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Michael DeBakey, MD, an Appreciation

By Richard L. Reece, MD, editor-in-chief

Michael DeBakey, MD, was one of the nation's most famous surgeons, innovators, and medical statesmen. He died at age 99 in Houston last month. A practicing surgeon for 70 years, he finally put down his scalpel at age 90.

Perhaps best known for his work to develop an artificial heart, DeBakey also helped to introduce more than 70 surgical instruments, including the heart pump. DeBakey performed 60,000 surgeries, trained hundreds of surgeons, and operated on the high and mighty, including Boris Yeltsin, the Duke of Windsor, the Shah of Iran, and Marlene Dietrich. He also conducted a famous feud with his protégé, Denton Cooley, MD, helped make Baylor University into America's leading heart and vascular center, and had a hand in developing an unparalleled list of innovations during his career, including the following:

- As a medical student at Tulane University in the 1930s, he developed the roller pump, first used in transfusions and later it became a central component of the heart-lung machine.
- In 1939, he and Alton Oschner, MD, brought the medical world's attention to smoking as a leading cause of lung cancer.
- In 1952, he was the first to repair an abdominal aneurysm.
- In 1958, he inserted a Dacron graft, showing that the synthetic fiber could be used to repair damaged arteries.
- In 1966, he and a team of surgeons perfected a left ventricular assist device to help patients with failing hearts.
- He helped modernize military surgery by advocating for mobile ambulatory surgical hospitals (MASH units) so that surgeons could operate near the front lines.
- He helped rejuvenate the National Library of Medicine in Bethesda, Md.

As a leader of surgical teams, he circulated among operating rooms, often snacking between cases. He sometimes did an entire case, sometimes played only a minor role, depending on his mood and the circumstances. Once in the midst of a half dozen or so surgeries, he poked his head outside of the door and said, "Anybody out there need surgery? We're just getting warmed up."

Many who knew him would often recall his tremendous abilities. An administrator told me 35 years ago that DeBakey helped bring in more than $50 million to Methodist Hospital.

John Denby, MD, a medical classmate of mine at Duke University, had served as a fellow in the DeBakey program and later became a prominent surgeon in Springfield, Illinois, once said, "He was a great surgeon, but he could be hell on wheels, and we often hid from him."

No stranger to controversy, DeBakey had a widely publicized feud with Cooley, whom he blamed for conducting an unauthorized surgery using a mechanical heart without notifying him. After 40 years, they reconciled and presented each other with awards. When the AMA opposed Medicare, DeBakey supported it and teamed with President Johnson to get the legislation passed.

A man of constant action, DeBakey seemed to be larger than life. He believed what one could conceive and believe in, one could achieve. For all these and other reasons, he was a truly remarkable man.

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

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MN Group Focuses on Care Quality

Recognizing that health care organizations are focusing on ways to improve the quality of care physicians deliver, the 50-physician Minnesota Gastroenterology, PA, is fostering a quality-oriented approach to patient care.

"The real essence of quality is value," says Scott R. Ketover, MD, president and chairman of the board of Minnesota Gastroenterology, PA, a group with 11 clinics in the Twin Cities. "We have to ensure that the services we provide have value to our patients as well as to the organizations that are paying for these services."

Becoming Premier Providers

While gastroenterologists are driven to pursue high quality for the same reasons as other physicians, growing competition from other providers makes proving that the physicians are indeed providing high quality care particularly important in gastroenterology. "By embracing quality improvement and reporting initiatives, gastroenterologists can solidify their position as the premier providers of certain services," Ketover notes. "Our field requires us to straddle two worlds. We provide cognitive services, which involve consultative medicine in the office and in the hospital, as well as procedural services, which require exemplary endoscopic skill.

"Recently, the procedural side of our business has been eroded by non-gastroenterologists, such as general surgeons, colorectal surgeons, general internists, and family practitioners, who have started performing endoscopic procedures," Ketover adds. "These physicians may perform the majority of the endoscopies in some communities, but typically they have not had the breadth and depth of training of a gastroenterologist for both diagnostic and therapeutic procedures. Accordingly, it is critical for gastroenterologists to be able to corroborate the value of their specialty training by demonstrating their outcomes.

"Also, everyone in the payer world is talking about quality and how we need quality outcomes to ensure that we are getting good value for the money we spend," Ketover explains. "Gastroenterologists will be much better off if we can define what we think is important to measure, rather than having these measures foisted upon us by an outside agency. If we become involved in quality efforts, we can ensure that the measures will be clinically relevant and can have a meaningful impact on the care we deliver to our patients."

Adopting Electronic Systems

While Minnesota Gastroenterology has had a focus on quality dating back to 1995 when it started collecting patient satisfaction data, its efforts to formalize its quality initiatives coincided with implementing of an electronic medical record (EMR) system in 2002.

"Prior to the EMR, it was very difficult to collect data quickly and easily," Ketover relates. "Once we had the EMR in place and started to mold it to fit our needs, we saw how easy it would be to collect specific data points during each patient visit or procedure by using templates with pick lists or drop-down boxes. Once this data is collected, it can easily be sorted by condition or outcomes."

