Visit www.MDOptions.com

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

April 2007

EDITORIAL

Going Solo Continues to be an Attractive Option

For well over 20 years, health care policy experts have advised physicians seeking to be successful in a changing market to practice in larger groups. The experts say solo practitioners will be a dying breed in markets in which managed care dominates.

But recently, we have written about how physicians in solo and small-group practices have continued to succeed, despite the advice from experts. In speaking with physicians in these solo and small group practices we have learned that they cherish their independence. They also seek a deep personal relationship with their patients while working hard to reduce overhead and use information technology wisely.

Gordon Moore, MD, a solo family physician in Rochester, N.Y., has only one staff member: a nurse. He uses computers to make referrals, verify co-payments, and document patient care. He suggests using an electronic medical record system with voice recognition software to help reduce transcription costs.

On the other end of the spectrum from Moore is David Lawrence, MD, chairman emeritus of Kaiser Permanente. In his widely acclaimed book, *From Chaos to Care: The Promise for Team-Based Medicine*, Perseus Publishing 2002, Lawrence said solo practice was dying because one doctor, acting alone, could not meet the demands of medicine in America today.

Lawrence said a solo practitioner does not have the time, money, or organization to be a high quality physician. “For the simple and routine illnesses, he provides a valuable service. But for more complex and chronic conditions, neither he nor his colleagues in other solo or small group practices are prepared for what medicine now requires and patients demand,” Lawrence wrote. “The forces are too strong and the changes too profound.”

Using data from the 2003–04 National Ambulatory Medical Care Survey (the latest data available), the federal Centers for Disease Control and Prevention in Atlanta said there were 311,200 office-based physicians practicing in an estimated 161,200 medical practices in the United States. The survey showed that about 35.8% of office-based physicians were in solo practice. The survey involves nonfederal physicians who see patients in offices and excludes radiologists, anesthesiologists, pathologists, and physicians who treat patients solely in hospital, institutional, or occupational settings.

Clearly, solo practice continues to be attractive and some physicians in these practices are finding ways to make such practices successful. Perhaps such practices are attractive to many physicians because, like Moore, they are interested in eliminating barriers between patients and doctors and in making time for meaningful interactions with patients.

Richard L. Reece, MD
Editor in chief
Phone: 860/395-1501
Fax: 860/395-1512
E-mail: Rreece@premierhealthcare.com

This newsletter is published by Premier Healthcare Resource, Inc., Morristown, N.J.

Publisher
Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor
Joseph Burns
508/495-0246
editor@premierhealthcare.com

Billing and Coding Strategies Crucial for Practice Success

Physicians can find it challenging to tend to practice management concerns while focusing on providing high-quality care to their patients. By spending some time each week on establishing processes to ensure careful billing, coding, and other practice management functions, however, physicians can ensure that their practices will run smoothly and successfully.

"Physicians today face a number of external pressures, including declining reimbursement, increased government regulation, an increasingly savvy patient base, and increasing costs," says Kenneth T. Hertz, CMPE, a senior consultant with the Medical Group Management Association (MGMA) Health Care Consulting Group who has worked with many medical practices to improve their business functions. "All of these factors together are resulting in significant economic pressures on medical practices across the country. Focusing on the performance of the practice is necessary to ensure that the practice remains viable and able to serve patients into the future."

Compliance Integrity

Improving practice finances is one of several reasons physicians should focus on management. "Practices must be very careful with regard to compliance," Hertz notes. "Both governmental and private payers maintain specific rules and regulations about what services a physician practice may and may not bill for and how these services must be documented and coded. Furthermore, physicians also have an obligation to their patients in terms of providing an accurate recording of the clinical transaction that occurs between the practice's clinicians and the patients. It is extremely important that physician offices operate with integrity with regard to their business functions."

Large medical groups face similar challenges and can consider similar solutions regardless of practice size, although the challenges may be on a different scale. "For a small practice, good business management is important because it means the ability to keep the doors open and continue to serve patients," Hertz says. "A larger practice may have more flexibility, but at the same time it is more likely that business functions can escape control."

There is no silver bullet in good practice management, Hertz continues. "Rather, it is a matter of being attentive to details, investigating, and paying attention to the group's core business processes in the context of continuing to provide high-quality patient care," he adds.

How practices structure their accounting and reporting is very important, Hertz continues. "All practices, regardless of size, need accurate, meaningful, timely, and trended reporting of various performance indicators," he notes. "For example, financial statements should be produced quickly following the end of the month. If they are excessively delayed, the opportunity for improvement is also delayed."

Benchmark Data

Practices also should track key performance indicators and benchmark the data both among members of the practice and externally as well, Hertz says. MGMA performance and cost surveys offer excellent data for this purpose. "For example, practices should monitor their accounts receivable days each month," he adds. "If a trend analysis indicates that accounts receivable days are growing, then the physicians know they have a problem." Physicians should pay particular attention to the portion of accounts receivable that are 90 days and older. "If accounts get that old, they are obviously not being worked," he explains. "And the older an account gets, the more difficult it is to collect." When accounts become older than 90 days, physicians can expect to collect only on about 10% of these accounts.

"The billing process needs to be systematized and calendarized," Hertz asserts. "Practices should have a regular schedule for running credit balance and accounts receivable reports

(Continued on page 4)

Good practice management is a matter of being attentive to details and paying attention to the group's core business processes while providing high-quality patient care, says consultant Kenneth T. Hertz, CMPE, of the Medical Group Management Association.

(Continued from page 3)

and other performance indicators. Furthermore, the practice should set goals and expectations for physicians and staff performance and then work toward those goals using carefully defined strategies that are communicated practice-wide."

Practices also should monitor denied claims closely. "Many insurance companies believe that medical practices won't work the denials," Hertz says. "But practices should quantify denials, understand their causes, develop solutions to reduce them, and track them over time. Working denials must be done daily and constantly monitored."

Coding and Documentation

Physicians face several challenges with regard to billing. "When physicians leave medical school, they typically have not received any formal training regarding coding and documentation," Hertz notes. "Therefore, the physician will not know how to effectively and properly code for services. Given ongoing changes to coding and documentation regulations, even experienced physicians may code improperly."

