

# PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

February 15, 2003

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## New Options for Malpractice Insurance

**A**s malpractice insurance costs continue to rise, physicians are seeking alternatives for cost-effective coverage. Some are simply choosing to forgo malpractice insurance, in effect self-insuring for malpractice liability. But others are creating new options for coverage.

In states hit hardest by the malpractice crisis (including Florida, Pennsylvania, and Texas), physicians are forming risk-retention groups to pool risk among group members. For example, the Bucks County Physician Hospital Alliance in Doylestown, Pa., has partnered with CLA Insurance Co., in Newtown Square, Pa., to form the Millennium Insurance Co., a risk-retention group. The company started operating on Jan. 1, and expects about 600 physicians to participate this year.

### Low Exchange Rates

Another option offered in Pennsylvania is an insurance exchange that physicians will capitalize. The Pennsylvania Healthcare Providers Insurance Exchange began underwriting policies on Jan. 1. The exchange is a commercial insurance company dedicated to providing malpractice insurance to physicians; it is fully licensed by the state, and subject to rules and regulations set by the state Department of Insurance. Tom Gaudiosi, an insurance executive in Philadelphia, serves as president and CEO of the exchange.

The insurance exchange will fully

insure member physicians who pay a one-time subscription fee to join and make annual premium payments. "The physicians get the exchange started by making a one-time capital contribution in the form of the subscription fee," Gaudiosi explains. "This fee provides the reserves that we must maintain according to state law."

The exchange itself has no employees. All day-to-day functions are handled by the attorney-in-fact, a role served by attorneys in the Philadelphia office of Duane Morris, a national law firm with a large health care practice. Duane Morris holds a major equity position in the exchange and manages its daily operations.

### Keystone Crisis

"Pennsylvania has received national notoriety in the last few years as one of the worst states in the nation in terms of the escalation of physician malpractice premiums and the exodus of malpractice insurers from the market," says Gaudiosi. "During the mid-1990s, between 15 and 20 insurers offered coverage to Pennsylvania physicians. Now, because many insurers have left the state or have gone out of business, many physicians who are good risks are left with virtually no option for malpractice coverage except for the joint underwriting association." The state insurance department runs the JUA, a malpractice insurer of last resort. Typically, it covers high-risk physicians rejected by other insurers, mak-

*(Continued on page 10)*

**It's Time to Confront Health Care Reform**

Last year, the health care system consumed 15% of our gross domestic product, the most since 1990. This year, when it comes to health benefits for the average employee, employers will pay \$5,496, an increase of 56% over the \$3,594 those benefits cost five years ago. But even while we are spending more for health care, 41.2 million people are uninsured, and this number could continue to rise. Researchers predict that for each 1% increase in health care costs, some 300,000 Americans lose health insurance. If premiums rise by 15% annually over the next five years, the number of uninsured will climb to 63.5 million.

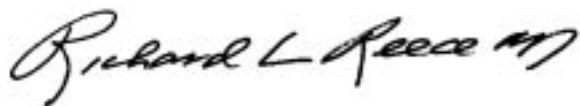
Calls for universal coverage are intensifying. For example, Bruce G. Bodaken, CEO of Blue Shield of California, which covers 2.6 million Californians, proposes that the state pass legislation covering six million uninsured Californians and require California employers to provide essential health benefits to all employees.

What's more, the single-payer system isn't being seen as a solution to the health crisis. Last fall, voters in Oregon defeated a proposal for a single-payer system after learning it would mean a tax increase of 17% and drive many businesses and health insurers out of the state. Elsewhere, many others are expressing fear about a single-payer system, saying it would be bureaucratic, costly, and limit choice.

Without universal coverage, health insurers foresee a crisis. As premiums rise, healthy employees will drop coverage while the sick hang on. Small wonder, then, that in letters to members of Congress, United HealthCare's CEO William McGuire, MD, has called for essential coverage, favoring a mixed package of universal coverage provided by private companies and some governmental assistance.

The Bush administration is avoiding the term "universal coverage" in favor of ideas that would expand coverage but not be too costly. These ideas include offering seniors a prescription-drug benefit if they join HMOs, establishing demonstration projects in states in order to extend coverage to the uninsured, limiting malpractice awards, and setting electronic standards to reduce paperwork costs and improve care.

But these proposals do not address the problems physicians face in providing care. Last year, the government cut Medicare reimbursements by 5.4%; another cut of 4.4% arrived in January; and a cut of 7% is proposed in the future. These cuts and other pressures are causing physicians to drop Medicare patients, to leave medicine entirely, and to seek work in other areas of health care. The upshot of this trend: Even if universal coverage is widely adopted, it will be of little value if physicians are not available to care for the sick.



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# Patient Privacy Deadline Looms

By Richard L. Reece, MD, editor in chief

**A**pril 14 is the deadline for physicians to comply with the patient privacy requirements under the Health Insurance Portability and Accountability Act. With only two months left to implement HIPAA's compliance policies, most physician practices are stymied: confused about the law's regulations and concerned over the cost of implementing technological solutions.

But HIPAA compliance does not have to be complicated or costly, says Bill Bysinger, principal of WGB Advisory, in Poulsbo, Wash. An expert on the act, Bysinger believes that HIPAA is not overly complicated, as some observers have characterized it.

"The actual law, which is only 17 pages, was not intended to offer a cookie-cutter approach or a definitive road map to adopting consistent policies, procedures, and standardized electronic data interchange and security technology," Bysinger says. "Rather, the rules were defined to be a guide and reference for health care organizations in their efforts to adopt process efficiencies and to reduce the costs of administration."

## Unnecessary Complexity

What has happened, according to Bysinger, is that many HIPAA experts and consultants have made HIPAA implementation extremely complex. "They expect organizations to spend an incredible amount of money and time attempting to reach a goal that was supposed to be easily adapted as

an iterative process over a number of years," he notes. "The industry has turned out thousands of pages in journals and books describing methodologies about HIPAA compliance. As a result, providers are extremely upset and apprehensive about the HIPAA regulations. The whole situation has gone out of control."

