

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

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EDITORIAL

Patients Getting More Engaged in Care 2

STRATEGY

Information Therapy Aids Patient Care 3

QUALITY IMPROVEMENT

Take Steps To Improve Communication 6

TECHNOLOGY

Hand-Helds Help Capture Charges 9

PRACTICE MANAGEMENT

Key Solutions to Design Problems 12

INTERVIEW

Solo Physician Succeeds by Seeking Payment at the Time of Service 14

Patients Getting More Engaged in Care

Patients are getting more involved in their care. Health plans are recognizing that patients who are emotionally and intellectually involved in their care are likely to be more loyal than other patients. In other words, engaged patients are worth the investment needed to educate them.

Patients invested in their care are helping to propel consumer-driven care by visiting such Web sites as MayoClinic.com, WebMD.com, and RevolutionHealth.com. They also are interested in viewing educational videos online on surgical procedures and diseases. In some cases, medical Web sites allow patients to watch surgery being performed live. For many patients, it is easier to learn by viewing than it is by other means.

"The engaged patient is more than an informed patient," says Michelle Sobel, chief creative officer for Emmi Solutions, LLC, a company in Chicago (at www.emmisolutions.com) that produces interactive patient education communication tools. "The engaged patient is activated. She understands information critical to her health, communicates effectively and confidently with her clinical team, complies with instructions related to treatment, and is positively transformed by her experience with care."

In addition, engaged patients help improve operational efficiencies. John Bachman, MD, a professor of primary care at the Mayo Clinic in Rochester, Minn., has written that computer interviewing saves 4 to 8 minutes per patient, creates a record justifying higher codes, and generates claims less likely to be rejected.

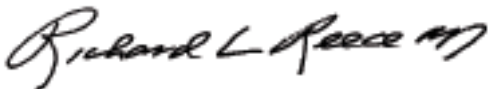
Other experts have found that engaged patients follow directions closely. Cancellations of procedures when patients don't comply with pre-op instructions cost an average of \$2,188, research shows.

Aware of the potential safety hazards inherent in hospitals and particularly after surgery, these patients are three times more likely to recognize complications, such as hospital-acquired infections, researchers say.

Increased understanding among patients also helps to reduce risk. Most nuisance lawsuits result not from negligence but from misunderstandings.

Consumer directed health plans have the effect of providing a financial incentive for patients to be involved in their care. Being involved requires that patients get informed, and that means patients in these plans are likely to have more questions for their physicians than other patients will have.

For practicing physicians, the message in this trend is clear. Patients today want to work more closely with their care providers than patients in the past. These patients may be more willing to comply with orders, which is an advantage, but they will also require more time and more of your expertise at the point of care, necessitating increased practice efficiency.



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Information Therapy Aids Patient Care

By Michael Bihari, MD

Physicians know that getting the right medical information to the right patient at the right time can improve the quality of care they deliver and also boost patient satisfaction and retention. Also, such information can protect against medical malpractice claims.

Donald W. Kemper, CEO and founder of Healthwise Inc., a nonprofit organization in Boise, Idaho, that produces consumer-oriented health information, says that for every moment in care, prescription-strength medical content is available that is evidence-based, medically validated, and specifically useful to help each patient with his or her medical issues. Such medical content is known as information therapy (or Ix).

Avoiding Information Erosion

Information therapy uses information triggers (such as diagnosis, procedures, or drug codes) to identify, categorize, and describe the diagnosis, treatments, and characteristics of a specific condition, Kemper says in a report, *Information Therapy: The Business Case for Information Therapy in Clinics*. The information triggers identify the patient's specific moment in care, meaning the immediate health and medical issues a patient is most likely to face.

The Center for Information Therapy, a nonprofit organization in Bethesda, Md., uses a similar definition. "Information Therapy (Ix) is the timely prescription and availability of evidence-based health information to meet individual's specific needs and support sound decision

making. Ix prescriptions are specifically targeted to an individual's needs at a particular moment in care and are delivered as part of the process of care." Physician-generated Ix prescriptions can improve patient-centered care, promote health and wellness, help manage chronic diseases, prevent medical errors, and help to improve the overall experience and quality of care.

Unlike health content available on the Internet, at a library, in magazines, or on television, information therapy is delivered to patients just before or after a health care visit, test, or surgery; when they receive medications; or at any other appropriate moment during the patients' care.

"Information therapy is about taking health communication and decision making out of the horse and buggy age," says Molly Mettler, a senior vice president with Healthwise. "Important information about health shouldn't be dependent on the doctor remembering what to say, or the patient remembering what he or she heard. We know there is information erosion when patients leave the doctor's office. Information therapy is designed to change that." Mettler and Kemper are coauthors of a book, *Information Therapy: Prescribed Information as a Reimbursable Medical Service* (Healthwise, 2002).

In their book, Kemper and Mettler state: "Health information is not just about care. Information is care." This view supports the growing emphasis on patient self-management and shared decision making, particularly

as the need increases for effective chronic illness management.

Meeting a Challenge

In its landmark 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine (at www.iom.edu) recommended a redesign of the health care system and set "Ten Rules for Quality Improvement." Three of these recommendations specifically addressed patients' knowledge and understanding of their health, including: the patient is the source of control, shared knowledge and the free flow of information, and the need for transparency.

As a practical matter, physicians and other providers can meet the challenge of the IOM by implementing information therapy and integrating the process into their routine office flow. Providing patients with complete, appropriate, and understandable information about their health or condition seems obvious but often doesn't happen. Many patients leave the doctor's office being unclear about what was said or what happens next. This failing is not necessarily the doctor's fault. There is usually not enough time to do a good job providing information during a short visit, especially for primary care physicians.

Although physicians are not reimbursed for providing patient information, there are benefits that information therapy delivers, including improved quality through better patient compliance, efficiency, and

(Continued on page 4)

"We know there is information erosion when patients leave the doctor's office. Information therapy is designed to change that," says Molly Mettler of Healthwise.