The next challenge practices face is the fact that most patients do not truly understand their insurance coverage, Hertz continues. "This means that the practice staff must understand each plan, and be ready to explain the plan's stipulations to the patient," he notes. "The practice's billing staff must have detailed knowledge about all the payer contracts and plans that cover their patients. Furthermore, this knowledge must be kept up to date, given ongoing changes in coverage and contract stipulations. All of that information affects how the practice bills, the amount of the bill, where to send the bill, what services should be coded, which laboratories must be used for which patients, and a host of other factors."

Such challenges exist for all groups, because all groups work with different payers and see patients in different plans. "However, the challenge can be especially acute for small practices, which have fewer administrative personnel," Hertz says. Small practices with fewer than three physicians may not be able to dedicate staff to billing and coding. "In a small group, staff members are multitasking. For example, the office manager may be the person who files the insurance claims and posts the charges and payments, because there is no real billing staff. In contrast, a larger practice has a dedicated staff to handle those tasks. These practices will have people who can focus on these activities and who will be much more knowledgeable and facile at handling billing and insurance issues."

All practices must ensure that staff members involved in billing are trained appropriately. "Not only the billing staff, but all the physicians should be properly trained and coached so that they understand the

Dedicated Staff Specialists Boost Group Collections

Nephrology Associates of Kentuckiana, a 16-physician medical group in Louisville, Ky., dedicates specific staff to certain billing and collections processes. Doing so has helped the practice earn the designation of "best-performing practice" in accounts receivable and collections management. The Medical Group Management Association in Englewood, Colo., has bestowed the designation on the practice in its MGMA survey of Performance and Practices of Successful Medical Groups each year since 1999.

"For example, the sole assignment of one staff person in the billing office is to examine every claim that is rejected, and to collect it," explains Janet M. Connell, the practice administrator and chief operating officer.

A second individual is responsible for working the aging list of accounts with insurers. "We often have claims that have not been rejected, but that have not been paid either," says Connell. "Maybe payers want to see additional documentation, maybe they say they never received the claim, or maybe they are just slow to pay and need prompting. These claims can easily fall through the cracks if they are not vigilantly tracked and pursued."

A third staff member enters and checks patient demographics and calls insurers to verify payer information, coverage, and claims submission processes.

Two years after these staff positions were designated, accounts receivable aging was reduced from 72 days to less than 40 days.

Connell points out that identifying the right people to fill these positions is central to the success of this strategy. "The people who fill these positions should be extremely focused, detail-oriented, patient, thick-skinned, and tenacious," she states. The group seeks to hire seasoned professionals with extensive experience.

"A third factor that contributes to success is that we work as a team," Connell says. "Everyone in the clinical area, the billing office, and the front office understands that we have to collect payment to keep our doors open and continue to provide excellent access, service, and clinical quality." —DJN coding and documentation rules and regulations," Hertz explains. "The staff should attend Medicare and Medicaid seminars and ensure that physicians and staff share information regarding coverage changes."

In addition, Hertz suggests that practices audit billing, coding, and documentation processes once or twice annually. "An external auditor can examine how charges align with visit notes to ensure that the charges and services billed accurately reflect the services rendered," he explains.

Improving Collections

Many practices spend a large amount of time on billing but relatively little on collecting, Hertz comments. "The billing part is actually relatively simple, while collecting is much more difficult," he says. "Practices must collect from several different insurance companies as well as from patients. Rather than treating insurers like the enemy, practices should develop a good working relationship with each one. Only through ongoing and civil communication can a practice understand the problems and issues regarding collections and increase the likelihood of collecting successfully."

One important issue involves ensuring that the payment posted matches the contracted rate. "A common problem we see is that an explanation of benefits comes into the practice, the payment is posted, and the balance is written off," Hertz explains. "But the practice never checks whether the amount that was paid equals the amount allowed under the contract." Practice management systems can flag such discrepancies. "Many of the more robust systems allow the practice to enter allowables for several payers, so that when a payment is posted, the system will flag that payment if it is less than the contracted amount," he says. "Both large and small groups should actively compare these amounts so they can avoid significant losses."

Collecting from patients also can be difficult. "Sometimes practices are unsure about how to communicate with patients, and how long to let delayed payments go," Hertz says. He suggests that all practices collect copayments at the front desk at the time of service, and that staff fully understand each patient's bill. "It is critical that bills be patient friendly, and that the balance due should be clearly allocated to the services rendered," Hertz comments. "In addition, staff should be trained to understand insurance issues so that they can explain the bills to patients who have questions."

Expense Management

Yet another business challenge for physicians is expense management. "It is hard to believe, but most practices do not have a budget," Hertz marvels. "Their budget is their checkbook. But practices that do not have a budget do not set goals each month, and cannot plan for future needs. By managing expenses, practices can ensure that they make the proper investments in labor and technology that will enhance care quality and access for patients." Practices should develop a plan first, and then design a budget to allow the practice to meet its planned expenses.

Most practices develop a budget by looking at their financial statements from the previous year and making new estimates, but Hertz suggests taking a zero-based budgeting approach instead. "Physicians should start with a clean slate, and build a budget based on a careful consideration of what they really need to spend," he offers.

Once practices design a budget, they can take steps to ensure that expenses are managed accordingly. "Physicians should compare their actual expenses to the budget and trend them over time, preferably graphically," Hertz says. "They can benchmark their performance to outside statistics to get an idea what similar types of practices are spending in certain categories."

Next, physicians and office managers should carefully assess each expense line item. "For example, consider health insurance for the practice's employees," Hertz poses. "Does the practice shop it around, and does it work with an insurance agent to determine the best plan? As the group gets larger, it will have more leverage in contracting for health insurance. The practice can also review its phone bills. Does the practice pay for any extra lines it is not using? Are long distance charges reasonable? Also consider journal subscriptions. Three physicians do not need to pay for the same $800 journal. Perhaps they can share the journal instead. Can the practice join a buying co-op for its office and medical supplies? Many of these items seem small, but when added together can be meaningful to the practice."

