards.”

Most practices should simply get started, experts say. “Physicians should embrace HIPAA as a new way of doing business,” Weintrub says. “Not only is it a government mandate, it is also the way physicians will get paid. In fact, they will have no choice but to migrate to HIPAA transactions.”

A Document Inventory

To meet the April privacy deadline, practices must inventory all types of electronic or written documents that could hold PHI. At a minimum, PHI includes a patient’s name, address, telephone number, Social Security number, and other demographic data associated with diagnosis or treatment information, explains Bysinger.

Once all documents are inventoried, the practice must show in a

Notice of Privacy Practices (a policy required under HIPAA) how it is storing and safeguarding these documents. “The notice outlines how information is communicated to others, and must be communicated to patients,” Bysinger explains. “In addition, physicians must ensure that everyone who works in the practice is trained and understands the policies and procedures for keeping patient information confidential.”

A practice should maintain medical files behind a desk or in a room that protects this information from anyone who could take it. “Most practices protect their files in some way,” says Bysinger. “The biggest problem is that files are necessarily left on file racks or are floating between examination rooms. Patient information is sometimes left open on a computer screen. HIPAA compliance is a matter of locking up the documents, keeping them away from casual traffic, and ensuring that people can’t see open files. These precautions are not difficult to accomplish.”

Physicians may be able to shift the burden of compliance with HIPAA to another party, experts say, because electronic security should fall to a systems consultant or vendor. “Other issues of security involve common sense—for example, placing locks on doors to areas that hold PHI, and documenting these precautions,” Bysinger explains.

Assuming Responsibility

While they may be able to get consultants and system vendors to do much

of the work, the responsibility for compliance remains with physicians, who have criticized the government for failing to provide comprehensive, intelligible guidance on how to comply with the law. “For example, the government has not provided standard forms for physicians to use to make it easier to comply,” Weintrub explains.

Despite the complaints by physicians, many may find that complying with HIPAA will help them identify some of the shortcomings in how paper is handled in their offices, experts say. “We hope that as a result of this analysis, physicians will be able to streamline the paper process so that everyone handles paper in a standardized way,” Bysinger comments. “Physicians may even be able to gain a real advantage in being able to see more patients and get bills out more quickly.”

Unquestionably, complying with the act can be confusing. Simply getting the regulations out has taken many years, Weintrub says. “The many permutations of HIPAA have resulted in a lot of changes, a lot of discussion, and a lot of misinformation being circulated among physicians,” he says. “But at this point, most HIPAA regulations are final. The deadlines are real, and the ways of moving forward to achieve compliance are fairly well defined.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. Readers may contact Bysinger at wgbysinger@earthlink.net, and Weintrub at jweintrub@dpmx.com. More information on physician practice strategies is available on our Web site (see page 16).

Consultant Offers Advice for Raising Physician Productivity



Greg N. Korneluk is chairman of the International Council for Quality Care Inc., a physician advisory and consulting company in Boca Raton, Fla. (at www.bestpractice.com). Korneluk, who has worked for the AMA's division of clinical practice, is the author of *A Physician's Guide to Success* (MacMillan Publishers, New York, 1986). Readers can reach Korneluk by e-mail at gkorneluk@bestpractice.com. Editor in chief Richard L. Reece, MD, conducted this interview.

Q: How did you come to form the International Council for Quality Care, and what is its mission?

A: The business concept for the council was based on a thesis I did in business school in 1974. In 1985, I began establishing a database of best practice solutions based on various measures gathered from successful physicians. The database revealed that successful physicians were all doing the same things in almost the same ways: how they schedule and how they run their offices, for example. In 1990, I founded the council and developed a model of high-performance care design, which included optimal facility design, as well as how to best structure nursing and support staff so that physicians could see a reasonable number of patients without killing themselves, minimize their paperwork, earn money, and provide high-quality care.

Q: What differentiates the successful productive physicians from those who are less productive?

A: There are six categories of factors for success. The first category is core service, which includes the care, skill, and judgment of the physician and the systems and processes that support the actual delivery of care.

The second category is access. Essentially, access includes factors such as productivity, flow responsiveness, and the ability of physicians to get through the day easily.