Interestingly, improving quality was not the practice's primary reason for adopting the EMR. "Actually, our main goal was to eliminate our paper charts," Ketover says. "With 50 physicians and close to 100,000 outpatient visits a year, we had massive numbers of paper charts. Storage and retrieval were costly and time-consuming. But we quickly realized that we could leverage the EMR's functionality to pursue quality goals."

One of the most basic elements of the group's quality initiatives involves measuring service quality. For 13 years, Minnesota Gastroenterology has invited patients to complete a survey that allows them to rate their experiences in the practice with regard to appointment and waiting room wait times and other aspects of care, such as physician and staff courtesy, respect, and sensitivity; physician thoroughness, care, and skill; time spent with the physician; the quality of educational materials; and patients' understanding of the next steps in care.

Last year, the practice replaced its paper-based survey with an instrument on a wireless device that patients were offered at the end of each visit. Using the device, patients answer a number of questions and the answers can be downloaded and compiled electronically. "It is very easy to collect patient satisfaction data, especially if you try to capture this information while the patients are still in the office," Ketover comments. The

(Continued on page 4)

"It is critical for gastroenterologists to be able to corroborate the value of their specialty training by demonstrating their outcomes."

—Scott R. Ketover, MD, Minnesota Gastroenterology, PA

(Continued from page 3)

quality committee reviews the surveys and proposes improvements based on the survey results.

Measuring Performance

Quality measurement allows the practice to provide quantitative feedback to physicians regarding their performance. "We track outcomes and provide a quarterly written report to each physician that lists the practice mean and the individual physician's performance for each outcome," Ketover explains. "We also hold an annual meeting during which we unmask each physician's data and compare that data to the practice mean and national benchmarks."

Revealing individual physician performance to the group was difficult, given that some physicians obviously fall below the mean. "For the first two years, we revealed physician-by-physician data without including names," Ketover says. "That process eased people into the concept of publicizing outcomes. Eventually, we matured to the point where we could unmask the data, identify physicians who were consistently above or below average, and then try to identify reasons why. Physicians who performed above the mean were asked to share their processes so that others could learn from them."

Internal Improvements Are Required

As a large practice, Minnesota Gastroenterology requires an organized governance structure. Scott R. Ketover, MD, the group's president and chairman of the board, explains that before the group could take the steps needed to improve quality, it had to revise its structure so that the physicians could focus on quality improvement.

"We have a standing quality committee, which is a subcommittee of the board of directors and that is empowered to help determine the possible outcomes to measure, establish which ones we should measure, decide how we should measure them, and then design initiatives based upon our findings," Ketover says. The committee members meet in person each quarter and by telephone each month.

"Anyone in the practice who has an idea about quality improvement or measurement is welcome to contact the quality committee with suggestions," Ketover adds. The board of directors must approve any initiatives that the committee proposes.

Each year, new initiatives and measures are added to current quality activities. "For example, this year, we will be measuring the percentage of our chronic hepatitis patients who are vaccinated for hepatitis A and B," Ketover says. "We are also tracking the proportion of our long-segment Barrett's esophagus patients who receive four-quadrant esophageal biopsies. In the colonoscopy area, we are continuing earlier initiatives to track colonoscopy screening rates, the effectiveness of different colonoscopy preparation methods, adenoma detection rates and withdrawal times. Also, we will be tracking compliance with recommendations for appropriate photo documentation, and we will be tracking the use of the Harvey Bradshaw index in assessing patients with Crohn's disease." The index is a measure of disease severity.

Other initiatives are developed with payers' interests in mind. "For example, we have developed programs in conjunction with payers to increase the utilization of generic drugs," Ketover offers. "We set annual benchmarks for generic utilization, and the payers provide feedback as to whether we are meeting these goals."

The group tracks the outcomes of all of these initiatives closely. "We track gaps in care in order to offer optimal services for each patient," Ketover says. "For example, the EMR sends a message to our staff members highlighting diagnostic test orders that are not fulfilled within a certain period of time. This allows us to follow up to see if the patient did not get the test or if test results were lost."

The practice has also developed protocols to enhance care for the population it serves. For example, the practice has established protocols to standardize the care of patients with chronic hepatitis, inflammatory bowel disease, reflux disease, anticoagulant use by patients undergoing procedures, and colon cancer surveillance.

"We set up a protocol, and then use the EMR to track our compliance with that protocol," Ketover explains. "Then, over time, we can analyze the data to see if the protocol is having a positive impact on care."

Protocol use is critical to enhancing care quality because, as Ketover says, "The art of medicine often overwhelms the science of medicine." When art overwhelms, it can lead to significant variation in care and that can have negative implications for patient outcomes.

"In our practice, we found that physicians did a lot of things differently, believing that their own way was the best way," Ketover says. "Because there are no evidence-based guidelines or recommended protocols for many patient conditions and circumstances, we decided to compile the evidence we could find, create protocols, try them, and then measure the results. Our protocols represent a consensus within our own group based on existing evidence and our own experience and expertise."

—DJN

The practice also tracks procedure complication rates, which a peer review committee evaluates. The committee can then make recommendations if it finds a particular physician might benefit from mentoring.

