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Will Pay-for-Performance Relieve Payment Woes?

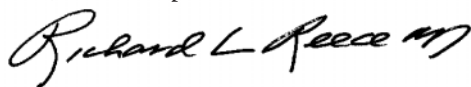
Over the next five years, Medicare's formula for paying doctors will reduce physician reimbursement by 30%. Recognizing that such cuts will have far-reaching implications, the federal Centers for Medicare & Medicaid Services is testing a pay-for-performance program to reward high-performing physicians with increased pay. By the end of this year, more than 600,000 Medicare recipients will be in demonstration programs in which doctors will get bonuses for measurably improving results for patients with common chronic diseases, such as congestive heart failure, coronary artery disease, diabetes, and high blood pressure.

Among the many questions physicians have about pay for performance is: Will it be fair? Edward Hill, MD, president-elect of the American Medical Association, says pay-for-performance systems are difficult to install and are dangerous. "The main problem is that if pay-for-performance simply drives down costs, it will not work, and it will not improve quality," he comments. "If it's truly going to be fair, evidence-based, really for quality care for patients, then of course, that's a good thing. But it's very, very risky and difficult. It's going to be difficult to implement as well." The AMA (www.ama-assn.org) recently published guidelines for pay-for-performance programs.

Joseph Antos, a scholar at the American Enterprise Institute, says, "Regardless of whether pay-for-performance is fair, physicians should prepare for such programs because Medicare wields significant clout in the health care market." In fact, Antos says, Medicare essentially runs the U.S. health system because 100% of hospitals and 95% of doctors must follow Medicare rules, and insurers typically mimic Medicare payment schedules.

"The cards are definitely stacked against doctors," Antos comments. "The cuts are built into the law, and Congress will have a hard time changing anything about these Medicare cuts. What the AMA and other physician groups are saying is: 'One, you have to give us an increase next year and not a cut; and two, you cannot institute pay-for-performance until you've given us an increase.' I'm not convinced any pay-for-performance system will be the answer. Over the next three years, doctors will find that some percentage of their Medicare fees will be determined on how well they meet certain government standards. That may get them a minor increase next year. However, it's a temporizing move."

William Jessee, MD, president and CEO of the Medical Group Management Association, observes that since Medicare is developing pay-for-performance systems, both Medicare and private insurers will be able to pay less to physicians who do not meet these performance standards. "In academia, the rule is publish or perish," he adds. "For hospitals and physicians, it may be perform, publish your data, or not be paid."



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Asthma Efforts Improve Outcomes

Across the country, asthma specialists and primary care physicians are finding that the outcomes of their asthma patients who participate in disease management (DM) programs are better than the outcomes of those who do not participate. The goal of DM programs is to identify enrollees with asthma, educate them about their condition, ensure that they understand their asthma triggers and the treatment plan outlined by their physician, and prompt them to contact their physician when an intervention is necessary. These programs can have significant benefits for physicians as well as patients.

“DM programs serve as the eyes and ears of the practicing physician between patient visits,” says Al Lewis, executive director of the Disease Management Purchasing Consortium International in Wellesley, Mass. “The most significant benefit to physicians is that they receive immediate notice if something is going wrong with one of their patients. In this way, DM programs enable physicians to achieve better outcomes for their patients at no additional cost.”

High Prevalence

Asthma lends itself to DM because its prevalence is high, under-treatment is common, and emergency department visits and hospitalizations can be vastly reduced with proper treatment and education, according to Mark Hackman, MD, medical director for physician affairs at American Healthways, a DM company in Nashville. “People with asthma tend to accept the shortness of breath and do not recognize that there is adequate treatment available,” says Hackman, who oversees the asthma DM program at American Healthways. “When peo-

“The most significant benefit of disease management is that physicians receive immediate notice if something is going wrong with one of their patients,” says Al Lewis of the Disease Management Purchasing Consortium.

ple understand the factors that trigger their asthma and are prompted to follow their physician’s treatment plan, their symptoms are reduced and outcomes improve.”