Another problem, Bysinger says, is that physicians are unclear about the penalties associated with HIPAA noncompliance. "According to the law, penalty amounts can reach as much as \$50,000, but the law does not specify how these penalties will be levied and enforced," he explains. "Any attorney can walk into a physician's office and charge the physician with having breached his or her patient's confidentiality.

"If physicians do not have enough documentation, meaning just a few relatively minor policies, as to their HIPAA compliance, they can be dragged into court," Bysinger continues. "In fact, I believe that the rules of HIPAA are going to be defined in the courts over the next five years. Medical malpractice may pale in comparison to the litigation that will develop around breach of patient privacy in health care."

Still, since physicians and other providers are required to comply with HIPAA, they are well advised to understand and embrace it. In doing so, they don't need to buy an excessive number of books or have someone in the organization become an

expert on HIPAA, according to Bysinger. "What they need is some guidance," he contends.

## Fostering Compatibility

"HIPAA is the catalyst for getting clinicians and others in health care to move toward integrated information delivery across electronic media," Bysinger explains. "HIPAA will help providers to be more efficient. It will allow claims to be paid electronically. It will help patients feel like they are important to the health care delivery process because when they show up at a care delivery location, providers will understand who they are and what their problems are, given that we will be able to build a longitudinal health care record."

The focus for practices should not be on the cost, but rather on the benefits to be achieved by complying with the law's regulations. By following a model for HIPAA compliance based on industrial engineering concepts, practices that implement HIPAA correctly should be able to lower operating costs by at least 10%, Bysinger believes. Also, HIPAA compliance should allow practices to reduce receivables by 30 days, reduce uncollectible bills by 10%, and increase patient satisfaction as well, he says.

"Practices should be able to get their claims paid much quicker than the turnaround of 60 to 120 days that is common today," Bysinger adds. "Payers will not be able to deny claims

*(Continued on page 4)*

**"The rules of HIPAA are going to be defined in the courts over the next five years. Medical malpractice may pale in comparison to the litigation that will develop around breach of patient privacy in health care."**

**—Bill Bysinger, WGB Advisory**

## Practices that implement HIPAA correctly should be able to reduce operating costs by at least 10%, receivables by 30 days, uncollectible bills by 10%, and increase patient satisfaction, says Bysinger.

(Continued from page 3)

due to incomplete information or formatting issues for practices that are HIPAA compliant because the act defines the information and the format necessary for clean claims.”

Health care has lagged behind other industries in terms of adopting technology, partly because health care organizations have not standardized data transmission formats. HIPAA should address this problem by setting mandates for the standardization of data collection and transmission, experts contend. As a result, the act may spur the development and adoption of information technology systems in health care, Bysinger claims.

“I have been disappointed in the efforts of the vendors in the health care industry to build good, network-based, easy-to-use systems,” Bysinger laments. “Unfortunately, many good technology companies in health care have failed because they could not get enough momentum in a market that has few visionaries. Consequently, there have been many good ideas over the last 10 years with regard to health care information technology, but few of them have come to fruition.”

### Ensuring Compliance

To comply with HIPAA regulations, physicians and other health care providers generally will need to ensure that medical records are

secure and that patient confidentiality is respected. “Of course, this is nothing new,” states Bysinger. “But physicians now need to define, in writing, what their practices have done to ensure confidentiality and why they have adopted those strategies. This process does not need to take a lot of effort.”

While many physicians say that HIPAA is a technological nightmare, Bysinger believes that complying with the act does not necessarily require more technology, but rather straightforward communication and collaboration with business partners. “HIPAA is 80% process and 20% technology that can be acquired from a vendor,” he says. “The process involves documenting that a practice is doing all the right things to ensure confidentiality. Physicians have been burned as a result of buying technologies that have had tremendous promise but did not deliver. I believe we can use HIPAA as a way to at least begin to adopt good processes. We can then automate the defined processes.”

Since HIPAA is based in part on fostering collaboration among multiple entities, physicians must ensure that the other entities understand the need to secure medical information. In fact, the best HIPAA consultants can help to guide physicians through HIPAA compliance, providing all the forms and templates needed.

“Physicians should have a method by which they communicate with the people to whom they are sending information and ensure that those entities will protect confidentiality,” Bysinger says. “Physicians also should communicate with their vendors and billing organizations to ensure that

data will be maintained in a format such that claims can be paid easily. Written correspondence confirming this understanding is the first step in HIPAA compliance.”

Bysinger also suggests developing a privacy and confidentiality policy to post in the office or to send to patients. “These written communications can be straightforward and not couched in the legalese that has developed in relation to HIPAA,” he adds.

### HIPAA Readiness

The federal Centers for Medicare & Medicaid Services has developed the “Provider HIPAA Readiness Checklist—Getting Started,” a tool for physicians and other health care providers to help them comply with HIPAA. Among the information and guidelines it advises are the following.

Both practicing physicians who do business electronically and their business partners will be significantly affected, CMS says, by the administrative simplification requirements of HIPAA in four areas:

1. Electronic transactions and code sets
2. Security
3. Unique identifiers
4. Privacy.

HIPAA does not require that all of the listed business transactions be conducted electronically. However, if physicians will be conducting any one of the transactions electronically, they will need to do so in the standard format outlined under HIPAA, CMS says. If a physician contracts with a third-party biller or a clearinghouse to conduct any of these transactions, the physician practice must ensure that its transactions are con-

*Editor's Note: More information on HIPAA readiness and CMS' "Provider HIPAA Readiness Checklist—Getting Started" are available on the Web (at <http://www.cms.hhs.gov/hipaa>). Also, CMS provides assistance by e-mail at [askhipaa@cms.hhs.gov](mailto:askhipaa@cms.hhs.gov), or over the phone at 866/282-0659.*

ducted in compliance with the act.

Therefore, the first step in HIPAA compliance involves determining if the practice is covered under the act. If a practice conducts, or if a third-party biller or clearinghouse conducts for the practice, any one of the following business transactions electronically, CMS says that the practice most likely is covered by HIPAA:

- Claims or equivalent encounter information
- Payment and remittance advice
- Claim status inquiry or response
- Eligibility inquiry or response
- Referral authorization inquiry or response.