Pay for Performance

As an extension of its quality improvement and measurement efforts, Minnesota Gastroenterology implemented a pay for performance system last year. "A portion of each physician's salary is at risk based on certain performance parameters," Ketover states. "Currently, about 5% of our compensation is at risk, but we plan to increase that percentage in the future. We started small, so that physicians would acclimate to being measured and having those measures affect their income." Initially, one clinical measure (signing off on pathology results within four days) and one business measure (accurate completion of billing slips) were incorporated in the pay for performance scheme.

Initially, the pay for performance concept was not well received. "However, by the end of 2007, we no longer heard complaints about being measured," Ketover says. "Rather, we heard a lot of discussion about what were the best measures to consider in the future."

This year, the pay for performance formula will include a third measure based on a benchmark for appropriate colonoscopy withdrawal time. "When physicians themselves have a say in the measures, the whole concept becomes more palatable," Ketover explains. "On a national level, some of the pay for performance measures that have been set may not actually foster improvements in health. We are trying to select measures that are really meaningful to patients. Over time, it will be interesting to see whether our pay for performance program drives additional quality improvements."

—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).*

Group Outlines the Lessons Learned

With pay for performance, quality care can affect an individual physician's financial success. But quality improvement efforts also can have a beneficial effect on a practice as a whole, leading to improved relationships with payers and enhancing the physicians' reputation among referring physicians and patients.

"In order for this to happen, however, practices have to consider how to publicize their efforts," explains Scott R. Ketover, MD, president and chairman of the board of Minnesota Gastroenterology, PA. "Payers, referring physicians, and patients have to know that we are doing these things."

For the past two years, for example, Minnesota Gastroenterology has published a quality outcomes report that it mails to all referring physicians and payers, distributes to patients in its offices, and posts on its Web site. "This booklet provides an in-depth view of the practice in many different areas," Ketover explains. "Aside from providing various constituencies with hard data about our care quality, proactively publicizing our performance in this manner helps to differentiate our practice in the marketplace and demonstrate our very strong commitment to quality care."

The experience of the physicians at Minnesota Gastroenterology can offer lessons to other gastroenterologists, whether they practice in small or in large groups, Ketover comments. Possibly the two most important lessons are these: First, have physicians drive the process, and second, measure quality continually, he adds.

"The more that physicians drive this process, the more appropriate the process will be and the less we will feel that we are being controlled by outside forces," Ketover says.

A third lesson is that, instead of viewing payers as adversaries, gastroenterologists can incorporate payers in the quality measurement process. "One way to enhance relationships with payers through quality measurement and reporting is to ask the payers, 'What outcomes would you like us to measure that would be worthwhile to you in terms of our contracting relationship?'" Ketover says. "The payers can participate in defining what they feel would be a helpful initiative. If quality measurement is approached as a collaborative effort, and if physicians can achieve the quality goals that are jointly agreed upon, the result will be a win-win for both the payers and the practice."

The fourth and final lesson is that if outcomes tracking and measurement efforts seem overwhelming, physicians in smaller practices or in practices without EMRs should start small, Ketover recommends. "Start collecting data on measures that are straightforward and easy to collect, such as wait time for appointments," he suggests. "Or, practices can choose one measure that is highly meaningful, such as complication rates. Once physicians assess the data, they can brainstorm strategies that will lead to improvements and then can add new measures as time goes on."

—DJN

EMR Fosters Eye Clinic Growth

By Byron Tabbut, MD

During our search for an electronic medical record (EMR) system, we stumbled across an anomaly—a solution that defied the lengthy timeline typically associated with adopting an EMR. Historically, the timeline required to install and use an EMR can delay the rewards a practice can realize from a fully digitized environment. Those rewards include growth, return on investment, increased productivity, and efficiency.

The story of our success shows how the solution we selected for the Wheaton Eye Clinic shortened that timeline. In less than a year, the clinic achieved a fully digital environment, gained efficiencies, enhanced productivity, improved patient care, grew the practice, and increased revenue.

Wheaton Eye Clinic at a Glance

The Wheaton Eye Clinic (at www.wheatoneye.com) is the largest private ophthalmology practice in Illinois. In addition to its office in Wheaton, the clinic has three other offices in Illinois: Hinsdale, Naperville, and Plainfield. The clinic has 24 board-certified ophthalmologists and seven licensed doctors of optometry. It also has 115,000 clinic visits per year. The Wheaton Eye Clinic provides full vision correction services, contact lens specialists, and a designer eyewear studio.

360,000 Charts

Wheaton Eye Clinic is the largest private ophthalmology practice in Illinois. It has four satellite offices, 24 board-certified ophthalmologists, and seven licensed doctors of optometry. Founded more than 60 years ago, the clinic is a major provider of eye care services and a resource for referring physicians whose patients have eye care needs. We have about 115,000 clinic visits per year, and maintain some 180,000 active charts and another 180,000 inactive patient charts. In addition to our highly trained and experienced medical staff, Wheaton Eye also provides full vision correction services, contact lens specialists, and a designer eyewear studio.