“A great deal of information has been published about asthma management by the National Asthma Education and Prevention Program and professional organizations both in the United States and globally,” says Kenan Haver, MD, pediatric asthma specialist at Massachusetts General Hospital in Boston and a member of the Partners Asthma Center. “DM facilitates translation of the current knowledge about asthma diagnosis and management by helping to link the various levels of asthma severity—mild intermittent, mild, moderate, or severe persistent—with appropriate treatment.”

Asthma management guidelines have helped health care providers adopt a step-wise approach to asthma, Haver continues. “The goal of this approach is to optimize outcomes with the least amount of medication,” he says. “In this context, DM programs help remind physicians about key points to help assess asthma severity, and then to link severity with an appropriate level of medication, helping them step-up or step-down therapy when appropriate.”

Following Best Practices

Asthma DM programs use published guidelines to standardize the best prac-

tice approach to care for all patients, Haver says. “While the guideline approach may not work for every patient, it provides a common place to start,” he explains. “Through regular contact we can learn for whom we need to think outside of the guidelines.”

Typically, DM programs contract with payers and identify program participants based on claims data. “American Healthways uses claims to identify a health plan’s enrollees with asthma,” Hackman explains. “We also obtain referrals from physicians and self-referrals from enrollees.”

American Healthways then uses software to stratify patients into two levels: active and maintenance level. “The goal is to direct our resources toward patients who are at the highest risk of decompensation,” says Hackman.

Once the patients with active asthma are identified, DM nurses make telephone calls to determine each patient’s level of severity based on guidelines for asthma treatment. An active asthma patient is classified into one of four levels: intermittent, mild persistent, moderate persistent, or severe persistent. “Nurses assign a level based on the patient’s symptoms (typically the frequency of shortness of breath) and frequency of use of reliever medications,” Hackman states. “For example, patients who need to use only reliever medication when they exercise are classified as intermittent. In contrast, people who

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are almost continuously short of breath throughout the day and frequently wake up at night are classified as severe persistent.”

Nurses also seek to understand the patient’s knowledge about the disease. “The nurses determine whether the patients understand risk factors and the elements of the physician’s treatment plan,” says Hackman. “They ask whether the patients are seeing their physician regularly and whether they are using a peak flow meter.”

Filling the Gaps

When the nurses identify knowledge gaps, they begin filling those gaps with information that allows patients to better manage their asthma. “Nurses provide information over the phone and reinforce that information via educational mailings such as quarterly newsletters about asthma-related topics, standard of care reminder sheets, and single-topic sheets,” explains Hackman. “Nurses also set goals with patients. For instance, a patient might need an inhaled corticosteroid to use in conjunction with a beta agonist; the nurse will ask the patient to set a goal to talk to the physician about adding the new medication.”

The frequency of phone calls from DM nurses depends on a patient’s severity level. “A level-four patient may get a phone call once a week or even as often as every day, depending on his or her needs,” Hackman says. “A level-three patient may get a phone call once a month, and a level-two patient once every three months.”

The benefits for patients are clear: “Patients build an improved under-

standing of their disease, the triggers that lead to their asthma, and their medications,” Hackman says. “We can help asthma patients live a healthy, normal life without being crippled by shortness of breath.”

Increased Patient Contact

Haver treats many patients covered by various DM programs that Boston-area payers use. “The consistent, and most important, feature of all the programs has been regular contact with patients,” Haver states. “This makes a big difference in outcomes.”

Regular contact can help overcome one of the biggest obstacles to asthma symptom management: encouraging the ongoing use of medications to control inflammation even in the absence of symptoms. “Even if physicians make the right diagnosis and correctly select the medications, patients will be at risk unless they actually use the medications on an ongoing basis,” Haver explains. “Often, the patients who need emergency care or hospitalization are those who use their medications only when symptoms are present. In contrast, patients who regularly take anti-inflammatory medications are less likely to have an acute exacerbation of symptoms. DM programs emphasize the message that regular use of anti-inflammatory therapy is necessary for long-term management of the condition, particularly for those patients who have persistent asthma. Regular contact reinforces the requirements of effective asthma care and puts patients back on track with ongoing medication use.”