(Continued from page 3)

cost control. "Information prescriptions can provide clear direction and supporting information to patients that help them improve adherence to medication and specific self-management plans," Kemper writes. In addition, Kemper says, "Information prescriptions also help patients actively participate in major decisions about surgery or other treatments."

Patient Retention

Many patients place a high value on information they receive from their physicians, and providing information relevant to a patient's condition can be a powerful retention tool. Well informed patients are more likely to be satisfied with their physicians and not only will remain in the practice, but will recommend new patients. For some specialty physicians in a competitive market, Ix becomes an important way to attract and retain patients.

An information therapy program can help improve relationships between physicians and patients and may reduce the threat of malpractice suits. What's more, it might even help reduce medical errors, Kemper contends. "The information provided to patients is often enough to allow them to catch a mistake before any harm is done," he writes. If a malpractice suit is filed, the information given to patients before a procedure can document that they were fully informed of the potential risks beforehand, he notes.

P4P Benefits

Providing information therapy also may help physicians be more compliant with pay for performance requirements and other quality initiatives mandated by insurers and government payers. A record of an information prescription helps document the scope of condition-specific health education provided before, during, and after a visit. Review organizations such as the National Committee for Quality Assurance

Few Patients Check Sources

Few Internet users check the source and date of the information they obtain when using a search engine to find health information online, according to a Pew Internet survey in October. About 113 million adults, or 80% of American Internet users, have searched for information on at least one of 17 health-related topics, the survey found.

Furthermore, the survey showed that about 85 million Americans look for health information online without consistently examining the quality or appropriateness of the information they find. The majority of health information seekers are pleased about what they find online, but some are frustrated or confused.

The report, *Online Health Search 2006*, is an ongoing service of the Pew Internet and American Life Project, a nonprofit research center studying the social effects of the Internet on Americans (at www.pewinternet.org).

In another online report, *Lost in Translation: Consumer Health Information in an Interoperable World*, Joshua Seidman, PhD, president of the Center for Information Therapy in Bethesda, Md., writes "Each day, more people seek information from online sources than from their own physician. But availability of information does not necessarily translate into understanding or taking appropriate actions."

In the report, published in 2005 by the California Healthcare Foundation (www.chcf.org), Seidman further states, "Consumers who go online to choose or manage their own care often encounter clinical information and technical jargon that they are unable to decipher because it is presented in a format that reflects the provider's point of view (diagnosis, treatment, outcome). As such, the information may not be personally relevant and no bridge exists to integrate these disparate concerns into a consumer-centered resource." —MB

(NCQA) and URAC assess documentation of patient education during quality evaluations.

Kemper also promotes information therapy as a tool for promoting visit efficiency. He recommends that physicians send patients specific information before their appointments so they will know what to expect from the visit and what information to bring with them. Reporting test results and providing explanations to patients through secure Internet pages also improve staff efficiency, since they would no longer need to call patients to report test results or field as many calls from patients who need help interpreting them.

As physicians have found, the amount of health and disease-related information available to consumers

on the Internet is staggering. Patients can access millions of citations for medical articles and health-related Web sites. A recent search on Google using the keyword "health information" produced 933 million results, for "heart disease" 74.2 million results, and for "diabetes" more than 85 million results.

Consumers not only seek information via the Internet but increasingly use that information to make health care decisions. Although such information can be empowering, it does not guarantee that consumers can find and use the appropriate information to help them make better choices about their health.

Given the great need patients have for information, Ix can be the bridge that connects physicians and their

IOM Report Says Information Needed

In its landmark 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine (at www.iom.edu) recommended a redesign of the health care system and set “Ten Rules for Quality Improvement.” Three of these recommendations specifically addressed patients’ knowledge and understanding of their health.

1. The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
2. Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
3. The need for transparency. The health care system should make information available to patients and families that allow them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments.

—MB

patients. It encourages patients to ask their providers better questions about their health and illness, have a better understanding of the answers they receive, become more self-assured in their ability to deal with their illness or condition, and participate more actively in their disease management and decision making.

Delivering Information

In the same way that a physician prescribes medications, a diet, or other types of treatment, a patient with an acute or chronic illness also can receive a prescription for information. The process can be as simple as having customized health education materials in the office that are issue-specific and given to the patient as needed or requested. As part of the therapeutic process, for example, a physician can negotiate a set of short-term goals, such as lowering blood pressure with medications and maintaining an appropriate diet and exer-

cise plan in a person with diabetes. Physicians can couple these plans with the relevant health information.

A more sophisticated way to provide information therapy is by having a clinician write an information prescription for the patient during the office visit. The prescription can be a preprinted checklist that reflects a set of education materials available at the office’s front desk. Or, the prescription could refer the patient to one or more Internet sites that the physician has reviewed and are appropriate for the patient’s current needs.

Several large health plans are using or promoting information therapy, including Aetna, Kaiser Permanente, and Group Health Cooperative of Puget Sound. Group Health has integrated it into its electronic health record (EHR) system. During an appointment, the EHR automatically produces a set of education lessons based on the patient’s diagnosis, test results, and medications. For patients

who use e-mail, the system automatically sends the health lessons to the patient’s e-mail box, followed by additional lessons as other test results become available.

Net Gains

In the past few years, physicians have begun to adopt e-health portals, which allow their patients to interact directly with physicians and appropriate practice systems using a secure Internet connection. Patients using these portals can access their health records, schedule appointments, request prescription refills, obtain information about conditions and medications relevant to their own care, and have an e-mail dialogue with a health care practitioner. Many of these portals include health education information that physicians can customize for patients based on a specific episode of care.

Using such a system, physicians can show patients health information on a computer screen in the exam room and then add links to relevant health articles in a post-visit secure e-mail message. For example, after a visit with a patient with type 2 diabetes, the physician can send an e-mail to the patient reinforcing the need for frequent foot exams. The physician can provide a link to an article about peripheral neuropathy.