For over six decades, Wheaton Eye endured the costs and delays of a paper-based chart environment. The challenges of dealing with paper charts represented minor annoyances, but became major obstacles as the clinic grew. Lost or misplaced charts prevented us from having access to pertinent patient information when it was needed most. Incomplete charts forced us to search for missing information and delayed our response time to our patients. Shrinking chart-storage capacity ate away at our revenue producing real estate. The effect on our business showed up in the added cost of these delays and the financial penalties that resulted from improper or incomplete coding.

With the addition of each new satellite office, it became more costly to maintain patient records on paper. Processing roughly 1,800 to 2,000 charts weekly, we began to hit our labor, finance, and real estate capacity. Although we experienced growth, the cost of that growth was substantial. We had to hire additional labor to transport, file, and maintain medical records, and we were incurring extra expenses to facilitate communication across our growing practice.

A Hybrid Solution

After evaluating the available technologies and systems, Wheaton Eye selected, implemented, and has had great success with a hybrid EMR solution. A hybrid EMR is a scalable scanning solution that gives a practice the option to add workflow and data management modules, such as digital messaging, electronic prescriptions, referral order management, integrated transcription services, and customized flow sheets. Hybrid EMRs are designed to fit a variety of needs and specialties without negatively affecting physicians' productivity or changing their preferred ways of practicing medicine.

For our clinic, we wanted simplicity but by saying that we do not mean to imply a basic system. To us, sim-

With all of the advancements in efficiency and productivity gained from a hybrid EMR, the Wheaton Eye Clinic added six new exam rooms and launched a new surgical center as well. Last year, it hired three partners and is planning to add two more this year without adding support staff.

Byron Tabbut, MD, *is president of Wheaton Eye Clinic, a group of 24 ophthalmologists in Wheaton, Ill.*

plicity means the system has straightforward, uncomplicated software and even the most robust features are simple and easy to learn. Historically, the most time-consuming phases of an EMR adoption are training and implementation. However, with the solution we selected, training and implementation were non-events. We were able to choreograph the handoffs between the three phases of selection, training, and implementation with weekly conference calls. The training itself was easy because the product was intuitive and we got a lot of support from our EMR vendor, SRSsoft, a company in Montvale, N.J., that produces hybrid EMRs. The process took so little time that we were able to achieve a return on investment within the first year.

Support for Growth

One aspect of the software that we value highly is its ability to support practice growth. We would not be growing at the same speed and scope if we had retained our paper-based system.

With all of the advancements in efficiency and productivity gained from our hybrid EMR, we were able to add six new exam rooms and launch a new surgical center as well. Last year, we hired three partners and are planning to add two more this year. Although we did not need a hybrid EMR to hire new partners, the system allowed us to hire these additional physicians without having to invest in extra support staff. Additionally, our superbills are scrubbed and cleaned in less time than it took to do so with paper claims, and our claims-denial rate is much lower than it was.

Since we installed this system, our optical revenue also has improved because our throughput and charge-capture rates have increased. When our physicians finish an eye exam, they print the eyeglass prescription to a laser printer in the optical shop, thus increasing internal referrals.

Using this new system has saved a significant amount of staff and physician time that previously was devoted to finding lost or misplaced charts. Plus, we no longer need to pull hundreds of charts each day. Even though some of our staff are now devoted to scanning paper charts so that physicians can view these records electronically, we still have more staff time available to respond to patients and referring physicians faster and more accurately.

One interesting advantage of the hybrid EMR is its ability to connect a non-related application easily. The potential of this one benefit is limitless. We integrated our peripheral

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Seeking a Solution, Team Settles on Hybrid

When the Wheaton Eye Clinic began seeking a solution to the problems inherent in using paper charts, the staff found the market for electronic medical record (EMR) systems to be confusing and muddled. To sort through the options, the staff put together a research team of physicians, clinical administrators, and key supervisors from core departments. The knowledge this assorted group brought to the process was reflected in their familiarity with their roles and the ways in which the technology would affect the practice.

The team investigated the various technology choices and vendors. During site visits with practices using the various systems we were considering, the team members compared their experience with that of our specialty, volume, and goals. We asked the physicians in these other groups about support, upgrades, and whether they had any say in the enhancements of the technology.

We found that the easiest way to categorize the different EMR technologies was simply by how physicians enter patient data into the system. The patient data entry method affects both how that data are represented in the system and how the system outputs data.

The input method has a significant effect on physicians and staff. We discovered three main methods of data input: discrete data entry, scanning, and a hybrid between the two.

Discrete data entry EMRs require physicians to click through multiple screens to enter data terms into rigid templates. At one time, EMR developers believed physicians needed software that collected—through data entry—and stored discrete information to achieve the goals of an EMR system. As the industry evolves, however, our team members found that entering all the information from our paper charts would take too much time. Plus, it would turn our physicians into data-entry clerks. In our fast-paced environment, this solution was not possible or desirable.

On the opposite end of the spectrum are systems that allow physicians to scan paper charts. Called document management solutions, these systems do not require physician data entry. When a document is scanned, the system takes a digital image of the document and files it within the appropriate patient record. Document management solutions use barcode technology and can be configured to mirror a paper chart. These systems also offer optional, customizable input templates.