If the practice is covered under HIPAA, it would need to assign someone in the office, such as the office manager, to be the HIPAA point person (HPP). The HPP would need to keep abreast of HIPAA requirements and would need the authority, resources, and time to prepare for HIPAA changes, CMS says. The HPP would educate others in the office about HIPAA.

The next step is to become familiar with the key HIPAA deadlines. By April 16, the practice or its software vendors must start testing the software and computer systems internally. Testing means ensuring that the software is capable of sending and receiving the transactions electronically in the standard HIPAA format. By Oct. 16, the practice must be ready to conduct transactions electronically in the standard HIPAA format with health plans and other payers.

Physicians need to determine if the office software is ready for HIPAA because each physician and other health care provider is responsible for making sure the software he or she uses will be compliant with the act. Practices should ask their practice management software vendor, billing agent, or clearinghouse to assess which items are conducted on paper and which are done electronically and then determine what needs to be done differently in order to comply with the act, CMS says. For instance, under HIPAA, additional data may

be required and data fields used now may no longer be required.

Physicians should ask vendors how and when they will be making HIPAA changes, and their answers should be documented in the physicians' files, CMS says. Physicians should remind vendors, third-party billers, or the clearinghouse about the April 16 deadline.

The next step involves discussing with health plans and other payers (especially those the practice bills most frequently) what they are doing to prepare for HIPAA and what they expect the practice to do, CMS says. Practices should ask if they have a HIPAA companion guide that specifies the coding and transaction requirements that are not specifically determined by HIPAA. While HIPAA mandates standard transactions, some health plans may not require data elements for every field, CMS says. For instance, payers should be asked for billing instructions on how to code for services that were previously billed using local codes. Under HIPAA, local codes are eliminated.

Also, health plans should be asked if they will have agreements with trading partners that specify transmission methods, timelines, and coding and transaction requirements that are not specifically determined by HIPAA. The health plans also may specify how HIPAA compliance testing and certification are to be done. Physicians should ask health plans about testing the physicians' software to ensure that the plans will be able to receive the claims they submit using the updated software. If the practice uses software or systems provided by the health plan (such as on-line direct data entry) to conduct transactions, it should ask whether the plan will continue to support these systems.

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

## HIPAA Compliance Deadlines

Date	Deadline
April 14	Privacy regulations apply for all covered entities except small health plans.
April 16	Electronic health care transactions and code sets. All covered entities must have started software and systems testing.
Oct. 16	Electronic health care transactions and code sets. All covered entities that filed for an extension of April 16 deadline and small health plans.
April 14, 2004	Privacy regulations apply for small health plans.
July 30, 2004	Employer Identifier Standard applies for all covered entities except small health plans.
Aug. 1, 2005	Employer Identifier Standard applies for small health plans.

Source: Department of Health and Human Services, 2003.

# California Starts Retreat From HMOs

Only 58% of physicians in California are accepting new patients with HMO coverage, and the so-called California model of loose networks of private practice physicians organized into large IPAs is unraveling, according to a new report.

At one time, California led the nation's charge into managed care, says Kevin Grumbach, MD, director of the Center for California Health Workforce Studies. California has always been a bellwether state for managed care. Many policy analysts anticipated that by the 21st century, the state would have a fully mature managed care market: Most patients would be enrolled in one of a handful of consolidated HMOs, and most physicians would be working in large organized medical groups, the report says. The results of the 2001-2002 *California Physicians Survey* conducted by the Center for the Health Professions at the University of California at San Francisco (UCSF) suggest that a dramatically different scenario is now playing out in California.

## Out of Patience

"Our study of the state's physicians tells us that California has now sounded the retreat," says Grumbach, a professor of family and community medicine at the UCSF and at San Francisco Hospital General Medical Center. Results of the survey commissioned by the California HealthCare Foundation (CHCF) and conducted by researchers at the Center for the Health Professions show that private physicians are abandoning

HMOs, IPAs, and managed care networks. For the report, researchers surveyed 1,033 physicians throughout the major urban regions of California.

The California HealthCare Foundation, in Oakland, is an independent philanthropy working to ensure that all Californians have access to affordable, quality health care.

More than 33% of specialist physicians in California have no patients in their practices who are insured by HMO plans, up from 23% of specialists without HMO patients in 1998, the survey results show. The rate of physician participation in private HMOs is approaching the historically low rate of physician participation in Medi-Cal, the state's insurance plan for low-income Californians, the researchers say.

"The problem of lack of availability of physicians in many regions of California is largely due to physicians not accepting patients with certain types of insurance, rather than to an absolute deficiency in the number of physicians practicing in California," Grumbach explains.

## Network Disruption

Even more telling is that fewer physicians are participating in IPAs, the most common form of network for physicians. In 1996, 73% of all office-based primary care physicians in California were members of an IPA; last year, 62% belonged to an IPA.

Only 55% of specialist physicians in California participated in an IPA last year, down from 65% in 1998, the report shows. The survey also

shows that many physicians remain in solo practice. Among specialists, 46% are in such offices, and among PCPs, 34% are in solo practice.

Compared with earlier surveys, physicians report a net increase in hours worked per week. While the majority of physicians reported no change in the number of hours worked in the past year, almost a third of primary care physicians and a quarter of specialists reported that on average they worked more hours in 2000 than they had the year before. The net change in hours worked amounts to an increase of about two hours per week per PCP and half an hour per week per specialist.

While most physicians reported that they received information about their patients' satisfaction with care, prescribing habits, preventive care service delivery, and disease-specific practice patterns, they did not always find such information useful. Most physicians said that they found these reports useful when they came from their medical group and less useful when they came from a health plan, an IPA, or a hospital. Physicians with Kaiser Permanente, however, rated the usefulness of these reports higher than did physicians in other offices.

Results from the survey also show the following:

- Satisfaction with being a physician has been stable for the past several years. About 80% of California physicians are satisfied with being a physician, similar to the percentage reporting satisfaction in past years.
- Retirement plans among physi-

**More than 33% of specialist physicians in California have no patients in their practices who are insured by HMOs, up from 23% of specialists without HMO patients in 1998, the survey results show.**

## Fewer physicians are participating in IPAs, the most common form of network for physicians. In 1996, 73% of all office-based PCPs in California were members of an IPA; last year, 62% belonged to an IPA.

cians have not changed over the past several years. About 80% of physicians plan to still be practicing medicine and seeing patients in three years, similar to responses from prior surveys.