For physicians and other members of the health care team, information therapy may help patients with a chronic illness be more involved, engaged, and satisfied with their care; improve their retention of important information; and increase adherence to therapy plans. It also helps clinicians focus more effectively on the information they can share with patients. More information about information therapy is available at www.informationtherapy.org

—Michael Bihari, MD, is a health care writer in Falmouth, Mass. More information on practice strategies is available on our Web site (see page 16).

Take Steps to Improve Communication

A medical group's support staff plays an important role in fostering successful communication between the practice and its patients. Therefore, physicians should be aware of the communication style and the abilities of support staff to communicate effectively.

"The communication and rapport-building skills of support staff are the best public relations investment a physician can ever make," says Susan Keane Baker, a practice management consultant in New Canaan, Conn., and an expert in the role communication plays in physician practice management. Baker is the author of *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients* (San Francisco: Jossey-Bass, 1998). "Whether it is to save the physician time, to build trust, or to foster positive word-of-mouth commentary, the behaviors and attitudes of support staff have a tremendous influence on a physician's success."

Raising Care Quality

At the same time, there are significant disadvantages to poor support staff communication skills from both a clinical quality and a business standpoint. "In terms of clinical quality, support staff can reinforce the value of the physicians' recommendations, can make it easier for patients to follow through on agreed upon treat-

ment plans, and can remind physicians about issues of importance to patients," Baker says. "When support staff do not have or use good communication skills, it is less likely that these important activities will occur."

In many instances, staff communication can affect quality of care. "Here are two examples," Baker offers. "A patient does not know the first or last names of any staff members at a practice. So the patient, who is a bit shy or embarrassed, does not ask for clarification of something the physician said. Or, a patient does not call when experiencing side effects of a medication, because she knows how busy the physician is, but does not feel confident in any of the staff, never having made a connection."

Unquestionably, support staff communication can help enhance patient compliance with prescribed treatment regimens. Patient non-compliance is a significant health problem. A survey from the National Community Pharmacists Association in December showed that most patients believe they are highly compliant with prescribed treatment regimens. Yet, 74% admitted to non-adherent behavior such as skipping doses, forgetting to take a dose, and taking less than the recommended dose, the survey showed.

Nurses and other caregivers and support staff in a practice play a sig-

nificant role in emphasizing the importance of medication compliance, thereby helping to improve outcomes. "Practice staff can reinforce the message that the physician has given," Baker observes. "Compliance can be enhanced through follow-up telephone calls by support staff, and even by a buddy system with a patient support group." In some communities, volunteers call patients to help ensure that they have taken their medications, she adds.

Follow-Up Visits

Written information is critical for patients who read, Baker notes. "Even if the physician mentions a test three times during the visit, the patient may not be able to remember the name of the test a few hours later," she says. "The ability of the patient to follow up and schedule the test is then compromised."

Understanding why the physician is recommending a course of action is important to most patients. "Staff members can provide reinforcement of the physician's recommendations in many ways, including scheduling a test for the patient before he or she leaves the office," Baker explains. "Providing written information, and perhaps jotting a personal note along with the information the patient needs, would help reinforce the physician's orders. Then if the staff

"In terms of clinical quality, support staff can reinforce the value of the physicians' recommendations, can make it easier for patients to follow through on agreed upon treatment plans, and can remind physicians about issues of importance to patients. When support staff do not have or use good communication skills, it is less likely that these important activities will occur," says consultant Susan Keane Baker.

Four Ways to Get Started

Susan Keane Baker, a practice management consultant in New Canaan, Conn., and an expert in the role communication plays in physician practice management, offers four suggestions for physicians who want to help their support staff improve their communication skills.

1. Determine if a local hospital offers educational sessions on communication, coping with difficult people, or other related topics. "Ask the hospital's director of education if the office staff could attend one of these sessions," Baker suggests.
2. Seek online resources for self-assessment. For example, Baker's Web site (www.susanbaker.com) offers a first impression checklist that staff could complete. Other topics include how to inspire trust, tips to end visits and telephone calls, six quick tips on telephone skills, and how front-line staff can show courtesy even when under pressure.
3. Anticipate challenging situations and provide appropriate resources, such as how staff can respond to patients' complaints. A company in Toronto called rl Solutions provides technology for health care organizations to gather and analyze information relating to adverse events and overall quality. Visitors to the company's Web site (www.rl-solutions.com) can download a guide, "I'm Sorry to Hear That..." The guide is also available as a book and provides responses to patients' most frequent complaints about health care.
4. Ensure that four actions take place during every patient interaction, whether in person or by telephone, e-mail, or videoconference. First is a warm welcome, second is listening for the patient's need or perspective, third is responding to the patient's need, or expressing interest in the patient as a person, and fourth is the kind close. "This checklist can serve as a prompt for enhanced performance," Baker says.

—DJN

member signs the note and leaves his or her phone number, it could help prompt the patient to follow through, and will emphasize that the staff cares about the patient's health."

From a business perspective, patients often spend as much or more time with support staff than they do with physicians, Baker says. "If a patient does not enjoy seeing the staff, over time the patient may feel less loyal to the physician, and more open to switching to another physician," she says. "Certainly, when patients are spoken to brusquely, or made to feel difficult, there is a high risk that they will defect to another practice."

Building Trust

Support staff can also inspire trust through communication. "Staff mem-

bers should refer to the physicians, and each other, in positive terms," Baker says. "Furthermore, they should not speak about patients when others can overhear. Finally, they should be fanatical about patient confidentiality. If a patient asks about someone who is also a patient in the practice, the staff member could respond in a respectful tone, 'I'm sorry, Mrs. Burgess. We care so much about our patients that we never talk about who they are without the patient's permission or as required by law. I know you want the same respect about your information.'"