After considering the advantages and disadvantages of these systems, the team decided that the most impressive innovation was in the middle of the spectrum: hybrid EMRs.

—BT

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diagnostic equipment into our digital environment, for example, and doing so gave our physicians ready access to more patient information at the point of care.

In the past, our physicians had to wait for costly diagnostic image reports that were slow to print. Simply printing these reports slowed our physicians and forced our patients to wait. With the diagnostic equipment now integrated with our hybrid EMR, we can quickly call up image reports from any one of our multiple locations, and the images have great clarity as well. As a result, we have eliminated the need to print these image reports, cutting the associated costs.

Communication Advantages

One of the most significant features of our hybrid EMR is that it allows us to improve communication within and outside of the practice. We can now service referring physicians more efficiently, for example, because dictation is now done right after we see a referred patient, decreasing turnaround time. We no longer have waist-high piles of charts awaiting transcribed dictations.

In addition, the hybrid EMR's communication module ensures that all messages get collected, stored, and tracked. By using the communication module, we can respond to patients' inquires quickly, and when physicians talk with or meet with patients, they have all pertinent information at hand. The module also allows us to communicate efficiently among all of our offices while also helping us to be more organized because we no longer rely on spiral log books or notepads.

When installing any new system, physicians are likely to be most concerned about its effect on patient care. The hybrid EMR has had a positive effect on our patient service and care, because our patients are directly affected by the control and access our physicians have over their medical records. The system allows us to respond to patients faster than before, and we are no longer spending time looking for lost charts. The control we have over our practice has allowed us to make more informed business and operational decisions and eliminate the bottlenecks paper charts created.

Although every practice has its own unique demands, we all essentially share the same challenge to do more with less whenever possible. As we learned, it is possible to install an EMR system at a reasonable cost that affords physicians control over their workflow, allows them to maintain their preferred way of practicing medicine, and that facilitates practice growth.

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

Digitized Charts Don't Get Lost

As many physicians know, having piles of charts poses two significant problems. First, charts stacked on a desk are out of circulation, meaning other departments cannot find them in the file room. Second, the time it takes physicians to go through stacked paper charts decreases their response time to patients and ties them to the office.

Once the Wheaton Eye Clinic installed an electronic medical record (EMR) system, all of our charts were digitized, meaning we no longer needed paper charts. Having digital charts solved both of these problems and liberated our physicians so that they could work from anywhere and still have access to patient records as long as they have a computer and an Internet connection. All patients' charts are now stored in one location.

Since physicians have access to patients' charts 24 hours a day and seven days a week, they update their charts more efficiently and within a timely manner because they are no longer tied to a physical location. Also, physicians and staff no longer have to call up the main office and have someone get the paper chart, disassemble it, fax it, and reassemble it for a physician in another office.

Additionally, our billing office no longer waits for charts. If the billing staff needs patient information from a chart to submit or resubmit a claim, the information is available immediately.

Our on-call physicians have gained peace of mind with universal access to patients' complete charts. Even when a physician is answering a call from a patient who may be unfamiliar, the physician can use the EMR to read the entire medical record, including medications, allergies, and the most recent diagnosis and plan of care.

—BT

Since it installed its EMR system, the clinic's optical revenue has improved because throughput and charge-capture rates have increased. Also, when physicians finish an eye exam, they print the eyeglass prescription to a laser printer in the optical shop, thus increasing internal referrals.

COMMENTARY

Who Shall Care for Patients?

By Richard L. Reece, MD, editor in chief

There are two major innovations sweeping across health care. These innovations will affect who delivers patient care and they may determine where some primary care physicians practice. Both of these innovations entail developing and expanding existing clinic models of delivery.

The first innovation involves in-store clinics at major retail outlets. Usually nurse practitioners and physician assistants run these clinics, which offer convenient and affordable care for consumers with minor illnesses. The second innovation is worksite health clinics that large employers are establishing. In these clinics, primary care doctors deliver comprehensive care in the workplace. Employees receive care along with free prescription drugs, and make no copayments. The physicians have access to best-practice information and make referrals to specialists with a history of good outcomes.

Point-of-Sale Medicine

A number of large retailers are developing in-store clinics, including CVS Pharmacy, Target, and RiteAid. Two retailers that have a significant presence in this market are Wal-Mart, Inc., which has 4,200 stores, and Walgreens, which has 6,237 stores. All of these retailers plan to expand their retail health care offers. Walgreens plans to open 500 in-store clinics.

Wal-Mart has 55 in-store clinics and says it will open 400 more by 2010. In addition, it plans to form partnerships with hospitals in 13 regions of the country. In these 13 regions, the clinics will be branded "Clinic at Wal-Mart" and will carry the name of the partnering hospital. The hospitals will pay nurse practitioners and physician assistants for dispensing care, and will pay doctors to oversee these mid-level providers. Also, just as retailers do for each item in their stores, Wal-Mart posts price lists.

This trend portends a potentially profound change for physicians because it could affect where patients will get care and who will provide care. In-store clinics provide an option for those patients who want a quick fix for minor problems and for patients who are uninsured.