- Physicians describe the practice environment in their communities as poor. Although most physicians remain satisfied with their profession, most nonetheless perceive major problems in recruitment and retention of physicians, payment rates, and the overall practice climate in their community.
- Most physicians are not threatened by proposals to expand the scope of practice for nonphysician clinicians, such as nurse practitioners, optometrists, and midwives. More than two thirds of physicians reported that laws that have increased the scope of practice for such nonphysician clinicians have had no effect on their professional security.
- Many physicians recognize that there are social disparities in access to medical care. In addition to being

concerned about how the health care system works for them, physicians also perceive problems in how the system works for certain patients. Among physicians, 77% believed the health care system treated people unfairly based on whether they had insurance, 33% thought the system treated people unfairly based on race and ethnicity, and 16% thought the system treated people unfairly based on gender.

### An Exceptional HMO

The one exception to the trend away from participation in managed care was found at Kaiser Permanente, the large HMO that operates in many markets in California. The HMO appears to have the most staying power for California physicians, the researchers say.

Compared with office-based physicians, Kaiser Permanente physicians are much more likely to:

- Believe their practice organization has advantages for shared practice responsibilities and quality of care

and not just for obtaining managed care contracts and patient volume

- Receive financial incentives related to performance based on quality of care and patient satisfaction
- Rate the practice pattern information they receive from their health plan as accurate, useful, and intended to improve quality of care
- Work in interdisciplinary teams
- Disagree that they experience pressures to limit referrals to specialists or the ordering of medical tests.

Physicians working in Kaiser Permanente consistently express more positive opinions about their medical practice organization than do physicians working in IPAs and other types of managed care networks, the UCSF researchers add. About 20% of California's PCPs and 15% of the state's specialists work in the Kaiser Permanente system.

—Reported and written by Joseph Burns, editor. More information on the survey is available on the Web (at [www.futurehealth.ucsf.edu](http://www.futurehealth.ucsf.edu)). More information on physician practice strategies is available on our Web site (see page 16).

## Value of Participating in IPAs or Large Groups (Percentage of respondents, 2001)

	Net practice income		Quality of care		Overall practice viability	
	PCPs	Specialists	PCPs	Specialists	PCPs	Specialists
Advantage	33	20	16	8	38	32
Neither	25	27	32	34	28	32
Disadvantage	42	53	52	57	35	37

Source: 2001-2002 California Physician Survey, Center for the Health Professions, University of California, San Francisco.

# Communication, Friendly Staff Build Loyalty Among New Patients

In the early months of a new year, many physician practices, including rheumatology practices, often get an influx of new patients. This is particularly evident when employers adopt new health plans or patients switch plans. Cultivating the loyalty of new patients through a welcoming atmosphere and attentive care is crucial to building a solid patient base.

Efforts to ease the anxiety of new patients are especially important in a rheumatology practice, which treats many elderly patients and those in pain or discomfort. In addition, a warm and welcoming practice atmosphere can help to ease the concerns of new patients who are anxious about their care, thereby making it more likely that they will be able to focus on the physician's recommendations and accept and adhere to treatment regimens.

## Meeting Expectations

"Patients who are new to a practice, especially those who have selected a physician from a managed care directory or from the telephone book, will have no idea about what to expect from the physician or the practice," says Susan Keane Baker, a physician practice management consultant in New Canaan, Conn. "The opportunity to shape these expectations in a positive way before the actual visit, and then follow up with a welcoming

experience at the office, is invaluable for setting the tone of the relationship. Making a good first impression is an opportunity that will never come again."

Baker is the author of *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients* (San Francisco, Jossey-Bass Publishers, 1998), and an expert on how to build and maintain successful physician-patient relationships.

## Practice Accessibility

A practice will be perceived by new patients as welcoming if it is easily accessible to them. "For example, rheumatologists may be part of large multispecialty groups, which often have impressive-sounding names," Baker points out. "A name such as Springfield Medical Associates can be an asset if it is easier to remember than the physician's individual name. The challenge for new patients is that they may arrive at the office looking for a Dr. Giles, but if Dr. Giles' name isn't listed, the patient might be confused and waste time trying to find where to go." Each physician's name should be listed on the medical directory in addition to the group's name, Baker advises.

Rheumatologists also should be sure that patients are easily able to find the telephone listings for their practices. "Patients whose friends recommend a rheumatologist may

look for the physician's name in the Yellow Pages," Baker says. "Rheumatologists should be sure that these potential patients can find them by having their names listed in local and regional telephone books."

Also, office signs should be clear and welcoming to new patients. "Rheumatologists' names, as well as the name of the practice, should be conspicuously visible in the lobby of the office building where the practice is located," Baker says.

"In addition, the rheumatologists' office building and address should be identifiable from the street," she points out. "Signs should face approaching traffic rather than be posted parallel to the street. And if cars park on the street outside the building, the signs should be higher than an SUV parked in front of the entrance."

## Preparing for the First Visit

Developing a database of patient information and expectations can be extremely helpful in creating a positive experience for new patients, Baker says. "During the telephone call scheduling the first appointment, the receptionist should note any questions the new patient asks," she says. "What is he or she concerned about? These concerns can be addressed immediately by the receptionist or later by the doctor during the visit.

"Notations can also be made of

(Continued on page 9)

**Efforts to ease the anxiety of new patients are especially important for rheumatology practices seeking to build patient loyalty because these practices treat many elderly patients and those who are in pain or discomfort.**

**“Patients are pleased when they feel that staff treat them as a top priority. If they are treated as interruptions in a staff person's day, their response is going to be negative. Patients, especially new patients, pick up on staff attitudes very quickly.”**

**—Susan Keane Baker, practice consultant**

*(Continued from page 8)*

other comments the patient makes,” Baker continues. “For example, if the patient mentions that a previous physician always had one thing on his mind—for example, football—and the patient hates football, a notation can be made to the rheumatologist to avoid any small talk involving this topic. A database can help physicians and staff members to quickly recall the kind of information they would never be able to remember on their own. Other information that can help rheumatologists and staff build relationships and personalize visit encounters—such as a patient’s career or favorite hobbies—can be noted as well.”