—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).*

"Physicians should compare their actual expenses to the budget and trend them over time, preferably graphically. They can benchmark their performance to outside statistics to get an idea what similar types of practices are spending in certain categories," Hertz says.

Physicians Urged to Get Involved

Efforts to measure and reward high quality have been gaining momentum in both primary and specialty care. Encouraged by this trend, the American College of Rheumatology (ACR) in Atlanta has embarked on an initiative to develop quality indicators for the specialty.

While the effort is important to rheumatologists, it also has implications for other specialists interested in quality indicators. What's more, it's important for physicians from a variety of specialties to participate in developing quality measures because a multidisciplinary approach improves the accuracy of such measures, says Kenneth Saag, MD, MSc, professor of medicine and epidemiology and director of the Center for Education and Research on Therapeutics of Musculoskeletal Disorders at the University of Alabama at Birmingham.

A Multidisciplinary Approach

"A multidisciplinary approach is often required to define high quality care in a particular clinical scenario," Saag asserts. "Working together, physicians can ensure that indicators are based on clinical evidence and represent standards of care. Across specialties, there is increasing recognition that the quality rather than the quantity of medicine should drive the way we practice. Both governmental and private payers have begun to implement measures to pay physicians for performance. Ultimately, it is very clear that adherence to certain standards of quality will impact reimbursement."

The primary aim of quality indicators or performance measures is to establish standards based on clinical evidence, Saag says. "These are not high bars to clear, but rather reflect minimal acceptable standards of care," he states.

Accepting a Dual Role

The co-chair of the ACR's Quality Measures Committee's Subcommittee on Quality of Care, Saag notes that all physicians (including allergists, oncologists, and pulmonologists) should be involved in helping to improve the quality of care patients receive. "Many of us have been conducting research over the years, collecting evidence that will help us define what constitutes high quality," he says.

Elizabeth Tindall, MD, past president of the ACR says, "Developing quality indicators will have far-reaching implications for our specialty with regard to both private practice and hospital care. The development and use of quality indicators will happen with or without us. Therefore, we want to make sure that the specialty is proactively participating in all of these projects rather than watching the government or another specialty area define quality measures for rheumatologists."

Over the past few years, many specialty physicians have become increasingly involved in defining and measuring quality of patient care. The ACR's efforts have been similar to those of other specialists. In addition to the ACR, the Arthritis Foundation also has been engaged in the quality movement by funding the Quality Indicator Project, a joint project of the Arthritis Foundation in Atlanta, the University of California Los Angeles, the University of Alabama at Birmingham, and the RAND Corp. in Santa Monica.

The ACR has defined a dual role for itself regarding quality indicators, Saag explains. First, it seeks to develop quality indicators, and second it is aiming to gather high-quality measures related to rheumatology that other organizations have already developed. As a result of these efforts, members of the ACR Quality Measures Committee and the Subcommittee on Quality of Care have put together a starter set of quality indicators that address minimally acceptable standards for certain aspects of rheumatology care.

Care of Older Patients

Saag and other physicians involved in these efforts hope the indicators will play an integral role in highlighting quality practices and promoting better care wherever shortfalls exist. One measure, for example, indicates that post-menopausal women who suffer a fracture should receive either testing or medical treatment for osteoporosis.

"Only around 20% of older women receive care for osteoporosis after a fracture," Saag notes. "In contrast, 80% of patients receive aspirin or beta blockers following myocardial

> **"Only around 20% of older women receive care for osteoporosis after a fracture. In contrast, 80% of patients receive aspirin or beta blockers following myocardial infarction."**
>
> ***—Kenneth Saag, MD, MSc, University of Alabama***

infarction. The limited consideration of osteoporosis risk after a fracture represents a significant national health problem, given that subsequent fracture rates can reach up to 20% in the year following the first fracture. So there is definitely room for improvement."

Suboptimal performance relates to increasing challenges in managing an older, sicker patient base, says Saag. "There are many preventive health care measures we should pursue aggressively," he adds. "Regrettably, as an example, fractures are often not viewed as a clear marker of osteoporosis or a harbinger of future fractures. Many patients with hip or wrist fractures are treated in the emergency room or cared for by an orthopedist and receive very appropriate acute care. But there is little additional interaction between those caregivers and physicians who might initiate preventive measures later. By defining a quality indicator that measures post-fracture osteoporosis care, we are hoping to highlight the risk and improve patient outcomes."

Another indicator tracks whether hematocrit and hemoglobin are tested at baseline and at one year in patients treated with daily nonsteroidal anti-inflammatory drug (NSAID) therapy who are at risk for gastrointestinal bleeding. "Many specialty societies agree that patients at risk of gastrointestinal bleeding should be given gastroprotective agents, such as a proton pump inhibitor, if they are also taking a nonsteroidal anti-inflammatory drug or a COX-2 inhibitor," Tindall says. "Still, we have seen that these guidelines have been largely ignored."

Indeed, defining quality is not easy, Saag observes. "Developing quality measures is a time- and resource-intensive process that involves systematically reviewing the medical literature, usually in combination with some sort of a process to achieve consensus by a multidisciplinary group of expert reviewers to validate the indicators," he explains.

Since the ACR set of rheumatology quality indicators is simply a starting point, the ACR intends to broaden its indicators in the future, as additional measures are deemed appropriate. In addition, the measures within the set will be expanded over the next two years to include more detailed specifications for use.

Certainly, performance measured against quality indicators will affect the business side of rheumatology practice. Already, report cards on the performance of many hospitals are being posted on the Internet, and some physician performance data are available online as well. In the coming years, more organizations will post physicians' quality scores.

In particular, defining quality measures will not only improve care, but also may affect physician reimbursement. "Recent pay for performance initiatives have illustrated how we are beginning to link the quality of care we provide with the reimbursement structure," notes Saag. In 2005, the federal Centers for Medicare &

(Continued on page 8)

Variety of Sources Contribute to Quality of Care Measures

The American College of Rheumatology's Quality Measures Committee and its Subcommittee on Quality of Care put together a starter set of quality indicators from a variety of sources. Among those organizations that contributed to the set are the Quality Indicator Project, the British Society for Rheumatology/Royal College of Physicians, the National Committee for Quality Assurance (Health Plan Employer Data and Information Set (HEDIS) measures), the Assessing Care for Vulnerable Elders Project, and the University of Alabama at Birmingham's Centers for Education and Research on Therapeutics.