Effect on Physicians

"These clinics serve a population that doesn't want a medical home," commented Brian Klepper, PhD, a health expert and a consultant. "They just want to go for care without waiting and when they need care, which could be at any hour. Also, they want to pay for it on a fee-for-service basis, such as $59, $89, or $119, depending on the level of service. They don't want a comprehensive evaluation. They just want what they need when they need it."

Some doctors in physician-short regions may welcome it. Other physicians may view it as unwelcome competition. Some physicians will complain that such clinics will upset the continuity of care and will threaten the existence of many primary care physicians who are already in short supply.

A number of primary care physicians have already said that they fear patients will go to hospitals for follow-up care rather than to their offices. But hospitals respond that doctors have nothing to fear from these new in-store clinics, saying that in-store clinics simply expand access to care and that these in-store clinics afford physicians an opportunity to enter into joint-ventures with them.

But the AMA and the American Academy of Family Physicians say in-store clinics must be investigated and regulated to ensure safety and continuity of care. The American Academy of Pediatrics opposes in-store clinics.

Health Care at Work

While the AMA and other organizations oppose in-store clinics, there is no such opposition to the second innovation sweeping the nation: worksite health clinics. One sign of this trend is Walgreens acquisition of CHD Meridian Health Care, Inc., and Whole Healthcare, Inc., two of the largest worksite health management companies. Worksite clinics provide a place for patients where a salaried primary care physician can comprehensively evaluate and treat their problem, and, if need be, refer

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The trend to develop medical clinics in retail settings portends a potentially profound change for physicians because these clinics could affect where patients will get care and who will provide care. In-store clinics provide an option for those patients who want a quick fix for minor problems and for patients who are uninsured.

(Continued from page 9)

them to a specialist.

"What you get in a worksite clinic is a primary care doctor who may get paid about 30% above the marketplace norm and who uses best practice guidelines and contemporary management tools," said Klepper, a consultant for a start-up worksite company, WeCareTLC, Inc., in Orlando, Fla. "These tools include electronic access to best practice guidelines using an electronic medical record (EMR) system, prescription drugs, no co-payments, a program geared to prevention, and a selected referral network of specialists who deliver good outcomes.

"Employers get cost savings of about 30% to 40%, a significant return on investment, and satisfied employees receiving convenient, less costly care from a primary care physician they know," Klepper added. "You get these savings if everything occurs in tandem in one setting: namely the workplace. You get something else too, which is important to employers: an analysis of how many employees have chronic conditions."

When a patient has an illness, the doctor does whatever he or she can do to help the patient, but in addition, physicians who work for worksite health clinics will first analyze the costs of care from other physicians to identify what steps produce the best outcomes at the lowest costs, Klepper said. "In a study we just did at our largest clinic, where costs were about $1 million per year, we found the return on investment was $2.44 for every dollar invested. And that doesn't include savings on worker's compensation, drug testing, and productivity gains. At this one worksite, total claims costs dropped by 34%," Klepper added.

Since the average cost of providing health care to an employee is about $10,000 annually, many businesses see on opportunity in offering health care and wellness advice at once. *The Wall Street Journal* has reported that one clinic serving about 1,000 employees can expect to save about $70,000 in its first year of operation, mainly because of fewer visits to the emergency room and self-referrals to outside specialists. Such savings may rise to $250,000 annually by the third year when preventive savings kick in, and productivity could rise because workers would spend more time on the job, the newspaper reported.

A Medical Home

Another advantage is that worksite health clinics create a medical home for patients, which is a concept the Association of American Medical Colleges (AAMC), the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association promote for patients. The AAMC defines the medical home as one that includes an ongoing relationship between a provider and patient, around-the-clock access to medical consultation, respect for a patient's cultural and religious beliefs, a comprehensive approach to care, and coordination of care through providers and community services.

Both the medical home and worksite health clinics likely will focus attention on primary care and change reimbursement to physicians so that they have a incentive to promote early detection and intervention of illness.

Therefore, worksite clinics can leverage the power inherent in pri-

Retail Health Lessons Learned

Regardless of one's view of corporate-run retail health clinics, there are lessons to be learned from Wal-Mart, Inc., the world's largest retailer. One could argue that in-store clinics are one of the most significant health care developments in the 21st century and that Wal-Mart is introducing innovations that physicians might want to adopt for their own practices.

Typically, in-store clinics take two to three years to show a profit, and some clinic operators have run short of capital and been forced to close. Retail success and success in primary care both can be challenging. It will be fascinating to see which models succeed.

Physicians interested in learning business lessons about these clinics would do well to consider the following strategies that Wal-Mart employs nationwide:

Price. Wal-Mart's slogan that, "We sell for less" has been a smashing success. Some physician groups have taken the clue by opening and owning their own clinics and by lowering overhead in cash-only practices.

Access. Being open for hours beyond the standard 8 am to 5 pm at many physicians' offices, means these clinics may be able to eliminate waiting time for care. Some physicians have responded with open-scheduling, meaning they see patients the day they call.