Baker finds the method of communication such as over the telephone, in person, or via video conferencing affects the style staff should use. "It is harder to demon-

strate great communication skills over the telephone," she explains. "We have all had the experience of being on the telephone with someone, and hearing a keyboard clicking, or a side conversation taking place. On the telephone, focused concentration on the caller is essential. It begins by listening for the caller's name at the start of the call, and then using the name quickly. The result? The caller thinks, 'Wow, if she heard my name, she also heard what I said. I don't need to repeat myself.' Listening for a non-medical bit of information, and then commenting on it at some point in the call leaves the caller thinking, 'I'm important.'"

Minimizing Distractions

In person, it is easier to make a connection with a patient, as long as distractions are minimized.

"Physicians should be very specific with support staff about when physician-patient visits can be interrupted," Baker counsels. "Physicians and staff alike should be reluctant to interrupt what a patient is saying, or interrupt a conversation taking place between any physician or support staff and a patient. The challenge is that practice members are often immune to distractions and interruptions, but patients rarely are."

Video conferencing or using e-mail or Web portals offer many advantages in communications with patients, but the same principles of good communication apply. "Staff members should prepare for the discussion," Baker observes. "They should write down key points to be addressed, and some of the points should be questions such as, 'What questions can I answer for you?' and 'What concerns you most about this situation?' Staff also should master closing the communication politely. 'It's been good to talk with you this morning, Mr. Smith. We look forward to your next visit. Until then, please call if

(Continued on page 8)

(Continued from page 7)

you have any concerns or questions. Thank you for your time today.”

One way to improve communication is for physicians to identify and monitor the communication styles and skills of support staff, Baker says. “First, physicians should examine their own communication styles,” she recommends. “If a physician is always pressed for time and never makes a personal connection with staff, it is less likely that staff will, in turn, make personal connections with patients. The physician who always seems annoyed or slightly irritated with staff can expect staff members to exhibit that same attitude with each other and with patients.”

The Elements of Style

Second, physicians can monitor the communication styles of staff members by having them answer a number of questions (see sidebar, “Questions Physicians Can Ask”), which leads to the third step, working with staff to enhance communication. “People are often unaware of how they may fail to use their best communication skills,” Baker comments. Role playing can be useful in helping staff understand how they sound to patients and learn how to improve communication.

Fourth, physicians can ask patients how to enhance their experience in the practice. “A simple question at the end of the visit, such as asking, ‘What would make visiting us a nicer experience for you?’ can generate some tangible suggestions for improvement,” Baker offers.

Training Sessions

A fifth option is formal training. Many organizations teach the essentials of good communication, such as listening, understanding, exchanging information, and showing empathy. Baker offers a variety of on-site interactive communication programs that focus on listening skills, coping with difficult patients, enhancing service quality,

Questions Physicians Can Ask

Physicians can take several steps to ensure that staff members are communicating effectively with patients. One way to do so is to observe staff members’ interactions with patients. Susan Keane Baker, a practice management consultant in New Canaan, Conn., suggests physicians answer these questions:

- Do staff members immediately acknowledge arriving patients?
- Do they smile and use the patient’s name?
- Do they use the doctor’s name, and each others’ names?
- Do they keep patients apprised of delays?
- Are their comments positive or negative in tone?
- Do they use courtesy words, such as please, thank you, you’re welcome?
- How many comments that staff members make are orders, such as “Put on this gown,” as compared with statements that show interest, concern, or appreciation for the patient?

—DJN

Improving Communication Through E-mail

Some 40% of patients would pay for a service that would allow them to have electronic communication with their physicians, according to Medem, Inc., a company in San Francisco that links patients and physicians. Medem, other companies, and health plans have developed systems that let patients and physicians communicate via secure (meaning private) messaging or through secure e-mail. Until recently, many physicians have been reluctant to use insecure e-mail because anyone who knows how can read it, Medem says.

Medem’s secure and confidential e-mail system is called Online Consultation. Using this system, patients can get advice on changes in a particular medical situation, gather information on options for treatment, and get an interpretation of abnormal test results with suggestions for further evaluation or therapy, the company says.

Medem was founded in 1999 by the AMA and several national medical specialty societies to develop and provide secure, online communication services for physicians and other providers.

and managing patient expectations, among other topics. The Institute for Health Care Communication Inc. in West Haven, Conn. (at www.healthcarecomm.org) has trained more than 100,000 clinicians and health care staff since 1987. The American Academy on Communication in Healthcare (www.aachonline.org) in Chesterfield, Mo., also offers courses and workshops. Hospitals and some mal-

practice insurers also offer communication seminars.

Communication training ranges from sessions of a few hours to week-long workshops. To improve skills, all trainers stress the necessity of role-playing, practicing, and getting feedback. Listening exercises are vital. —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).

Hand-Helds Help Capture Charges

A few moments each day is all it takes Michelle A. Smith-Levitin, MD, to do a small task that adds value to her practice. While standing in a grocery store checkout line or waiting to pick up her children after soccer practice, she can use her personal digital assistant (PDA) to enter patient charge information.

Using advanced portable software, it takes her only about 30 seconds to enter codes for each patient. Several taps of the stylus on the screen quickly lead the user through queries to create highly accurate ICD9 and CPT codes.

Ease of Use

"It's very user-friendly," says Smith-Levitin, a specialist in maternal-fetal medicine at North Shore University Hospital in Manhasset, N.Y. "Because you're using it on a PDA, it's portable." Mobility is important since she spends so much time in the hospital seeing patients and is only in her office intermittently. "It's so easy to enter the charges that it's almost sort of fun," she adds.

Using charge-capture software on a PDA makes it much easier for the office staff to do the billing, says Angela Kobus, assistant supervisor for ob-gyn billing at North Shore. When physicians without PDAs use paper-based data, Kobus must manually enter codes and correct inaccuracies. But data from physicians with PDAs is transferred seamlessly and the data from these physicians requires little intervention from the

office staff, she says. "It's rare that I have to question them," she adds.