The starter set includes 16 quality indicators addressing drug safety (six indicators); and the diagnosis, treatment, and monitoring of rheumatoid arthritis (three indicators), osteoporosis (three indicators), and gout (four indicators). The full set of indicators is available online (at www.rheumatology.org).

"The starter set includes performance indicators that seek to assess how well physicians and health care systems are meeting acceptable standards of care," says Kenneth Saag, MD, MSc, of the University of Alabama at Birmingham. One measure tracks how many patients with an established diagnosis of rheumatoid arthritis are treated with disease modifying anti-rheumatic drugs.

The starter set also includes indicators that are not only meaningful from a quality-of-care standpoint, but also are realistic and practical to measure. The complexity of developing indicators for specialty care is one reason the use of indicators has been common in primary care and less so in specialty care.

The ACR starter set also includes measures for rheumatoid arthritis care that are relatively easy to track, such as data from joint exams, functional status assessments, acute phase reactants, pain measurements, and physician and patient global assessments at three-month intervals.

—DJN

(Continued from page 7)

Medicaid Services (CMS) selected 10 medical groups of 200 or more physicians to participate in a pay for performance demonstration program. Employers and commercial payers have instituted similar initiatives.

Contract Implications

Experts also speculate that quality indicators may eventually affect contracting and referral decisions, as payers and consumers demand to see data on physician performance. Using quality indicators to evaluate patient care could affect a physician's accreditation status if a physician does not perform well against such indicators.

"A health plan could pull physicians' charts as part of a review," Tindall notes. "Quality indicators can have big implications for physician practices if health plans choose to micromanage care based on such indicators."

Given such important repercussions, experts suggest that physicians should willingly participate in the development of quality indicators. Some physicians, however, are naïve or take a somewhat confrontational approach to quality measurement, Saag says. Despite these reservations, Saag emphasizes that the quality movement is gaining momentum.

"We are all busy," Saag comments. "Patient needs have become more complicated and diseases are more challenging to manage due to the plethora of treatment options available. Physicians certainly will find it challenging to have more yardsticks by which they are assessed, but this situation is inevitable. The idea behind quality indicator development is to provide better health care. By regulating ourselves and by participating in quality indicator development, we will ensure that the right indicators are used, thereby preventing medical errors and improving quality of care."

Fortunately, quality indicators typically reflect care patterns that a majority of physicians are already delivering even though many may not be documenting that they do so. Once the minimal standards are in place, physicians can begin improving on the standards and develop successive generations of quality measures.

Getting Started

Initially, physicians involved in developing quality indicators should seek to define indicators that are practical and easy to measure, not too expensive to measure, and supported by strong clinical evidence, Saag suggests. "The idea is to pull in measures that have been carefully developed using standard approaches and that cover the key areas of care," he says.

Next, physicians should disseminate the indicators broadly. "We need to make information very accessible so that physicians who might not be expert in managing a particular condition can quickly reference it and ensure they are providing good care," he adds. The ACR has made a strong effort to publicize its quality indicators, for example. The indicators have been disseminated via the ACR Web site, seminars at the annual meeting, and newsletters.

Forward Thinking

Nevertheless, Saag is uncertain about how many rheumatologists use the rheumatology starter set. "We hope that all rheumatologists and other physicians involved in the care of rheumatic diseases are generally following these guidelines and practicing medicine at a high level, whether or not they are referring specifically to the quality indicators," he says. "But as payers begin to implement pay for performance initiatives, indicators will play a key role. More physicians will need to become aware of quality standards and the care they should be offering to satisfy payer requirements consistently."

Therefore, another important consideration is to determine how to facilitate indicator use among physicians. The ACR will develop checklists, for example, to help physicians pursue quality measurement more easily and cost effectively. Tindall says, "One of our goals is to make the process of complying with these indicators and documenting compliance as painless as possible, so that any rheumatologist can comply easily." The ACR recently put out a request for proposals to develop tools that might be used to collect data related to the starter set.

The growing use of electronic medical records will facilitate quality measurement, tracking, and improvement, Saag adds. "Currently, the huge challenge nationally is that only a relatively small proportion of physicians are using electronic medical records and thus can easily and systematically capture data on their care quality," he says. "The health care quality movement highlights the need for a rapid departure from antiquated pen-and-paper record-keeping toward a more uniform nationalized electronic medical record. This will allow us to better track our progress and quantify care in a formalized way."

—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).

Quality indicators can have significant implications for physician practices if health plans choose to micromanage care delivery.

EMRs Enhance Patient Care

Some physicians are unsure about whether electronic medical records (EMRs) will generate significant cost savings. Other physicians, however, have adopted EMRs with a different goal: improve care quality.

Leveraging the efficiencies of EMR technology can improve the quality of care by enabling access to complete patient data at the moment it is needed. An important quality-related feature of EMRs is clinical decision support, which alerts physicians to provide appropriate care based on a patient's condition.

Clinical Decision Support

"There is a lot of clinical logic built into many EMRs. By prompting physicians to consider certain elements of care, EMRs help increase care quality and reduce errors," says Scott Zakarian, owner of EMR Consulting, LLC, a firm in Eugene, Ore., that helps physicians select and implement EMR systems. Zakarian also offers technical support after implementation.

Clinical decision support is typically built on evidence-based guidelines, and some systems can be tweaked to reflect the physician's own practice patterns, Zakarian says. Such support mechanisms can check for drug-drug and drug-allergy interactions to identify potential adverse events. "Clinical decision support is not a replacement for the physician," he adds. "Rather, it functions as a reminder to ensure that aspects of care do not fall through the cracks."

In particular, patients with chronic conditions benefit from EMRs because these systems provide reminders about follow-up care and monitoring needed at specific intervals. "For example, clinical decision support features can help a physician ensure that patients with diabetes receive all of the elements of care they need, such as an annual check-up, periodic blood work, and ongoing foot care," Zakarian says.