Rheumatology practice staff can keep track of the questions new patients ask and try to address those that are most common. “For example, new patients often ask: ‘How do I get to your office?’ ‘Where is the restroom?’ and ‘What is the doctor like?’ So many of these questions can be answered on the practice’s Web site or in a letter mailed to the patient in advance of the first visit,” Baker notes. “In addition, information can be sent in response to identified concerns or needs. There is no need to create, print, and distribute an elaborate brochure. A hand-signed welcome letter is equally effective for most practices.”

### Identifying New Patients

A practice’s staff should have a way to identify new patients prior to their arrival at the practice for their first visit. “Asking, ‘Are you a new patient?’ is not the best way to greet

new patients,” Baker says. “This question risks offending an established patient, who will feel unrecognized and unimportant to the practice. What’s more, it may unintentionally create bad feelings. A better approach is to know in advance that the person scheduled to come in at 10 a.m. is a first-time patient.”

Of course, staff should greet all patients—whether they are new or are returning to the practice—with a warm smile when they arrive, adds Baker. “A friendly greeting reduces a patient’s anxiety and increases his or her trust,” she says. “Patients are pleased when they feel that staff treat them as a top priority. If they are treated as interruptions in a staff person’s day, their response will be negative. Patients, especially new patients, pick up on the staff’s attitudes very quickly.”

### Lasting Impressions

The atmosphere in the office’s reception area is extremely important for any practice seeking to create a good first impression for a new patient. “The first 60 seconds of the new patient’s visit are critical,” says Baker. “Anyone who has ever walked into a store or a restaurant, taken a quick look, and immediately turned around and walked out knows that whether or not a particular business is going to meet his or her needs can be revealed in just a quick scan. Patients react the same way. They are very attuned during that first minute as to whether they expect to be happy in the relationship.”

Cleanliness and safety of the reception area are particularly important

in creating a good first impression. “Cleanliness and safety are two areas where improvements are relatively easy to make if the staff in the practice notice the need,” says Baker. “Aside from the obvious fact that if a patient is injured in the practice generates the wrong kind of word-of-mouth commentary, it’s also a time-waster. Insurance brokers can arrange for a complimentary consultation on safety in the practice. Fire departments also occasionally offer this service. Physicians and staff may pick up and act on patients’ comments, such as, ‘Someone could fall on that frayed carpet,’ or ‘My cane almost got snagged by the loose threads.’”

Rheumatologists may also want to take what Baker calls the dead-bug décor test. “Patients often spend time staring at the ceiling, and so they notice the light fixtures,” she says. “Physicians and their staff don’t usually look at light fixtures, or even the window sills adjacent to where patients sit. The patient who notices two dead bugs in a light fixture in March and then five dead bugs in June is likely to begin to wonder how clean the practice is. If dead bugs are present, it’s possible that there are other areas that also need attention. It is hard for some practices to ask patients, ‘Is everything clean enough for you?’ but practices might consider approaching the matter the way some hotels do: Have a notepad for patients that asks, ‘Please help us have the best possible atmosphere for your next visit. Is there anything that we should bring to the attention of our cleaning and maintenance staff?’”

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ing it the most expensive coverage option in Pennsylvania.

"In the last few years, carrier after carrier has withdrawn from the market," says Sheri Putnam, executive director of the Bucks County Physician Hospital Alliance. "Pennsylvania is a disadvantaged state in terms of tort reform. We have not had the benefit of the same tort reforms that other states have had for probably 20 or 30 years. Furthermore, insurers had cut premiums to low lev-

els in order to steal market share from competitors; those low premiums caught up with them when increases in the frequency and the amount of malpractice awards exceeded the amount of money the insurers had collected in premiums."

Physicians in other states have seen similar trends. Currently, 17 states have been designated by the *Medical Liability Monitor* as having a malpractice insurance crisis. The most critically affected states are

Florida, Nevada, Pennsylvania, and West Virginia.

Contributing to the crisis is the exodus of insurers from the malpractice business. "For example, St. Paul Insurance Co. was the largest malpractice carrier in the country," says Greg Scott, executive vice president of Millennium Insurance Co. "It wrote about 10% of medical malpractice policies nationwide. At the end of 2001, St. Paul announced it was exiting the malpractice business. That left many physicians without insurance."

### A New Option

For physicians formerly insured by St. Paul and other insurers that have left the market, the exchange in Pennsylvania is a welcome alternative. "The insurance exchange model is actually not a new model," Gaudiosi explains. "In fact, many physician insurance companies that were created in the 1970s when the first malpractice crisis hit were created according to an exchange model."

An insurance exchange is like other commercial insurance company models in that the financial risk is transferred to the exchange, which is responsible for paying claims. The physicians are not liable beyond the premiums they have paid.

The exchange will offer rates that are lower than those of the JUA. "But we will not be the cheapest insurance available, either," Gaudiosi states. "If rates are too low, we will not be able to sustain the exchange. We will charge premiums that we think are adequate in an effort to provide stable coverage for the state's physicians."

Making stable and reasonably priced malpractice insurance available will not be enough to mitigate the malpractice insurance crisis, however. Physicians will need to change their behavior as well,

## Three Ways to Cut Risks

**T**here are steps physicians can take to ease their medical liability burden, including reporting adverse events earlier, agreeing to a coordinated legal defense when several physicians are named in a lawsuit, and improving physician-patient communication, experts say.

Data collected by the Physician Insurers Association of America in Rockville, Md., shows that physicians take an average of 23 months to report adverse incidents to their insurers.

"If physicians have a bad outcome, they do not report it if they decide that they did not do anything wrong," says Tom Gaudiosi, president and CEO of the newly formed Pennsylvania Healthcare Providers Insurance Exchange. "They are afraid that their rates will increase or that they will be dropped by their carriers. It appears that physicians are waiting until they are sued before reporting adverse events. But 23 months is a significant length of time during which plaintiffs' attorneys can make their case."