At least 45% of physicians use PDAs, also called handhelds, for a variety of tasks, such as personal scheduling and calculating doses. A study in the May 2006 issue of the *Journal of Medical Internet Research* estimated PDA use at 45% to 85% of all physicians. PDA users tend to be younger, work in hospitals or large practices, and are slightly more likely to be men than women, the article said. Since so many physicians are accustomed to using PDAs, technology expertise was not likely be a barrier to deploying hand-held applications, the article added.

Achieving ROI

One of the most useful functions of PDAs, according to many users, is capturing charges at the point of care. Physicians use PDA-based charge capture software to select codes at the point of care, eliminating manual data input, improving coding accuracy, and reducing claim denials. Each of these steps helps to improve practice income and cash flow.

Linda Hershon, assistant vice president of the faculty practice plan at North Shore-Long Island Jewish Health System, the parent of North Shore University Hospital, reports substantial income gains from physicians such as Smith-Levitin using charge-capture software from PatientKeeper, in Brighton, Mass.

"We anticipate nearly a 5-to-1 return on investment in Patient-

Keeper Charge Capture over five years," Hershon reports. "In fact, we're already seeing a 10% increase in patient evaluation and management charges billed by our participants."

Debbie Rivers, manager of financial services at the 300-physician Carle Clinic Association in Urbana, Ill., says denial rates drop when providers use PDA-based charge capture systems. PDA-based ClaimsManager software from MDeverywhere in Durham, N.C., reduced Carle's denial rate from 11% of claims to less than 1%, she adds.

The PDA itself costs between \$250 and \$700, and advanced charge-capture software typically requires a monthly fee of about \$200 per doctor, but prices vary.

Users say it is important not to skimp on investing in PDA-based charge capture software. The simplest programs list the available codes and more sophisticated ones can be customized to provide physicians' most common codes, have search functions to help find other codes, supply regular updates of payers' coding rules, and warn physicians if code combinations are wrong.

The return easily justifies the expense for such technology. MDeverywhere reports that the endocrinology and nephrology divisions in a department of medicine at a large academic group practice pay \$24,960 a year for the company's software, but the divisions realize \$126,412 a year in additional income

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Billing officials at one facility anticipate nearly a 5-to-1 return on investment from a charge-capture program over five years. The hospital has already produced a 10% increase in patient evaluation and management charges billed by physicians.

(Continued from page 9)

due to the software, representing a return on investment of 406%.

From Paper to Digits

The typical practice, it is said, loses an estimated 10% of gross billings due to misplaced, forgotten, or incorrectly prepared charges, and many billing experts think this is largely due to the paper encounter form. For example, MedAptus, a maker of PDA-based charge-capture software in Boston, found that physicians using paper make 17% more errors than those who use its software.

Smith-Levitin found paper charts were cumbersome and lead to mistakes. Paper can be lost, physicians sometimes guess the wrong code, and handwriting can be illegible to payment clerks entering the data. "If I am writing out the diagnosis code 648.93, and someone misinterprets a digit, the wrong code goes in," Smith-Levitin says.

In contrast, the hand-held stays with the provider and its data are secured with a username and password. Occasionally, PDAs get lost or broken, but users say it is easy to retrieve the information because back up copies of the data are frequently stored on a server.

Features Added

Just as features proliferate for all systems, PDA technology has made significant strides in recent years. Memory, speed, and battery life have improved, and high-resolution color has replaced grainy black-and-white screens.

When charge-capture software was introduced, programs presented simple lists of codes. Today, physicians can customize programs so that codes for their most common procedures are readily accessible in drop-down lists. To set it up, doctors provide their most common codes to programmers. Using these shortcuts, physicians can complete coding with just a few taps of the stylus. "In most cases, there's no

Systems Boost Speed, Accuracy

For Angela Kobus, assistant supervisor for ob-gyn billing at North Shore University Hospital in Manhasset, N.Y., dealing with paper forms involves much more work than using electronic data from a hand-held or other charge-capture systems. "When physicians use charge-capture software, the information is almost always accurate," she adds.

What's more, coding on paper forms frequently leads to mistakes, Kobus says. To correct these errors, Kobus has to call the doctor and read him or her the description to make sure it's right. The physician may not remember the encounter, in which case the reimbursement for care of such a patient may be lost. Conversely, PDAs record the encounter at or near the time of service, when it is still fresh in the physician's mind.

While it can take many days to send a paper-based claim to an insurer, Kobus can send out a PDA-based claim on the day of the patient encounter.

—LP

writing or typing," Smith-Levitin says. "It's all drop down lists."

Using MDeverywhere, for example, one tap on the patient's name opens the encounter. The physician hits next if the diagnosis is unchanged from the previous visit, then indicates the type of visit, and selects the level of care. A final tap indicates the physician is done.

When codes are not listed on the physician's customized drop-down list, the physician can use the look-up feature. For Smith-Levitin, a pregnant patient with pneumonia would not be on her list. She could hit search and type in the first few letters of pneumonia to generate a list. She then could scroll down the list to find her choice.

Many claims-capture programs also prompt physicians to enter coding modifiers, which physicians sometimes forget when using paper charts, but which are key to getting full payment. "Using the prompts, it's much easier for us to put in coding modifiers on Patient Keeper than doing it on paper," Smith-Levitin says.

Charge-capture software may also include an evaluation and management coder to automatically calculate the right E&M service level. The E&M coder also can be purchased as a stand-alone product, such as Stat

E&M Coder from StatCoder.com in Austin, Texas. This program uses automated checklists that count the documentation elements of a patient visit and displays the elements needed for various levels of care on the program's status bar.

Automatic Billing Links

Users synchronize their PDAs several times a day, which involves plugging the device into a port or using a wireless connection to download and upload information. "I sync my PDA with the hospital system so that I can access my patients on my PatientKeeper," Smith-Levitin says. She often completes her coding work after she leaves the hospital. "Then, the next time I'm in the hospital, I just sync it again, and everything goes into the system," she explains. "It automatically updates the billing system."