Many practices use EMRs to track care for a population of patients so that quality initiatives can be implemented. "We can gather large quantities of data and perform detailed analyses," says Jeff Weintraub, CEO of Southwest Kidney Institute. "For example, looking at our population of chronic kidney disease patients, how many are getting appropriate follow up? How many are receiving anemia management? How many have hemoglobin levels of 11 or greater? By establishing physician-developed, nurse-driven protocols for care, our practice manages our patients much more effectively, allowing physicians to focus on the more subjective areas of care and patients in need."

These systems also ensure adequate preventive care. A study published in the May 2001 issue of the *Delaware Medical Journal* examined the effect of EMR implementation on recommended preventive care interventions. The researchers found that intervention rates were higher following EMR implementation for all outcomes studied. The largest increases were found in mammograms (28.7% to 52.5%), varicella immunizations (29.6% to 55.9%), glycosylated hemoglobin levels (53.0% to 80.3%) and influenza immunization for patients with diabetes (29.7% to 55.1%).

Specialist physicians who use EMRs also have improved care quality. In a study published in the *American Journal of Medical Quality* (September-October), researchers examined the effect of an EMR-generated reminder on physician prescribing behavior in a community oncology practice. The reminder was generated during the patient visit and flagged patients with low hemoglobin (anemia). The researchers found that patients with low hemoglobin were almost twice as likely to be treated with erythropoietin when the reminder system was used.

Improved Record Access

An EMR also enhances quality of care simply by allowing quick, easy access to complete patient information. In stark contrast to paper charts, which can be cumbersome, incomplete, or easily lost, electronic records are always accessible. "One of the most straightforward ways an EMR improves quality of care is that with an EMR, patient information is always available when patients need care," Zakarian says.

Cardiologist Arthur McDowell, MD, agrees. McDowell is one of eight physicians with Middlesex Cardiol-

(Continued on page 10)

In a study, researchers found an EMR-generated reminder system for physicians in a community oncology practice identified patients with low hemoglobin, and these patients were almost twice as likely to be treated with erythropoietin when the reminder system was used.

(Continued from page 9)

ogy Associates, in Middletown, Conn. "The main benefit of an EMR is quick and easy access to complete information from any location," he says. "This is very important in a specialty like cardiology, where access to testing information can dramatically influence treatment decisions. Specifically, we need information on stress test outcomes, echocardiogram outcomes, and cardiac catheterization results."

In addition, many providers can review a chart simultaneously. "The chart is not just in one room anymore," Zakarian notes. "It is electronically available to the physician in his or her office, the nurse who is with the patient, and the billing staff. The chart can also be electronically sent to a consulting physician. Alternatively, the practice can print copies of the chart and fax it to other physicians."

EMR sharing among clinicians will be facilitated with the development of the Continuity of Care Record (CCR), an international standard designed to organize and make transportable a set of basic information about a patient's health. Developed by the American Society for Testing and Materials International (ASTM), the CCR will allow an electronic snapshot of the patient's chart to be transmitted among providers using different EMRs.

The fact that patient information can be accessed from locations outside the practice is another way these systems improve quality. "When physicians are at the hospital treating inpatients, or if they are on call and must advise a colleague's patient, they can simply log into the system and review the information needed," Zakarian explains. "Furthermore, physicians do not need to carry paper

Physicians Match Systems to Group Goals

Physicians interested in adopting an electronic medical record (EMR) system should first identify their goals and expectations for the system, says Scott Zakarian, owner of EMR Consulting, LLC, in Eugene, Ore. "Those expectations and goals will drive the decision about which vendors to consider."

Many practices new to EMR adoption already have a practice management system in place, but do not have an EMR. "These physicians need to consider how the system will communicate with the EMR," Zakarian explains. Optimally, scheduling and billing functions, and demographic and clinical information should be integrated. "Physicians should ensure that the proper interfaces can be created, especially if the systems are not from the same vendor," he adds.

Another important consideration involves the stability of the vendor. "Physicians should ask how long the company has been in business," he adds. "If the company fails, there will not be any future updates to or support for the system." Also, companies providing specialized EMRs may not be as well established as companies that provide systems to primary care practices. Therefore, physicians should assess the vendor's experience and ask how many practices are using the software.

Security features also are significant. "Patients are concerned that their records remain secure," Zakarian explains. "In addition, federal law requires that all patient information be kept confidential, so physicians must be able to prove that security is in place. Physicians should ask about the audit trails created within the EMR, so that they can tell who made changes to charts. Physicians should be able to delineate which staff members will have access to specific parts of the system."

Finally, physicians should consider the specific features that interest them. Clinical decision support and computerized physician order entry are important features that can alleviate or reduce administrative hassles. "Using computerized physician order entry, physicians can transmit orders for lab tests and submit prescriptions easily and accurately," Zakarian says.

An important feature is a task system that enables communication with staff. "A task system is like an e-mail substitute," Zakarian says. "However, all the tasks requested will be automatically entered into the patient chart so there is a record of care and who provided it."

EMRs vary in the amount of free-text entry they allow. "The mix of free-text entry and template entry is a personal preference that physicians can consider," he says. "But the EMR will provide less coding support when more free-text entry is used. In contrast, when physicians use templates, the EMR tracks all the different services provided, helping physicians to avoid overcoding and undercoding. This step provides proof that for every visit, all of the elements of care were covered to justify a certain code."

Some physicians look for a system that is specific to their specialty, while others find a more general system that can be adapted to their particular specialty. "Given the high number of EMR vendors, physicians might want to find an EMR that is general but can be adapted, and determine whether it can be adapted to meet their needs," Zakarian explains. "Then they can compare it to a system that is more specialized."

—DJN

charts from location to location, which would increase the risk of misplaced or lost information."

The greater efficiency of care associated with EMRs has a quality implication as well. First, because the patient's record is easily accessible, physicians may be able to address the patient's needs more quickly, which is especially important in urgent care. Over time, EMR use can improve practice efficiency, perhaps enabling the physicians to reduce wait times for appointments or increase access for new patients. Furthermore, an EMR can give nurses quick access to patient data and eliminate the need for time-consuming chart pulls.