The exchange is asking physicians to report incidents early, so that costs can be controlled more effectively. "If they do not, participation in the exchange will be denied," Gaudiosi says. Several Pennsylvania hospitals have expressed an interest in working with the exchange to facilitate physician reporting, he adds.

Another issue that makes it difficult to defend physicians is that plaintiffs' attorneys often list as many defendants as possible in a lawsuit. "The plaintiffs' attorneys have found that their most successful cases are won when defendants start pointing fingers at each other in an effort to protect themselves," Gaudiosi observes. "To participate in the exchange, insured physicians, when they are jointly named in a lawsuit, must agree to a coordinated legal defense."

Improved communication between physicians and patients may reduce the number of claims as well. "We hear anecdotal stories about physicians who can talk themselves out of any lawsuit because they have great bedside manner, and physicians who are superb clinicians but who are arrogant and do not have good patient rapport," Gaudiosi observes. "The whole issue of physician-patient communication is one that needs to be stressed from an educational standpoint."

—DJN

## Since Pennsylvania has not had tort reform, malpractice insurers have left the state, says Sheri Putnam, executive director of the Bucks County Physician Hospital Alliance.

experts say (see sidebar). “We are promoting some very strong behavioral modifications along with offering malpractice coverage,” Gaudiosi notes.

The development of the exchange has spurred interest in the model from physicians in other states. “We have received many calls about how the exchange model can be implemented elsewhere,” Gaudiosi reports. “Right now, all eyes are on us. The Pennsylvania Healthcare Providers Insurance Exchange is trying to help physicians in a state with few options for malpractice insurance. Physicians may initially be uncomfortable with some of our conditions and initiatives, but by offering malpractice insurance at reasonable rates and by encouraging changes in physicians’ behavior, we may be able to get the malpractice crisis in our state under better control.”

### Risk Retention

Another option for physicians in Pennsylvania and in some other states is risk retention. Approximately 40 health care risk-retention groups are operating nationwide, Scott says. “Risk-retention groups can be local, regional, or even national,” he explains. “They are formed under federal as opposed to state law, and most insurance companies are regulated by the state in which they operate. In 1986, when the last general insurance crisis hit, Congress enacted a federal law allowing groups of people or companies that have similar business exposures to join together to self-insure. The risk-retention group must be owned by its insureds. For doctors, the advantage of such an arrangement is that they can own the

company and control their destiny. They finance and run the insurance company and then share any profits.”

Since the Bucks County alliance physicians are located about 30 miles outside of Philadelphia, they were subject to the high cost of insurance in the Philadelphia market, Putnam explains. “Our malpractice rates reflect the situation in the city, with its many academic medical centers and very high acuity cases,” she adds. “Yet as suburban doctors we don’t have the same high risk exposure that physicians in Philadelphia have. We find it attractive to be able to create our own risk pool and self-insure among our own colleagues. In addition, we do not have the huge infrastructure costs that a large established insurer must pay. And a risk-retention group does not have to worry about returning specified profits to shareholders, as does a traditional insurance company.”

Any physician in Pennsylvania can apply and will be insured by Millennium if he or she meets the underwriting criteria, which includes an acceptable claims history and proper risk management, Putnam says.

The risk-retention group will not offer malpractice insurance much below the rates that are available on the commercial market, Putnam adds. “But we hope that by keeping our rates very conservative over the first few years, we will remain viable and provide stability,” she says.

The physicians face some risk by participating in the risk-retention group, although this risk is manageable, notes Scott. “If the company were to fail, the physicians would have to shoulder the cost of defending their own claims and paying any

judgments, and they would lose their capital contribution,” he says. “But they are not responsible for any of Millennium’s corporate losses or debt, and they can replace their coverage with another carrier that offers prior act coverage or the JUA such that any claim that hasn’t already been brought will be covered.”

Whenever a claim is filed, the risk-retention group is required to put aside money to cover it, Scott says. “The amount of capital in the risk-retention group becomes very important,” he says. “As long as there is adequate capital in the company and the regulators are doing their jobs, the money to pay claims will be there.”

The key to minimizing risk is proper capitalization, Scott points out. “Some risk retention groups try to get by with statutory minimums, but that is risky,” he adds. “The company must be able to support its exposure and have surplus funds beyond those set aside to pay estimated claims.

“Physicians are beginning to understand that risk-retention groups are a viable alternative to traditional malpractice insurers,” Scott continues. “They have been very successful over the years, and many big-name organizations have used risk-retention groups to serve their insurance needs. Physicians just need to be cautious in looking at the risk-retention group to make sure it is prudent in its finances. If physicians hear about a group that is offering cheap rates, they should run in the opposite direction.”

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

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To get an idea of the atmosphere in the reception area, Baker advises doctors to sit there as a patient would and ask themselves: What message does this room send about my practice? “That area is the first part of the practice that patients and their family members are going to see, and they may spend some anxious time there,” she says. “So it needs to be as reassuring as possible.”

Another way to increase a new patient’s comfort while also helping to build loyalty is to offer to give the patient a tour of the facility. “Giving a tour, showing the equipment, pointing out the rest rooms, and introducing staff are all ways of reducing the anxiety of new patients,” says Baker. Such activities, simply by being unusual in most physician practices, can enhance patients’ positive perceptions of the practice and will be undoubtedly be mentioned when the patients tell friends and family members about their visit, thus helping the physician build new patient volume.

### Improving Interactions

New patients are also likely to notice how the staff interacts with other patients, a factor that can contribute to a patient’s perception of the practice. “When a new patient enters a practice, he or she watches how other patients are treated, knowing that that is how he or she will also be treated,” says Baker. “A practice’s staff and physicians are well advised to never make jokes or speak about one patient to another patient when others can overhear the conversation.”

Rheumatologists also should understand how their body language and general social interaction skills might make a new patient feel

either welcome or uncomfortable. “Physicians know that it’s the simple things—such as greeting their patients, shaking hands, making eye contact, using the patient’s name, sitting if the patient is sitting—that can make a difference, but they forget how important these social skills are,” Baker observes. “Physicians who create physical barriers between themselves and their patients, who speak too quickly, or who seem distracted will not make a good impression, and may instead increase a new patient’s anxiety.”