If another physician takes over a case, he or she can download the updated patient information and help generate unified billing information on that patient.

When the charge-capture data comes in, billing staff ensure that the doctor has billed for every patient. "Using a list of all the patients in the hospital under our service, our billing staff makes sure that they have a

Charge-Capture Vendors Offer Software for PDAs

Here is a list of vendors that provide charge-capture software for personal digital assistants (PDAs).

- IQMax Inc., Charlotte, N.C. (www.iqmax.com)
- MDeverywhere, Durham, N.C. (www.mdeverywhere.com)
- MedAptus Inc., Boston (www.medaptus.com)
- Mobile Design Technologies Inc., Houston (www.mobiledesigntech.com)
- PatientKeeper, Brighton, Mass. (www.patientkeeper.com)
- PocketMed, Charlottesville, Va. (www.pocketmed.org)
- PracticeXpert, Calabasas, Calif. (www.practicexpert.com)
- StatCoder.com, Austin, Texas (www.statcoder.com)

charge for each patient every day," Smith-Levitin says.

On some systems, when billing staff want to understand how the physician determined the codes, they can retrieve documentation showing the process, thus making it unnecessary to call a physician. Another advantage of having electronic billing data is that it can be formatted to assess productivity or analyze payments. Some charge-capture software helps physicians generate a variety of such reports. And some software can facilitate submitting claims to insurers.

A Contrarian View

Although physicians use PDAs for a wide variety of functions, some veteran PDA-users still do not use their devices for capturing charges at the point of care. Robert S. Miller, MD, an oncologist in Sacramento, Calif., for example, has been using a PDA for nine years. He uses his hand-held

several times a day for such tasks as keeping a to-do list, calculating chemotherapy doses, looking up drug interactions, and finding pharmacy numbers. But he does not use it for charge-capture. He uses a paper system instead.

Unlike Smith-Levitin, who frequently visits the hospital to see her high-risk patients, Miller sees most of his patients in his office. "Claims capture makes sense if you are working between a few different offices or are rounding a lot at the hospital," he says.

Smith-Levitin agrees. "PatientKeeper makes sense for physicians who have large hospital-based practices and are doing a lot of procedures and visits and consults in a hospital setting," she says. "If you admit two patients in a hospital, it doesn't make sense to have a system like PatientKeeper."

But Kobus, Smith-Levitin's claims clerk, argues that even physicians

who are less mobile could realize significant benefits from charge-capture programs. At the North Shore ob-gyn department use of hand-helds for charge capture is not mandatory and many of Smith-Levitin's colleagues, who do not visit the hospital as much as she does, have chosen not to use them, she adds.

"No one is really pushing them, but it would be better for me if they did use PDAs," Kobus comments. Those physicians who don't use charge capture software make more errors and require more of her time to process bills, she says.

While Miller admits his paper-based system is primitive, he is waiting to use charge-capture software because his practice is about to make a much bigger technological leap. In less than a year, his office will convert to an electronic health (EHR) record system, which will computerize the patient's entire medical record as well as billing information. Using this new system, Miller will be able to enter codes at any workstation in his office. Doing so would be preferable to squinting at a small PDA screen, he says.

Despite the growth of EHRs, however, PDA-based charge capture may continue to be a viable option. Because of the cost, many physicians' offices are not adopting EHRs, and even those that have such systems may still need handhelds for their mobile doctors.

—Reported and written by Leigh Page in Chicago. More information on physician practice strategies is available on our Web site (see page 16).

The return on investment (ROI) from charge-capture software easily justifies the expense for such technology. MDeverywhere reports that the endocrinology and nephrology divisions in a department of medicine at a large academic group practice pay \$24,960 annually for such software, and realize \$126,412 in additional annual revenue from the programs.

Key Solutions to Design Problems

By Jill K. Arena, FACMPE

Given that many specialists are likely to be intensely interested in the clinical or business aspects of practice, it may be easy to overlook some of the more mundane issues related to office space. This situation raises a question: how can one acquire functional office space that is inviting for patients and useful for physicians and staff? All physicians should consider several design elements before any building starts.

One of the first questions to answer involves whether you'll rent, buy, or build. Check with the real estate experts in your area before you begin your search. If you consider renting space or buying a building, you may find the latter makes more sense depending on your situation. These are issues to address with your tax professional and financial planner. Once you decide to proceed with construction in the office, here are some of the more difficult questions you will face.

Form Follows Function

First, what activities will happen in the office versus in the hospital? Is the office space mainly for in-office consults and pre-op appointments, or is it a space primarily for dictating notes and completing paperwork? If the emphasis is on in-office consults, exam room size and placement are paramount. If your patients usually come for visits alone, a smaller exam space may be best. If your average patient

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If you consider renting space or buying a building, you may find the latter makes more sense depending on your situation. These are issues to address with your tax professional and financial planner.

visit includes the patient and one or more family members or caregivers, consider exam rooms measuring at least 10 feet by 10 feet. If you use anything larger than a conventional exam table, consider adding a few more feet to one dimension as well.

If your office is largely a place for dictation and paperwork, be sure to include an area that is quiet where you can dictate notes with few interruptions. If you need space for consults with patients and family members, be sure to incorporate adequate seating and think carefully about the composition of the room. Do you wish to sit across a desk from your patients? Doing so is clearly a position of power, and reinforces a specific role. Many physicians eschew that layout in favor of a friendlier furniture arrangement that gathers people together as a group with no seating or power disparities. Making this decision requires some soul-searching about how you prefer to interact with patients, and what role you will assume: dictator or advisor.

Other questions to raise include: Who will spend time in the office, and what is their function? Will you have a scheduler, receptionist, and biller? How do they interact with one another? One should consider if and how the workers will be required to do each other's jobs, which may call for co-located or line of sight work spaces. How much sound insulation does the scheduler need from the

front desk if the majority of her work is done by phone? If it is done largely by computer, does that change the office dynamic?