The third category is representation; that is, the ability of physicians to win patients and retain their loyalty

of the physician organization. In this plus category, the top producers really shine.

After examining successful physician practices, we found that they had achieved significant levels of success in all six categories.

Q: What are the main techniques successful physicians use in the core service category?

A: Most physicians provide good core service, but within that core service, physicians differ. How clinical information is documented makes the biggest difference. Clinical

“The average PCP’s time is worth \$3 to \$4 per minute, which is \$180 to \$240 an hour in terms of what PCPs can generate. Yet, our studies show that physicians waste about 55% of their time.”

through customer service.

The fourth category involves earnings—cash flow, profitability, and how the practice collects the dollars it has earned. Successful physicians have systems for collecting their money, managing their overhead, and making sure they maximize the amount of money they keep as income.

The fifth category involves staff; that is, the people who help the physicians and how the physicians deploy them. Successful physicians organize their support staff to maximize their own time, encourage teamwork, and keep staff morale high so that turnover is minimized.

Finally, the sixth category is the “plus,” which encompasses the attitudes, the mindset, and the culture

documentation should support the quality of service rather than detract from providing the service. The key is to understand the best ways to collect, display, and deploy information in patient charts to support good outcomes and patient compliance.

Successful physicians have a defined clinical documentation system that supports their ability to provide care. We often meet with physicians who have a good understanding of what they can do clinically but who are not trained in how to use a system that captures information so that it is displayed effectively and efficiently such that the information can be accessed and used quickly, efficiently, and accurately.

Also, successful physicians have an

(Continued on page 14)

Six Success Factors

There are six categories of factors for physician practices, according to Greg N. Korneluk, chairman of the International Council for Quality Care Inc., in Boca Raton, Fla. He says that successful physicians typically have achieved significant levels of success in all six of the following categories:

1. **Core service.** This category includes the care, skill, and judgment of the physician, and the systems and processes that support the actual delivery of care.
2. **Access.** Access includes factors such as productivity, flow responsiveness, and the ability of physicians to get through each day easily.
3. **Representation.** This category involves the ability of physicians to win patients and retain their loyalty through customer service.
4. **Earnings.** This category involves cash flow, profitability, and how the practice collects the dollars it has earned. Successful physicians have systems for collecting money, managing overhead, and making sure they maximize the amount of money they keep as income.
5. **Staff.** Successful physicians organize and deploy staff so that the physicians can maximize their time, encourage teamwork, and keep staff morale high.
6. **Plus.** This category encompasses the attitudes and the culture of the physician organization.

—DJN

(Continued from page 13)

uncanny ability to have a positive effect on the care of the patient and be able to leave the exam room without making the patient feel that he or she is being rushed. The average U.S. physician spends 12 minutes with a patient. My database includes data on physicians who spend 20 minutes with their patients and yet their patients don't think the physicians are spending enough time with them. Meanwhile, some physicians spend less than five minutes with each patient, yet patient satisfaction scores reveal that their patients feel that the physicians have spent plenty of time with them. These physicians are particularly adept at listening and connecting with patients, as well as at delivering the right information in the right way.

Q: What are your findings regarding access?

A: On the access side, successful physicians are good time man-

agers. They have excellent control over their schedules and their staff.

The average primary care physician's time is worth \$3 to \$4 per minute, which is \$180 to \$240 an hour in terms of what they can generate. Yet, our studies show that physicians waste about 55% of their time. In other words, less than 50% of their time is actually spent on hands-on care, seeing patients, and doing what they went to medical school to learn.

Rather, physicians are spending too much of their time doing documentation, finding and completing forms, and other such activities. Our time and motion studies have revealed, for example, that physicians actually spend a lot of time wandering around. We have done many pedometer studies and found that the average physician in an office walks five to six miles a week. Our most successful physicians walk a

maximum of two to three miles in the same amount of time.

Q: Why is it important to analyze physician practices in terms of all six categories?

A: Let's say that a physician is not doing well financially. The cause of the problem will be in one or more of those six areas. If physicians focus only on earnings and economics, they may miss the fact that the solution actually lies with better access or better staffing systems, documentation, or interpersonal contact. If the physician has a problem with staff—or if the practice does not employ the right people or deploy the staff in the right way—financial success will be reduced.