More thorough documentation of care is also possible using an EMR. "Many EMRs have templates, which include all the elements of care the physician might provide during a specific kind of visit for a certain patient," Zakarian says. "Templates serve as a reminder to ask specific questions and perform certain tests. Then, the templates automatically populate the note for that visit. Not only do templates ensure that the physician covers everything needed in the care of that patient, but they ensure that the final documentation is readable and organized for reference during a future visit."

Patients who observe physicians using an EMR may have greater confidence in the quality of care they are receiving, although this benefit depends heavily on the way the physician uses the EMR. "Physicians using EMRs who simply stare at the screen and never make eye contact with their patients are actually hampering interaction and conversation and will ultimately hurt the relationship," Zakarian says. "It is important to keep in mind that patients still need that personal connection."

Implementation Requires Deliberate Steps

As many practices have discovered, it can be difficult to get all physicians in a practice to support a plan to adopt an electronic medical record (EMR) system. It may be that older physicians will be more reluctant to use an EMR than younger physicians, for example. For this reason, browser-based systems may be perceived as user-friendly because the interface is already familiar.

Staff support for EMR use is also crucial to successful implementation. "Nurses, billing staff, and front-office staff are the ones that can make the system work or not," explains Scott Zakarian, owner of EMR Consulting, LLC, in Eugene, Ore. In addition, a significant amount of training should be built into implementation to ensure proper use and to minimize frustration. "The human aspect of implementing an EMR can easily be overlooked," he adds. "Many EMR implementations fail because the practice did not ensure sufficient training and staff involvement ahead of time."

One factor that is often overlooked is the network and hardware infrastructure required to support the EMR system. "Many vendors will try to lowball physicians on the server and the network purchase because the software itself is so expensive," Zakarian comments. "But if sufficient infrastructure does not exist, the EMR will be slow and cumbersome, and users will not like it."

Some practices implement the EMR gradually, either by starting with simpler functions or with a subset of users. Other practices may choose an all-at-once strategy.

"Phased implementation is probably preferable," Zakarian says. "The practice can begin by using electronic prescription transmission, task orders, and the lab interface, and then expand from there. By starting with functions that are easy to learn and generate an immediate benefit, users will build enthusiasm for the system." —DJN

Questions to Ask

Once physicians identify an EMR to purchase, Zakarian recommends conducting reference checks and going on site visits. "Physicians should visit a practice in the same specialty and that has a similar work flow to assess how the EMR functions," he says. "Physicians might also want to visit another practice in a different specialty or with a different workflow in order to determine the system's flexibility and potential uses."

As with any new system, consider the learning curve. Conventional wisdom holds that physicians face a tradeoff. If the system is simple, the physicians will start using the system quickly, but functionality may be lacking. A system that is more complex, however, may take longer to master, but ultimately will prove more useful.

"This is true to a point, but many EMRs with extensive capabilities also have basic core functionality that is very simple to use," Zakarian observes. "The bottom line is that an EMR should not be difficult to use just because it is more flexible. If it is cumbersome and difficult to use, it is probably a poor choice."

—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).

Finding Success in Small Groups

Many physicians dissatisfied with working in large groups wonder about the viability of practicing in a smaller setting. A solo or small group practice can certainly afford opportunities for personal empowerment, but an independent setting also can be challenging.

Successful practices of all sizes must balance patient care with rising insurance costs, complying with regulations, and managing administrative requirements. It stands to reason that such factors are exacerbated in a small or one-person practice. Can a small practice be successful under such circumstances?

The Business of Medicine

The consensus among experts is that solo and small-group physicians can survive as long as they understand that they're running not just a medical practice but a business enterprise. "Often I ask physicians whether they read the monthly or quarterly reports their accountants give them, and they rarely do," says Gary Matthews, president of Physicians HealthCare Advisors, LLC, in Atlanta. "In the past, it's been okay for physicians not to be good business people, but those days are over." Matthews has more than 30 years of experience consulting with physicians on the administrative side of their practices. It's difficult for some doctors to appreciate the importance of sound business tenets, he says.

One physician who believes strongly in focusing on improving the efficiency of his business operations is solo practitioner L. Gordon Moore, MD. The founder of Ideal Micro Practices, an online collaborative that helps physicians improve the efficiency of their operations, Moore serves on the faculty of the Institute for Healthcare Improvement in Cambridge, Mass. A leader in the movement for systemwide redesign in medical practice, Moore operates a one-person family practice in Rochester, N.Y.

Moore has one nurse on staff, no clerical help, and no billing vendor. For most physicians, staffing is costly and unnecessary, he says. "They take on staff to handle the administrative trivia of dealing with insurance companies, regulation, and reporting functions and billing, but in doing so, they drive up the costs of their practices," Moore says of most physicians. "To support that, they boost patient volume, which then has a negative impact on efficiency. I wanted to see if it was possible to run a practice on the cheap. I wanted to get off the hamster wheel, and get back to caring for patients in a way that made me feel proud of the work I was doing." Since Moore established his practice in 2001, he says it has been financially viable.

Cutting Overhead

After the physician's own salary, salary and benefits for staff are the most significant portion of overhead. When physicians analyze what steps staff take to accomplish each task, Moore believes they will find ways to cut costs. A pediatric group in North Carolina cut its daily phone call volume by 66% by handling all prescription refill requests within one hour each day, he says. The group then was able to cut staff as well.

For practices seeking to cut staff, consultants advise doing so whenever a staff member resigns. At that time, it might be possible to divide the former worker's duties among remaining staff, they say.

Survival Strategies

Moore believes his success is due to the use of information technology and carefully controlling overhead. "Be thoughtful about what you ask others to do for you," he advises. "It's very easy to fall into the trap of paying a premium for what may not actually be good work. That's something you can end up losing your practice over." By keeping the number of staff low, Moore has dramatically reduced his overhead, and thus the number of patients he needs to see to support what he calls a "Norman Rockwell practice."

Billing is one example of an outsourcing cost that can be reduced with careful management. While billing is commonly outsourced because it's a complex process, Moore says, many doctors are taking billing back into the office setting. "It's not easy to do, but I've seen doctors actually take on billing themselves to learn the ropes, then hand it off," Moore says. "When they do, revenue goes up and costs drop. That approach makes it possible to survive in what would otherwise be an impossible environment."