### Taking Time

Despite their busy schedules, rheumatologists should make time to help new patients understand how to work successfully with their practice, Baker suggests. “Taking this time during the initial patient visit will pay off later in terms of patient loyalty,” she says. “The first visit is an ideal time to explain how the practice operates and how it is different or unusual.

“For example, perhaps a rheumatology practice maintains a policy of not ordering refills after hours because the rheumatologists want to have the patient record at hand when they renew a medication,” Baker continues. “It is easier—and certainly less uncomfortable—for a patient to learn about this policy during the first visit instead of after having called the physician on a Friday evening. Or perhaps the rheumatologist on call, rather than the patient’s own rheumatologist, sees patients who need a same-day appointment. Explaining these policies at the start of the relationship helps new patients know what to expect and prevents them from being disappointed or feeling awkward later.”

### Ending the Visit

New patients are most likely to tell others about their new doctor during the first seven days after the initial visit. “Simply asking, ‘How are you feeling and how was your visit with us?’ can provide the kind of information that generates both patient loyalty and tangible opportunities for improvement,” Baker explains. “Suggested improvements should be considered carefully and undertaken when appropriate. A new patient satisfaction survey is an interesting idea, since it lets patients know that their feedback is welcome. Information gathered could be used specifically to enhance the first-time patient experience.”

Finally, Baker suggests that it is effective to close the new patient’s first encounter by asking, ‘What questions do you have?’ ‘Is there anything else I can do for you today?’ ‘I’m looking forward to seeing you next time,’ or ‘Please call me if you have any questions.’

“Patients like to have the sense that the physician wants the relationship to continue and that he or she cares whether or not they will come back,” Baker adds. “Some sort of assurance of a continuing relationship is comforting to patients. In addition, a follow-up note or a telephone call to the new patient can inspire the kind of positive word-of-mouth that can lead other people to call for an appointment.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16). Readers may contact Susan Keane Baker by phone at 800/980-8444 or on the Web (at [www.susanbaker.com](http://www.susanbaker.com)).

**Simply asking a patient, “How are you feeling and how was your visit with us?” can provide the kind of information that generates both patient loyalty and tangible opportunities for improvement, says Baker.**

# Physician Simplifies Practice, Achieves Greater Satisfaction



**Keith E. Berger, MD**, a gastroenterologist in solo practice in Virginia Beach, Va., has been in practice since 1981. In this interview, he discusses the dramatic changes

he recently made in his practice with **Richard L. Reece, MD**, editor in chief.

**Q:** Why and when did you decide to practice as a solo practitioner?

**A:** I began practicing as a solo practitioner about 20 years ago. After a few years, I added a partner and subsequently added additional partners. By 2001, when I made a major change in my professional life by returning to solo practice, I had added three additional partners to the practice.

**Q:** What convinced you to make that change?

**A:** In general, I was unhappy with the practice environment. We had a traditional consultative gastroenterology practice, including five partners working out of three office locations. But I came to a point where I didn't feel I could maintain a high-quality, patient-oriented focus in my work. I knew that somehow I needed to make a change. The practice was not giving me the satisfaction I wanted. I didn't feel good about the work that I was doing, and I actually hated coming into work. I dreaded my on-call time.

Life is short. I want a professional life that I could enjoy. So I committed myself to creating a professional life that I love. I was willing to cut myself loose from the practice, and I did not necessarily know at the time

what I would choose or what I would create. I just made a commitment to change.

**Q:** What were some of the factors that led you to this point?

**A:** There are many factors that I could list: managed care, administrative harassment, rushing, and doing too many things. I just got the sense that I had lost touch with the original commitment I had when going

**Q:** How did you decide on the direction to take your practice?

**A:** I started considering different ideas. In general, I felt that given the way managed care has been implemented, the practice of medicine has become more impersonal. The personal touch has clearly been missing. We have become high tech, low touch. I thought patients might be willing to pay to see a doctor who

**“I committed myself to creating a professional life that I love. I was willing to cut myself loose from the practice, and I did not necessarily know at the time what I would choose or what I would create. I just made a commitment to change.”**

into medicine. I was not doing the things that I loved, or I was doing them in an environment where I was not appreciated.

The story about the slowly boiled frog is an appropriate metaphor for my situation. If you put a frog in hot water, he'll jump out; but if you put him in cold water and turn up the temperature slowly, he'll stay in there until he's cooked. Similarly, I remained in my professional situation as it became more and more unpleasant, and I was cooked.

But change is scary. The practice was financially successful. We had three offices, we were busy, we had a good reputation, we had nurse practitioners, and we were in a large limited liability corporation. It was a stable, secure environment. I had been complaining for years, but then I took a stand, despite the fear of change.

would truly listen to them and provide great service.

I eventually decided to focus on an area of my gastroenterology practice that was enjoyable for me and a good fit for my personal and professional ideology: preventive medicine, particularly colorectal screening. I love doing colonoscopies, and I have a real skill and ability to do them quickly and well. So I decided to create a practice centered on preventive medicine. I could then focus on the diagnostics and not do the hospital work, which would simplify my life.

**Q:** So your key to success has been simplifying your practice by specializing in something you do well.

**A:** Yes. If physicians would think about which aspects of their practices they love, they could find a way to reorganize or change their practices to be centered on that pas-

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sion. Of course, this takes courage and a willingness to stop complaining and to start taking action. But the payoff comes when physicians find that they are not only much happier, but are probably doing better financially as well. I have simplified my practice by focusing on one niche, so that all the processes in the office have also been simplified. In addition, my practice is more service oriented, more patient oriented. I don't have all of the excess administrative work I had in my former practice, and I have the freedom to create a system that really works.

**Q:** By what measures would you say your practice is successful?

**A:** I leave the office by 5:30 p.m. with all my work done. When I leave, I don't have a single chart on my desk.

I earn enough money to increase my income, fund my retirement, reward valued employees, and introduce innovative new services. Our

in compliance, and we have no concerns about how we are coding. We also avoid expensive rework, such as denied claims and the need for additional documentation.