The goal is for asthma patients and their families to develop a better understanding of the disease, recognize when the asthma is not well controlled, and encourage them to regularly refill and use the long-term control prescriptions, Haver adds.

The Physician’s Role

Many physicians ask what effect these programs have on them. Typically, DM programs do not directly affect practice patterns, Hackman says. “Our goal is not to tell the doctor how to treat asthma,” he adds. “Rather, we reinforce the treatment plan that the asthma specialist distributes to the patient. We do not want to conflict or interfere with the medical management of the asthma specialist.”

DM programs also fill the gap in education for patients between office visits. “Physicians frequently do not have time to provide an optimal amount of patient education,” Hackman observes. “Patient education, particularly for a chronic condition like asthma, is a very time-consuming process. This is an area in which we really excel, because our nurses will spend as much time as needed with patients to ensure that they clearly understand their condition and how to manage it. Physicians appreciate that.”

American Healthways distributes guidelines to physicians outlining the four classes of asthma patient severity and describing appropriate treatment for patients in each class. While guideline distribution does not necessarily change practice patterns directly, Hackman believes it does help physicians keep the guidelines in mind. “Of course, doctors will always use their medical judgment, and even clinical guidelines have flexibility,” he says. “But for those physicians who might not be aware of the detailed stipulations of the guidelines, such as primary care physicians, we do help reinforce the guidelines.”

A bigger influence may be the information that the patients bring to

“Patient education is an area in which we really excel, because our nurses will spend as much time as needed with patients to ensure that they clearly understand their condition and how to manage it.”

—Mark Hackman, MD, American Healthways

the visit. "If patients bring information based on evidence-based medicine, the physician is more likely to deliver care based on that information," Hackman notes.

Improving Patient Knowledge

The interaction between the DM program and the physicians is non-intrusive. A DM nurse will call a physician only if a patient's situation is urgent. Physicians receive a biannual report outlining the prescription and over-the-counter medications each patient uses. "We also work with doctors through our provider service managers, nurses who visit with the doctors and review the DM activities with patients participating in the program," says Hackman. "Sometimes, a physician will request that a patient receive additional educational materials on a particular topic, and the provider service manager will follow through with that request."

For physicians, the most important benefit of participating in a DM program is that they achieve better outcomes for their patients, Lewis asserts. "Physicians find that the outcomes of their patients in the DM program are better than the outcomes of patients who are not in the program," he says. "The best programs track a wide range of indicators quite closely in order to confirm that the patient population is achieving improvements in health."

Hackman agrees, saying, "Those asthma specialists working with us over a period of time do report that the outcomes of their patients in the DM program are better. In general, physicians are a little nervous when their patients are first engaged by a DM program, but as they start seeing improvements in their patients, they become our champions."

DM programs help patients achieve better outcomes in part because they alert physicians to patient problems early. "DM helps me practice higher-quality medicine," Haver says. "There is a big gap in information about patient status between visits. With

"DM helps me practice higher-quality medicine. There is a big gap in information about patient status between visits. With DM, I get feedback on my patients on an ongoing basis."

—Kenan Haver, MD, Massachusetts General Hospital

DM, I get feedback on my patients on an ongoing basis. For example, I can find out how often they are refilling their prescriptions. Other information about my patients' asthma symptoms can inform my decisions about whether or not to escalate therapy. I can also find out which patients have not filled their prescriptions, prompting me to find out why. Finally, I sometimes learn that my patients are taking medications for other conditions, which they may not have mentioned during an office visit, that may affect their asthma treatment or I learn that they have needed to be seen in the emergency department. This extra information makes me better informed and gives me the opportunity to have more meaningful conversations with my patients about their health, and ultimately, provide better care for my patients."