Q: How do you handle the documentation problem?

A: Many doctors do not document care efficiently and that leads to undercoding. We have several strategies, depending on the physician's learning style.

Essentially, learning styles differ. Some physicians are auditory, meaning that while they are talking to the patient, they are formulating what's actually going on. Others are more hands on; they need to feel the chart and see the patient. Still others are visual learners. Based on the physician, we can prescribe the best methodology to achieve adequate, accurate documentation.

Last week, for example, I was with a kinesthetic physician who was leaving the office at 8 or 9 p.m. every night because she had been told that dictating is the best way to document. Although dictating is a good way to document, it was not working for her. Rather, she needs to do the documentation while she is in the room with the patient. I switched her to a template that she uses during the patient visit so that her documentation is ongoing and complete at the end of the visit.

Using a template would drive an

“Physicians seem to perpetuate the pain of doing their own charting, which is based on bad habits they learned during their training. Medical school teaches physicians to write everything down, but this is a slow method of documentation.”

auditory physician crazy; for this type of physician, dictation is best. Even so, an auditory physician is better off dictating during the visit rather than at the end of the visit or at the end of the day because too much information is missed.

Q: *What is a documentation assistant?*

A: A documentation assistant uses a template to collect the data during a visit and offers an alternative to physician dictating. The assistant uses a checklist to make sure the physician does not miss anything as the visit progresses. The assistant has to listen well and needs to be able to write what he or she hears. There are simple tests that verify a person's listening and writing capabilities.

I was with a pulmonologist several months ago. The procedure he did took about 14 minutes, then it took him about 20 minutes to write the notes documenting the procedure. I told him he should have someone in the room with him to do the documentation during the procedure so that when he was done he could immediately go to another room and do another procedure.

Q: *Is it important that when the doctor leaves the room, no further documentation is required?*

A: That's the whole idea. The theory behind time management focuses on working in real time. Physicians who work in real time are 30% to 40% more effective than those who do not. Physicians should not put off doing something that they can do right now. Why should they stay in the office until 9 p.m. to complete charts? Physicians seem to perpetuate the pain of doing their own charting,

which is based on bad habits they learned during their training. Medical school teaches physicians to write everything down, but this is a slow method of documentation.

Q: *Have many doctors adopted electronic medical record systems?*

A: Not many. The doctors who have adopted these systems are usually in the office until 8 p.m. typing into the EMR. The problem with the current EMR software and the reason it is not widespread are that most EMR systems turn the physician into a transcriptionist: Physicians are forced to enter a lot of extra data and many are not good typists. Those who dictate and have someone else enter the data are doing much better.

Q: *Do physicians find it hard to change?*

A: Once we connect physicians with their vision, they change quickly. But they face challenges. One is they haven't allowed enough time in their day to be creative or to take the necessary time off to recharge their batteries.

Physicians are not destined to be unhappy for most of their careers. Most of the things that depress them about their work can be fixed.

Q: *How do you offer your services? Do clients come to Boca Raton?*

A: We offer a two-day training course on physician success strategies in Boca Raton. Many of our clients take the ideas presented in this course and implement them in their workplace.

We also go on site and do a comprehensive benchmark analysis of practices. We first look for what we call the low-hanging fruit, meaning the easy, straightforward ideas that

they can implement. Typically, the return on investment for our services comes in 30 to 45 days. We know the business of physician practices, and we know what to look for. It is startling how many simple, workable ideas are not being implemented.

To illustrate, let's take an average small practice that has \$1 million in cash flow per year. The practice may take all its checks and put them into a checking account that generates no interest. But if the practice opens an account that offers even 1.5% or 2% interest per year, that can add up so some serious dollars by the end of the year. It could be \$24,000, just for depositing the checks in a better way.

Q: *What types of practices do you advise?*

A: Our clients fall into three areas. The first group includes hospital-owned and HMO-owned group practices. These are corporately owned group practices that have been overlaid with a corporate philosophy and methodology of business that are incompatible with a medical practice, which operates more like a retail enterprise.

The second group includes subspecialty groups in niche markets that we help to build into large regional, national, and international practices.

The third group includes high-volume, successful independent practitioners who are looking to push the envelope of their business model, and we help them maintain or enhance their success.

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

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