Price transparency. Patients want to know in advance or at the site of care what things will cost. Some physicians, particularly in cash-only practices, are posting prices in their offices.

Location. Wal-Mart got its start by placing its stores in rural areas and suburbs where competitors were scarce and where parking was ample and free.

Brand name recognition. In any given community, both Wal-Mart and the local hospital are well-known. Physicians could take a cue here by engaging in joint-ventures with community hospitals.

—RLM

mary care. "These clinics are not just a standard environment where the doctor is being a doctor," Klepper comments. "It's a whole analysis process. It's figuring out what the patient needs with tools ordinary doctors don't have. It's driving huge amounts of money out of the system.

"For many years, primary care doctors have been disorganized," Klepper adds. "They know they should be paid more, but they don't have enough financial wherewithal to affect the system. Under this model, primary care practitioners will refer only to specialists whose data show they provide the best outcomes at the best price. And, you can be sure that the corporations who own these clinics will leverage primary care power, and they will leverage that power to enhance their own prescription services."

"What you get in a worksite clinic is a primary care doctor who may get paid about 30% above the marketplace norm and who uses best practice guidelines and contemporary management tools," said Brian Klepper, PhD, a health care consultant.

Concern for Independence

Despite the many advantages of worksite clinics, there are disadvantages as well. Only about 10% of Americans work in large corporations with enough critical mass or resources to support worksite clinics. And employees may not want their employers to know confidential information about their health status, addictions, and life styles. For this reason, many employers hire outside companies to run their clinics.

But physicians themselves also represent some of the disadvantages inherent in worksite clinics. They tend to be independent and autonomous, for instance, and so don't always make model employees. After having seen the role corporations played in developing managed care plans, many physicians are distrustful of how well corporations will invest in health care. Also, not all physicians believe in the power of data to identify best care practices.

One last caveat deserves a mention as well. Worksite health clinics have been tried before. Some of the nation's largest employers, such as General Motors and John Deere, have run them for years and they have not proven to be a panacea. One of the reasons is that not all employees trust their employers and so are reluctant to visit on-site clinics.

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

AAMC Supports Medical Home Concept

The Association of American Medical Colleges (AAMC) supports the medical home model of health care delivery, saying it provides patients with a coordinated, comprehensive approach to primary care. The AAMC aims to work with medical schools and teaching hospitals to develop a better understanding of how the medical home model can be adopted in academic and community settings.

In the medical home model of health care delivery, the relationship between care provider and patient is essential, AAMC said. A medical home ensures around-the-clock access to medical consultation, respect for a patient's cultural and religious beliefs, and the comprehensive coordination of a patient's care among providers and community services.

"Many Americans, even among those with comprehensive health insurance, feel medically homeless and lost in a system that is difficult to navigate when they require care," explained AAMC President and CEO Darrell G. Kirch, MD. "We believe the medical home model holds great promise for improving Americans' health by ensuring that they have an ongoing relationship with a trusted medical professional.

"As the health care workforce is increasingly challenged to provide care for a growing population of aging and chronically ill citizens, it is critical that patients have access to effective care for both prevention and treatment," Kirch said.

In addition, the AAMC says:

- Every person should have access to a medical home, meaning a provider or team of providers to help patients navigate the system and with whom there is a continuous relationship.
- Further research and evaluation of the medical home model is needed, and more evidence must be gathered on how the model can be implemented most effectively.
- Payment for the medical home model should appropriately recognize and reward providers for illness prevention, care delivery, and coordination.
- Health care providers should be trained to understand and implement the medical home model within a team environment.

Tax-Saving Ideas Practices Can Use Now

By David B. Mandell, JD, MBA, and Jason M. O'Dell, CWM

Few physicians realize that they spend 40% to 50% of every day working to pay off the taxes owed to the state and federal governments. While death and taxes are inevitable, and there's no way to avoid death, at least there are ways to reduce one's tax burden.

For physicians seeking to cut their taxes on the tax returns they will file at yearend, now is a good time to begin putting these ideas into action.

Here are the six tax strategies we will outline in this article:

1. Protect your practice's most valuable asset and reduce taxes
2. Share income with lower-income family members
3. Gain tax-deferral, asset protection through cash value life insurance
4. Hire investment managers who manage with taxes in mind
5. Use charitable giving to reduce income taxes
6. Buy cash-value life insurance as a supplemental investment.

Protect your practice's most valuable asset and reduce taxes. Physicians face malpractice liability as well as general business risks, such as employee liability. What physicians may not realize is that a claim by a patient or employee against any physician could threaten all of a practice's accounts receivable. Typically, accounts receivable are a practice's most valuable asset.

For this reason, physicians implement asset protection strategies for their receivables (A/R). Explaining all the details of the options physicians have for A/R asset protection is beyond the scope of this article. Nevertheless, physicians should be aware that these strategies may allow the practice to protect its assets while also reducing its income tax burden.

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Physicians should consider investment managers who manage clients' portfolios with the goal of reducing taxes on investors' income and capital gains, not simply investing money with no concern for the tax implications.