Small practices should seek cost savings by analyzing all operations, Moore advises. Use technology to make referrals, to verify co-payments,

"It's not easy to do, but I've seen doctors actually take on billing themselves to learn the ropes, then hand it off. When they do, revenue goes up and costs drop," says L. Gordon Moore, MD.

and to document patient care, and consider how an electronic medical record system with voice recognition software might help reduce transcription costs, he adds.

Sound Management

Matthews agrees that practices must conduct a thorough assessment of their operations to find ways to cut costs. One area that is particularly important is cash flow management. Offices must carefully control all aspects of the process, from proper coding and optimization of fee schedules to following-up on claims and collections. "You absolutely cannot slide through operations of the practice, and the practice has to be willing to change systems when it's appropriate," he says.

Physicians should review all accounts at least monthly, Matthews adds. The practice's accountant should establish a regular reporting system and deliver accounting data in a clear, comprehensive format that physicians can understand. "You should know what you bill, what you adjust, what you collect, what you deposit, what's in the checking account, and what's in account receivables," he says. When a number doesn't seem right, the physician should ask about it, he adds. "It's no longer possible for a physician to think that if you practice good medicine, good things will follow," he comments. "It just doesn't happen that way anymore because medicine is too complex now. In addition, small group practice is getting more competitive, and that's not going to change."

Consultant Steven Peltz of Physicians Healthcare Advisors, LLC, agrees. "When physicians don't look at their practices as businesses because they're too busy, or because they don't know what to look for, they're vulnerable to sales people, insurance companies, hospitals, and government," he comments. One of the most important areas to monitor is collections, he says.

Financial Principles

First, practices should collect all co-payments during visits to eliminate the expense of sending bills to patients after the fact. Second, practices should concentrate on collecting funds within the first 90 days, he adds. "The longer money sits uncollected, the less valuable it becomes," he adds. "You don't want to spend time and money chasing a small claim. Put all your efforts into collecting money in the first 90 days."

Third, practices should analyze their top 10 billing codes each year to compare reimbursement by payer. By doing so, practices may find it's not feasible to continue participating with some payers.

Health Savings Accounts

One other way physicians can succeed is to build their practices on patients who use health savings accounts (HSAs), says Donald Copeland, MD, a former primary care physician in Mooresville, N.C., who later moved to a rural group practice in Clinton, N.C. He retired in 2001, and now sees patients as a public health physician for the Lincoln County Health Department.

Since he left private practice, HSAs have become more popular among patients. "If I were a young doctor now, I'd open an HSA practice," he says. "Physicians need to understand how HSAs work, particularly if they're going into a solo practice."

Usually linked with high-deductible health insurance plans, HSAs are tax-deferred funds established to pay medical bills. Using HSAs, patients typically pay for most health care expenses, such as doctor visits, out-of-pocket. Since patients pay cash, HSAs help physicians keep billing costs down, Copeland says. When he started practicing medicine, most patients paid cash, he adds. "Nobody had insurance, so they paid out-of-pocket for medical care," he comments. "There was no co-pay, there was no billing, and there was no problem."

In addition to keeping payment costs to a cash basis whenever possible, Copeland believes a successful solo practitioner also must establish good coverage and referral bases. "You can't be available 24/7, but you have to take care of your patients," he says. "You can't be a solo physician unless you set up a good system to work with other doctors in your community."

Most important, physicians should remember that practicing medicine goes beyond delivering clinical care, Copeland adds. "In reality, you have to deal with everything that goes on, unless you want to work without being paid," he says. "Know what's happening in the front office. I put my office manager in a room across the hall from me, and nothing went on that I wasn't aware of. The physician needs to be fully in control of everything from patient care to finances."

—Reported and written by Judith Reppucci in Cotuit, Mass. More information on physician practice strategies is available on our Web site (see page 16).

"It's no longer possible for a physician to think that if you practice good medicine, good things will follow. It just doesn't happen that way anymore because medicine is too complex now."

—Gary Matthews, Physicians HealthCare Advisors

Group Pursues Retail Strategy

***Jack Reed** is the chief executive officer of ProHealth Physicians, Inc., in Farmington, Conn. ProHealth is the largest group practice of primary care practitioners in Connecticut. The group includes approximately 165 physicians and about 45 mid-level practitioners in 75 offices throughout Hartford, New Haven, Litchfield and Middlesex counties. Specializing in internal medicine, pediatrics, and family practice, the physicians have more than 725,000 patient encounters each year. Reed spoke with Editor-in-Chief Richard L. Reece, MD, about the group's growth strategies.*

Q: *Please tell use about how and why your group opened retail health clinics.*

A: We view the retail clinic strategy for ProHealth as furthering a commitment to our patients and payer/employer relationships to provide more efficient, cost effective health care services. Our first site opened in a Price Chopper grocery store in Putnam. We are planning as many as six to eight retail clinics over the next couple of years. We have learned a number of lessons from the first six months of operating that business. Given that we're a physician-driven and a physician-owned company, we have the clinical model which enables superb clinical oversight on what we provide within our new retail locations.

Frankly the issue that has proven to be the most challenging for us involving retail clinics is gaining consumer adoption. We have to persuade consumers that they can get the same services within a drug store or a grocery store that they can get from more traditional offices, urgent care clinics, or hospital emergency rooms.

To a large extent our retailing lessons during this period have been intense in terms of what kind of marketing we need to do to make consumers aware of the service. And we are learning about the scope of services we should provide in these retail clinics. We're starting to see, for example, that there may be an opportunity to provide some chronic disease management in these sites. We will, for instance, work with patients who have asthma or diabetes. Alternatively, we could use these sites as wellness centers or work with area employers to do employment physicals.

There may some product line expansion that was not obvious when we first started the program. At the same time, we may have to be more nimble than health care providers might normally be within this particular space.

Since we installed an electronic health record system in these retail clinics, we have the ability to communicate electronically with these sites and with all ProHealth offices. We are also learning that these retail clinics allow us to be in a much stronger position than we were previously to guarantee same day appointments.