Given that the design and décor of one's office communicates many factors to patients, physicians should pay attention to the details of how it is furnished. Old furniture and dusty fake plants may make your patients question your clinical competence. They may also question your ability to be current with clinical issues if your waiting room suggests a bygone era. Walk through the front door of your office with a naïve set of eyes or ask a friend to do so and give you his or her first impression. What messages are you sending to patients? What messages do you want to send them?

If the carpeting is plush, the furniture luxurious, and the artwork expensive, your patients may begin to wonder how much you are billing them (or more likely, their insurance company) for the services you provide. One should strive to have clean, attractive, and current furnishings of good quality without going overboard.

Location, Location

Oddly, the location of the office and proximity to the hospital also can speak volumes about your practice. In general, if the hospital in your community enjoys a good reputation, a suite on campus or close to it allows institutional transference, which will

allow you to bask in a bit of the facility's glory simply by stating to patients, "We're located on the St. Mary's campus." The opposite is also true. If the hospital has a poor reputation, any co-located practice may be painted with that brush as well. What is the reputation of your admitting facility? Is it time to move closer or farther away? Once established in a community, most physicians give little thought to this issue. While challenging at first, a move to another hospital can frequently make or break a practice over time.

Technology is an oft forgotten element that is gaining importance in office design as electronic medical records (EMR) become more prevalent. How do you use technology? How would you like to integrate it into your new space? If you are using an EMR, or plan to install one soon, consider putting PCs in each room. If you will use laptops, tablets, or other portable devices, you'll have more space and more design options. After years of study, many physicians have found that a wall-mounted articulating arm is best for integrating a PC into an exam room, and they can be used in nursing or dictating stations as well. Consider screens that sit below the desktop with glass panels for minimal desktop clutter and maximum security of patient information in public areas.

Integrating technology likely will have a tremendous effect on workflow and should have a bearing on your floor plan. If you have not yet implemented an EMR, but plan to, consider these issues before construction starts.

A Sense of Space

Whether it is feng shui or karma each office and room has a certain "feel." It could be cold or warm; inviting, or not. We don't often consider it, but this element is palpable in most places. How do patients and visitors remark about how your space feels? In general, would they say the space is calming or frenetic? It is important to consider the feel of the space, which includes such important elements as natural light, live plants, artwork, and other features.

Consider all five senses, not just sight. What do you want your patients to hear when they come in? Soothing music (such as one would hear in a spa) or a ringing telephone or blaring television? What do your patients smell when they enter the office? A medicinal or musty order can be off-putting. Fresh coffee may be inviting. Or perhaps no odor is best. What textures can instill the feeling you want? In general, health care professionals can agree on the elements of the office and their need to promote a sense of calm and healing. Does your space do this? If not, what should you change?

Interior designers can help in creating the look and the feel of the office you want. Hire an independent designer or consider using the in-house designer from your architectural firm or furniture vendor. Ask if the designer's fee is included in the project budget or added separately. Also ask if its equipment vendor will provide design services (called computer-aided design or CAD or computer-aided manufacturing or CAM) for its

equipment and built-ins. Many do so, and this step can reduce your design costs. Also consider what existing furniture and equipment you can reuse in the new space, and if you do, how to incorporate these elements into the design. A significant consideration for design is any specialized diagnostic equipment that requires special building accommodations such as reinforcements in the walls or ceiling.

Square Footage Costs

Finally, one should consider financial implications of space, beginning with how much space is needed for the practice, which will drive ongoing rent costs, property tax, and other factors. A general rule of thumb is 1,000 square feet per physician, although this can be increased or decreased dramatically depending on the practice and the use of the space. Office space varies in cost, and can range from \$10 per square foot for Class C space or space in a down real estate market to more than \$50 per square foot for Class A space in a high demand area.

Lastly, if you go into an undeveloped space (shell or vanilla shell) your build out costs (usually called tenant improvements) can range from \$75 to \$200 per square foot depending on your design and finishes.

Most physicians will rent or build new office space once or twice in a career, and the decisions to be made are numerous and have far reaching effects for the practice and its viability.

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

Consider the financial implications of how much space the practice needs. The amount of space will drive other ongoing costs, such as rent and property taxes. A general rule of thumb is 1,000 square feet per physician, although this can be increased or decreased dramatically depending on the practice and the use of the space.

Solo Physician Succeeds by Seeking Payment at the Time of Service

Robert Berry, MD, is the founder of the PATMOS Emergiclinic, in Greeneville, Tenn., which Berry says provides affordable, quality health care through payment at the time of service (or PATMOS) (at www.emergiclinic.com). He provides care to patients who lack health insurance, saying billing and collecting from insurers is needlessly expensive and time consuming. Health insurance should be reserved for major illnesses and major accidents, he says. Berry has testified before Congress on the costs of health care and the need to provide care for the uninsured. He spoke with editor-in-chief Richard L. Reece, MD, about his practice.

Q: Please describe the market for physician services in northeast Tennessee.

A: Greeneville has a population of 16,000 in a county of about 65,000 in rural northeast Tennessee. In this market I compete against four government subsidized clinics within 15 or 20 miles of the clinic. That's a hard thing to compete against. When we started in January 2001, 23% of the population of the state was on Medicaid. That's decreased but we still have a high percentage of Medicare patients.

Today we have more than 7,400 patients and about 60% are uninsured, 35% are commercial patients, and the rest are in other plans. I suspect the uninsured come here because they don't want to go to a government subsidized clinic. The

uninsured are generally hard working people who don't have time to sit in a government clinic to be treated. And, they don't want to suffer the indignity of going through a sliding scale to see what they need to pay when they will have to pay more than they pay here. Even with a sliding scale, they don't pay that much less than they pay here.