Gaining Physician Support

Initially, it can be difficult to win the support of physicians, given that they may be suspicious of health plan initiatives, Hackman adds. "Physicians have been skeptical of health plans because traditionally payers have focused on cost and utilization outcomes regardless of how they are achieved," he says. "But when the physicians realize that we are trying to improve quality and achieve only those cost improvements associated with better outcomes, they become more accepting."

Given data showing improved outcomes, physicians typically do not need any other incentive to participate, says Lewis. However, DM programs provide other benefits. "Physicians who participate in these

programs say that the volume of calls and visits with patients does not necessarily change, but the content of those calls and visits does," he observes. "They are much more likely to be contacted for appropriate reasons than for inappropriate reasons. Physicians participating in DM programs also receive detailed and ongoing data about their patients, facilitating their care."

Hackman agrees, saying, "Patients participating in DM programs are much better prepared for their office visits. The time with the doctor is spent on the most relevant issues for the patient. This definitely improves the efficiency of the office visit."

Participating in a DM program also can enhance a physician's standing with a payer. "There is no doubt that payers who sponsor DM programs track the level of cooperation by participating physicians," Lewis says.

What's more, Hackman adds, is that when DM programs are part of quality improvement efforts, the next logical step could be pay for performance, a movement that is growing throughout the country. "Health plans are now rewarding doctors for the quality of care they provide, rather than whether or not they keep costs down," he notes. "Payers are closely examining quality indicators and finding ways to reimburse and reward physicians based on quality. There is great potential for pay for performance initiatives to be applied to asthma treatment, which embodies easily measurable quality indicators."

—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 8).

Program Boosts Billing Accountability

By Ted Sullivan and Linda Roy

In physician offices that outsource their billing, staff might start to finger point and play the “blame game” when claims don’t get paid or charges are lost. But doing so doesn’t resolve problems or improve the process to prevent the same mistakes from happening again.

Lack of control over the billing process also makes it difficult for staff to assume responsibility and take pride in their work because they can’t see the end result: the claims getting paid. At Miami Pediatrics, a seven-physician, three-location general pediatrics practice in Miami, we noticed staff in the three clinics were developing an “us versus them” attitude, especially when errors occurred.

Assigning Blame

When our formerly hospital-owned practice went private in June 2000, we used an in-house billing program but found we didn’t have the time and resources to bill effectively. We switched to an outsourced billing company but this system only compounded the finger pointing.

At Winchester Physician Associates (WPA), a 19-office group in Winchester, Mass., we noticed the same problem. We used to have an outsourced billing company and whenever something went wrong with claim payments, staff would place the blame on the billing service. Staff also felt little desire to learn more about how the billing process works because they relied on the service exclusively.

Ted Sullivan is the director of physician services for Winchester Hospital, in Winchester, Mass., and Linda Roy is the practice administrator for Miami Pediatrics, in Miami.

In the past if the billing service noticed a problem with a claim, the service would call the practice and ask the physicians or office staff to correct the problem. As a result, the staff never learned from its mistakes.

For example, if the billing service noticed a problem with a claim, the service would call our practice and ask the physicians or office staff to correct the problem. It was turning into a daily negative phone call, and the billing service started trying to correct problems on its own. The problem was that our staff never learned from its mistakes.

We wanted to improve our billing and collection processes, and like Miami Pediatrics, signed on as clients of athenahealth, Inc., a company in Waltham, Mass., that provides an online revenue-cycle management solution. athenahealth improved our collection rates but we discovered we could also use the system as a teaching tool to improve staff accountability.

Improving the Culture

To create a culture of accountability, we had to develop a new way of thinking at WPA. We had several goals. We wanted staff to fix the mistakes and learn from them, we wanted a system that would clearly show how everyone on staff performs, and we wanted to develop a culture of collecting payments at the time of service.

At WPA, physician compensation is tied directly to the amount of cash

we collect. Therefore, we encourage our physicians to be decision makers, and they in turn ask us to adopt better technology and tools to increase cash flow and reduce costs.