Q: *In addition to the retail clinics, does ProHealth have other facilities besides physician offices?*

A: We also have one of the state's largest clinical laboratories, and we have physical therapy units and imaging centers. We believe we can provide any diagnostic service more efficiently and with a higher degree of cost effectiveness, service, and quality than others can. The lab that we created a number of years ago has proven to be one of our most successful ventures. The data from the lab system enable us to match lab test results with clinical outcomes. It has allowed us to pursue clinical programs such as diabetes management. This program is a success because the lab services provide us with data we might not get otherwise.

We also have looked aggressively at building our imaging division and at providing physical therapy services. We have an ADHD center and just opened a sleep lab in one of the hotels in greater Hartford.

As we build new facilities, most of them have diagnostic centers attached to them. That allows our physicians to use these diagnostic centers for their patients. It's somewhat like a hub-and-spoke business model in which our physicians can refer their patients there for different levels of diagnostic testing. This model has proven to be of value not only for us but also for our patients and for the payers we do business with.

Q: *Do these services create other advantages with your managed care clients?*

A: Undoubtedly these services create significant advantages in our relationships with the payer community. First of all, we have always maintained a customer-first philosophy with regard to managed care. That means we view them as

"We are learning about the scope of services we should provide in these retail clinics. We're starting to see, for example, that there may be an opportunity to provide some chronic disease management in these sites."

customers of ProHealth. As a result we are highly focused on the value of the services that we provide to them. We have to demonstrate to the payers on a consistent basis that we can provide our clinical services and products in a cost effective manner. Furthermore, by using our diagnostics and clinical performance initiatives to their fullest extent, we are able to better meet P4P targets and identify other areas for clinical and cost improvements. A major benefit of using our diagnostic services lies in how we can access and use data.

Q: *Do the health plans appreciate that you offer them an integrated group of services?*

A: Yes. We offer an integrated product and that creates value because they know that we can get a higher degree of compliance from our patients on what the doctors prescribe. When the patients follow through on the advice of their physicians, that creates a better health product in terms of wellness, and that's an important part of a primary care program. Also a major component of our overall clinical program is based in prevention and maintaining the overall health of our patients.

Q: *How was ProHealth Physicians formed and how is it different from an independent practice association (IPA)?*

A: ProHealth started in June 1997 in an effort to organize primary care more effectively. At that time, 130 primary care physicians fully integrated their practices into a common group practice. In part this was a response to capitation, and for physicians in adult medicine, there were opportunities to participate in managed Medicare. The core business of the company is to work with commercial and governmental payers on fee for service and other contracts.

The difference between ProHealth and an IPA is that we are a single group practice. ProHealth is a stock corporation that owns the assets of its practices. The physicians are shareholders within ProHealth and also employees. Our doctors know that to deliver health care effectively, you have to constantly look to offer value to the companies you contract with whether they are employers or insurers or governmental entities. As a company, our goal is to provide a measurable difference in the quality and the cost of the care that we offer to our patients.

In an IPA, you don't necessarily have the same level of commitment on behalf of the providers to produce a common and consistent service. We're always coaching the physicians that we have to play according to what the market wants, and if the market is looking at clear differentials in terms of cost, quality, and service, we're in a much better position to do that as a single entity as opposed to an IPA which is made up of perhaps hundreds of independent entities. That is the fundamental difference.

Q: *Do patients have high deductible health plans and health savings accounts?*

A: We're seeing an increase in that volume within our practices. In the past few years, we have seen an increase in more cost conscious behavior among consumers and our patients. Today, they ask more questions about the cost of services than they did in the past and they frequently ask about the need for referrals to specialists as opposed to having the service being provided by primary care. That means we need systems to verify the eligibility and the availability of funds of patients using HSA accounts as these programs become more popular.

Q: *Do you foresee a day when a patient will simply swipe his or her smart card to pay for services at the point of care?*

A: That's possible. It's hard to predict when, but that technology has been around for a while. But as smart cards become more widespread and health savings accounts become more popular, we will have the technology to support those services.

Q: *How do you communicate with more than 200 providers in offices all over central Connecticut?*

A: We have a level of consistency among our providers about how we care for our patients in the marketplace. We have one information technology platform for the entire company. That means one common billing system and one common scheduling system for all 75 locations. The connectivity among the sites is generated through a common location for internal e-mail and communication between the offices.

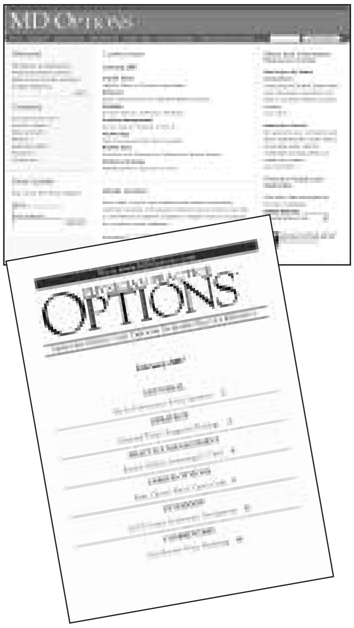
But we also have very carefully nurtured consensus among the physicians through a variety of board-appointed committees that deal with such issues as clinical performance. We have teams of doctors go through our clinical performance strategy to determine how to improve the quality of the services we offer and the cost of services we deliver. So in essence, we are very physician focused.

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

"As a company, our goal is to provide a measurable difference in the quality and the cost of the care that we offer to our patients. In an IPA, you don't necessarily have the same level of commitment on behalf of the providers to produce a common and consistent service."

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

MD OPTIONS.com



Our FREE online resource includes:

- Strategies and tactics to build your practice
- A complete database searchable by keyword, subject, or issue
- Interaction with experts on all aspects of the Business of Medicine™
- Links to business resources, such as practice management, marketing, and CME
- E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let MDOptions.com come to you! MDOptions.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOptions.com or fill in your name and e-mail address below and fax it to us at **973-682-9077.**

Name: ______________________________

E-mail: ______________________________

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY April 2007

Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

PRSRT STD
U.S. POSTAGE
PAID
Permit No. 664
S.HACKENSACK, NJ

04/07