My practice has become more patient responsive and friendly. Many physicians are unhappy, and one of the reasons is that they know they are not providing the service they want for their patients. They can't take the time with their patients that they would like to, and they hate themselves for it. I get extraordinary compliments almost every day, and I received only one complaint last year. Partly as a result of this, my staff of three full-time and one part-time employee are happy. I hire manager-level staff to work in my office, and I pay them good salaries. I feel that it is critical to hire competent people and pay them appropriately.

I now have fun practicing medi-

**Q:** Please describe the activities of your typical day.

**A:** I perform colonoscopies on Mondays, Tuesdays, and Wednesdays. We start at 7:30 a.m. and perform procedures until 2 p.m. I usually do paperwork regarding those procedures for two or three hours in the afternoon. On Thursdays, I handle the other administrative needs of the practice, either in the office or from home. These types of tasks include legal work, new projects, revising forms, and improving our computer programs. I take Fridays off, and my weekends are free. My on-call duties consist of being available for any potential complications of a colonoscopy, which are rare.

**Q:** What technologies or strategies have you implemented to enhance your practice?

**A:** I wanted to communicate easily with my referring physicians, so I implemented a speech recognition

**“If physicians would think about which aspects of their practices they love, they could find a way to reorganize or change their practices to be centered on that passion. Doing so takes courage and a willingness to take action. But the payoff comes when physicians find that they are much happier and are probably doing better financially as well.”**

collection percentage is high, and I am getting paid fairly for my work. My overhead is at least 10 or 15 percentage points lower than it was in my former practice.

I have no concerns regarding the efficiency of my practice. We are completely office based. We deliver tremendous cost savings for screening colonoscopies. So, in my view, we are an asset to an HMO. In addition, it is painless to audit our charts because we use only a limited number of codes. While we do chart reviews, we are very familiar with the few codes that we use, and it is easy to remain up to date on the coding rules for these few services. We are completely

My staff and I enjoy our work, and we deliver top-quality service. My practice is satisfying because our work is focused around the patient, the doctor, and the staff. We have been able to design our office processes so that our systems are transparent to the patients. All the incentives are aligned around what is best for them.

Patients can easily be put on our schedule, and they need to come in for only one appointment. While the typical outpatient colonoscopy takes about three hours of a patient's time, a colonoscopy visit in our office is 75 minutes from start to finish—including time in the waiting room, the set-up, the procedure, and recovery.

system. When I complete a procedure, I immediately go to my consultation room and dictate into the computer a complete letter and report to be sent to the referring physician. Frankly, it takes me longer to do that myself than follow up using a transcription service, but the referring physician receives the letter more quickly. The letter is electronically faxed to the referring physician's office before the patient has left my office.

In addition, the system saves me \$10,000 to \$15,000 a year on transcripts. Furthermore, I find a tremendous satisfaction in being able to write a personal letter to each physician, thanking him or her

**“Unfortunately, the HMOs have yet to become interested in quality of care. They say they are interested, but we find that we have to engage them and explain the value of providing extraordinarily high-quality work and service.”**

for the referral and reporting my findings. The referring physicians appreciate this level of communication, and it's part of my practice's service orientation.

In addition, we are probably the only practice in our area that routinely uses anesthesiologists. Incorporating anesthesiologists into care enables us to use a more rapid-acting sedation, so that patients experience no discomfort and have less down time. What's more, we are able to improve our own efficiency.

Previously, charts would sit on my desk, and I stopped sending letters to physicians because it was just easier to send them a copy of the report when the pathology results came back one to two weeks after the procedure. Now, for a colonoscopy that was performed on Monday, I send off a letter to the referring physician that day, and that same week, I send the pathology report.

We also send patients a history screening form prior to their visit. When they come in, the nurses interview the patients and do a thorough screening. We are very careful to screen patients for possible risk factors prior to the procedure. Then, before the colonoscopy, I meet with the patients, review all the information, and generally spend time answering their questions rather than extracting information from them.

**Q:** What has been the feedback from HMOs?

**A:** Unfortunately, the HMOs have yet to become interested in quality of care. Of course, they say they are interested, but we find that we have to engage them and explain

the value of providing extraordinarily high-quality work and service. For example, the fact that we use an anesthesiologist has been a problem for some of the HMOs because they are not interested in paying for anything that they deem is unnecessary. But we believe that having an anesthesiologist makes an enormous difference in the quality and the comfort of the procedures. Since we want that additional safety margin, we are committed to persuading the HMOs that this is the best way to practice. On the other hand, HMOs like the fact that we perform the colonoscopies in an office setting because we are saving a lot of money.

We have no problem with getting reimbursed from Medicare. In Virginia, we have a law that keeps us from collecting a facility fee for doing office colonoscopies, but I treat Medicare patients anyway because I feel it is consistent with the ideology of my practice to offer preventive care wherever it is warranted.

**Q:** Given your experience with simplifying your practice, what advice do you offer to other physicians?

**A:** Physicians are perfectionists, are highly committed, and have a high level of idealism. When people like that allow themselves to be put in situations that do not allow them to be committed, idealistic, and perfectionists, they create an environment conducive to frustration, resignation, and cynicism.

I recommend the book, *Built to Last: Successful Habits of Visionary Companies*, by James Collins and Jerry I. Porras (New York: HarperCollins, 1994). It's a wonderful study of what it takes for people

to create extraordinary businesses and organizations and is very applicable to medical practice. Collins recently wrote another book, *Good to Great: Why Some Companies Make the Leap... and Others Don't* (New York: HarperCollins, 2001), which is about what it takes to transform a company. His premise is that you have to find and keep the right people first, be doing something you love, and keep it simple.

Another tool I can unhesitatingly recommend is the Landmark Forum, a course offered by Landmark Education in San Francisco ([www.landmark-education.com](http://www.landmark-education.com)). During this weekend course, participants examine their thinking and their relationships, and how they relate to their professions. The outcome of the course is that participants see many pathways and opportunities they might not have otherwise seen, giving them more choices for their future.

The most important point I would like to make is that anybody is capable of making changes. The tendency is to blame other people or certain factors rather than take a chance on making a change that could lead to a much more satisfying life. My recommendation to physicians is to be honest with themselves regarding whether they are happy with their practices. If they are not, then they should take some committed actions. All of us should gather the courage needed to pursue what we love to do.

—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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