They don't go to urgent care clinics because the urgent care costs two to three times as much as what it costs to get care here. And, they can't afford to go to the ER because the ER is usually the most costly option. Most other doctors won't accept uninsured patients around here. So I get many of them. I'm also seeing more insured patients who have high deductibles so they're essentially uninsured for routine care and look at my practice as a way to get affordable medical care. Those who have conventional low-deductible copay insurance come here because they can't get in to see a doctor in a timely fashion. During our walk-in times I try to be fast, and during my appointment times I try to stay on time. I recognize that patients value their time. People appreciate that.

Q: Do you find your practice is satisfying and provides sufficient income to maintain the lifestyle you want to lead?

A: Yes, I'm satisfied with how it's worked out and it provides a

sufficient income. I could do better if I worked in a high volume ER and my income over the last couple of years has been basically a little bit above the average for a primary care physician, either an internist or family practice doctor. I work about 32 hours each week in the clinic.

But after the clinic closes, I have charts to do because I do my own books. I probably spend 10 hours each week on charts and about 10 hours a week advocating for consumer driven health care and against single payer medicine.

Q: Do you believe other doctors could do what you are doing?

A: Absolutely. Doctors are dissatisfied because insurance companies and third party payers are reducing reimbursement and increasing the hassles that practices face. Plus, whenever third party insurers sign a contract most of these contracts allow the third party payers to review the patient's chart at any time, which is a breach in confidentiality. Those contracts represent a breach in medical ethics, and doctors should not sign such contracts. I work for the patients. I don't work for insurance companies.

What I do lends itself primarily to primary care physicians but there are specialists doing it too. Dermatologists, for example. A number of them don't take any health insurance. Psychiatrists are another. I

“Most of the contracts third party insurers sign allow the third party payers to review the patient’s chart at any time, which is a breach in confidentiality. I work for the patients. I don’t work for insurance companies.”

—Robert Berry, MD, PATMOS Emergiclinic

know of a urologist in Michigan who accepts no third party payment. But some other specialists, such as those who are hospital based, are not going to be able to do what I'm doing.

Q: *Do you exclude insurance companies from payment, and if so, how does that work?*

A: They can reimburse the patient if they want to. We don't have anything to do with that except we will take the super bill and code it and send it to a professional biller and the biller can get the money for them, or they can try to do it themselves. But we don't have anything to do with collecting from insurers other than that.

Q: *How have other physicians responded to what you do? Do they ask you for advice?*

A: I have had doctors call me from all over the country about what I do, and some of them have started practices like mine. But to some primary care physicians in this town, I'm a pariah. One physician called me a traitor. But some of the specialists have been more accepting toward what I do. Some of them have treated me and my patients very kindly. Some of them have agreed to see patients for cash on a reduced fee basis. Some of them I've e-mailed for consults and they have e-mailed me back with advice that they don't charge me for. So some have been very cooperative in helping the practice and our patients. Others haven't been so helpful.

Three months after I started, one hospital offered to provide outpatient services at a discount and has been doing so for imaging and lab work. I've approached another hospital several times and they refuse to provide me with the prices of what they charge uninsured patients.

Q: *One of the benefits of a cash practice is reduced overhead. Is that so?*

A: The Medical Group Management Association says the

“You need to start out simple and keep it inexpensive. For my practice, all I need is one office assistant. Also, you can't have a traditional insurance-based practice for some patients and a cash only practice for others. It has to be all or nothing,” says Berry of PATMOS Emergiclinic.

average family practitioner has annual operating expenses of about \$300,000. Ours is roughly about \$100,000. So that's quite a substantial difference. We don't have any billing processes and claims rejection problems.

Q: *Would you say your practice is essentially a neighborhood clinic?*

A: Yes. It's personal in that way. Some people think it's heartless to actually charge for medical services but people charge for everything else. They don't get upset about grocery stores charging them for food or a lawyer charging them for his fees. Maybe it sounds cruel to call our practice pay at the time of service, but people understand that means it can be a lot less expensive for physicians if patients pay at the point of care. Certainly, the uninsured understand that concept because they come here. How else are we going to provide affordable, quality health care for the uninsured if you pay \$300,000 a year in overhead and need to hire three to five staff just to do billing? The math doesn't work. The system is rigged against my kind of practice.

Q: *Do you post your fees for various services up front?*

A: Yes. The fees are listed on a sign outside the front door. If someone wants to know how much it would cost to see me for a sore throat, it's \$40. If I see them for something more serious, it might be \$60. If it's really serious, it might be as much as

\$100. If it's a laceration or a mole they want me to take off, I'll quote them a price and they can take it or leave it. If a patient wants a growth removed, for example, I'll generally charge \$135. In addition, the pathologist will charge them for the pathology.

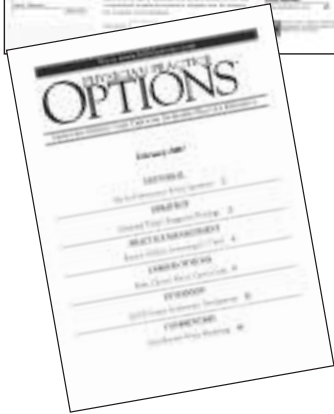
I do a lot of those procedures in my office and I want to do more because people will not go to a dermatologist because of the high deductibles. So I'll do more of this work if the demand increases, and it will increase in the future. Many primary care doctors and internists don't feel comfortable doing these procedures because most of them are not trained to do them. But I've had a lot of ER experience and that experience has been extremely valuable.

Q: *What lessons have you learned that might be useful to other physicians?*

A: You need to start out simple and keep it inexpensive. For my practice, all I need is one office assistant. Also, you can't have a traditional insurance-based practice for some patients and a cash only practice for others. It has to be all or nothing. Once you start billing Medicare you've got to keep up with new regulations. You need someone to do the billing and follow-up on the billing. You either have to cut it all out or go full force to accept third-party payment.

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