New Technology

Once new technology is in place, we have to monitor staff performance and how well the new technology performs. Staff members appreciate having the tools to help them do their jobs more effectively, and, as a result, take more pride in their work. We recognize and reward staff members’ efforts, which is the final step in creating a culture of accountability. Then, since the physician compensation increases because of improved cash flow, they keep encouraging staff to improve performance and learn how to make the most out of the technology.

After WPA switched to athenahealth, we experienced a 20-day drop in days in accounts receivable and have sustained a 6% increase in collections. For us, that translates into a net cash increase of \$1 million per year.

Learning From Mistakes

Before WPA switched to athenahealth, we wanted to investigate why claims from our practice were not get-

ting paid in a timely manner and why there was a large outstanding self-pay balance. Initially, we thought the problem might have been equally split between our staff and the billing service. But we also wondered if the billing service actually was responsible for a majority of the errors.

Finding the Source

Instead, we learned that most of the errors came from our practice staff. There were errors in coding, failure to check patient eligibility, and neglecting to collect co-payments. These errors occurred regularly, preventing us from maximizing revenue. Once we started using the new system, it became easier to correct these problems. The system prompts staff when an incorrect code is entered and puts incomplete or inaccurate claims in “hold buckets” where staff can easily see the inaccuracies or identify problem trends. Once staff can see the problems and then fix them, they become accountable for their work.

Using such systems, it is also easy to track which staff member registered a particular patient and find if he or she collected a co-payment, and checked the patient’s insurance eligibility. It is much easier to collect payments up front than to call patients who have outstanding balances and ask them to make payments. At WPA, we developed a number of strategies to help us collect payments at the time of service.

The office managers now use the system to identify staff members who do not collect co-payments and work with them to correct the situation. The office manager can educate staff about the importance of reminding patients prior to their visits about any outstanding balances.

Office managers also use the system to learn why there are outstanding balances. For example, an office manager can see if a staff member did not properly check a patient’s insurance and then can explain how to prevent such denials in the future.

Back Office Problems

At Miami Pediatrics, we had similar problems but because we corrected billing and coding problems behind the scenes, staff members never learned from their mistakes. Now, if a claim is posted incorrectly, we can e-mail the staff member who handled the claim, identify the problem, and have the staff member correct the mistake. Office managers frequently use athenahealth as a teaching tool, either for individuals or system-wide, and as a result, staff members have a greater sense of responsibility and accountability for their work. Also, we have found that for the first time, staff are interested in coding and want to learn more about the process. In fact, various staff members compete with each other to see which office can work through its hold buckets fastest. When one office learns a new way to handle

claims or eliminate problems, staff will share that knowledge with those at other clinics.

At WPA, staff are willing to accept responsibility for their jobs, because they have the tools to do their jobs properly and to succeed at them. Now that staff have a tool that prompts them to enter the correct codes on claims and know how to sort claims on hold by denial reason, they have started to focus on developing creative solutions to other problems. When we outsourced our billing, staff didn’t worry if there was a problem collecting payments or sending claims. Since they are held accountable for their actions, they care more about the problems and are developing new ways to solve problems.

Recognizing these efforts, we let staff know how much we appreciate their work through praise and rewards. For example, at the end of each month, we go over our days in accounts receivable and other results and praise staff in our monthly financial reports for good performances. Some practices have developed incentives for reducing the days in accounts receivable (AR). One office manager created a “daysies” award for the best results compared with established benchmarks for days in AR and self-pay percentage of AR.

In addition, practice managers have better access to information. Physicians often ask practice managers about the financial details of their work. In the past, the practice managers used systems that did not allow them to run proper reports quickly or easily. When the practice managers could not access the necessary information, they were left feeling incompetent in how they did their jobs. Now they have a tool that provides answers to such questions within minutes.

—More information on physician practice strategies is available on our Web site (see page 8).

After installing a new revenue cycle management system, Winchester Physician Associates had a 20-day drop in days in accounts receivable and has sustained a 6% increase in collections, increasing net cash by \$1 million per year.

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May 2005



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