Share income with lower-income family members. In 2006, the U.S. Congress changed the rules regarding sharing income with family members, by increasing the minimum age for children involved from 14 to 18, and it raised the minimum age for full-time student children in this program to 24. Nonetheless, it still remains a viable option for many physicians with older children.

This strategy involves spreading the income created within a family limited partnership (FLP) or limited liability company (LLC) to the limited partners or members who are in lower tax brackets. Since many physicians are in a 40% tax bracket for state and federal taxes and many of them have children who are in either a 10% or 15% tax bracket, the LLC/FLP can save significantly on income earned by LLC/FLP assets such as mutual funds, rental real estate, stocks, and bonds. Many accountants recommend this technique for practices that own real estate in a lease-back arrangement.

Gain tax-deferral and asset protection through cash value life insurance. Under realistic assumptions, a $500,000 mutual fund portfolio may generate an annual tax liability of $10,000 to $25,000. Similar investments within a cash value life insurance policy will generate no income taxes because the growth of policy cash balances is not taxable. Also, nearly every state protects the cash value of such policies from creditors, although there is tremendous variation among the states on how much is shielded. There is even an employee benefit plan that allows a business owner to take a partial tax deduction if the policy is structured properly.

Hire investment managers who manage with taxes in mind. One of the most frequent complaints clients make about their portfolios is the associated tax burden of investments, especially when they hold their portfolios for the long term. One option is to consider investment managers who manage clients' portfolios with the goal of reducing taxes on investors' income and capital gains. Individually managed accounts (IMAs) can invest in the same securities a mutual fund holds but have some advantages. With a mutual fund, the investor will get no input on the timing of purchases or sales of securities, for instance. But with an IMA, the manager works with the investor individually to harvest losses and manage taxes. Often, physicians who have six figures to invest have outgrown mutual funds and should consider IMAs.

Use charitable giving to reduce income taxes. There are many ways investors can make tax-beneficial charitable gifts while benefiting their families as well. The most common tool for doing so is the charitable remainder trust (CRT). A CRT is an irrevocable trust that makes annual or more frequent payments to the investor (or to the investor and a family member) until the investor dies. What remains in the trust then passes to a qualified charity of the investor's choice.

CRTs offer three advantages:

1. The investor will obtain a current income tax deduction for the value of the charity's interest in the trust. The deduction is permitted when the trust is created, even though the charity may have to wait until the investor's death to receive anything.
2. The CRT is a vehicle that can enhance one's investment return. Because the CRT pays no income taxes, it generally can sell an appreciated asset without recognizing any gain, enabling the trustee to reinvest the full amount of the proceeds from a sale and generate larger payments for life.
3. The trust will be eligible for an estate tax deduction if it passes to one or more qualified charities upon the investor's death.

Buy cash-value life insurance. A famous financial adviser with her own TV show is one of many who suggest that investors buy term insurance and invest the difference between buying term and cash-value life insurance. This advice is excellent for the average American who earns $42,000 annually, pays 12% in federal income taxes, and has no liability or estate tax risk. Since the head of such a household would pay little tax on investment income, it is possible that the tax on investment gains ranges from 10% to 15%.

The head of an average household, however, is not worried about having his or her assets taken through a lawsuit. Also, the average parent buys insurance solely for temporary income protection against the premature death of the breadwinner. As a result, the average father or mother has little interest in long term liquidity for estate planning purposes because he or she will never have an estate large enough to warrant any estate tax.

The income of most physicians is well above that of the average American. Therefore, physicians should buy cash-value life insurance as a supplemental investment tool that will offer permanent life insurance protection as well.

These tax-saving strategies are only a partial list of what is available to physicians. For larger practices with $5 million in annual revenue, there are additional techniques that could offer significantly greater deductions. But these additional strategies are outside the scope of this article.

—More information on tax strategies for physicians is available online (at www.ojmgroup.com). More physician practice strategies are available on our Web site (see page 16).

The Cash-Value Versus Term-Life Debate

Some physicians will be skeptical about the advice to buy cash-value life insurance simply because they have often heard that term life insurance is a good value. Before making any decisions, physicians should consider the following simplified analysis of the benefits of cash-value life insurance policies.

First, mutual funds growing at 8% annually in taxable income are worth 5% to 6% after taxes to high income taxpayers such as physicians and are worth 7% or more to the average American wage earner. Second, investment gains from cash-value life insurance policies are not taxed. Third, for relatively young and healthy insureds, the annualized cost of all internal expenses is 1% to 2%. Fourth, for families in high marginal tax brackets, the cost of the insurance policy is less than the cost of taxes on the same investment gains within mutual funds.

Without even factoring in the cost of the term insurance (which would reduce the total amount in the mutual fund portfolio), the cash-value insurance investment outperforms an investment built by buying term insurance and investing the difference between term and cash-value policies. Yet another benefit is that life insurance is protected from creditors, and, in many states, it is protected from bankruptcy creditors. This benefit may interest a physician family, but an average taxpayer may not see this value.

Consider the example of a 45-year-old healthy male who wants to invest $25,000 per year for 15 years before retirement and then withdraw funds from ages 61 to 90. Assume this individual's tax rate on investments is 31% (50% long term gains and dividends, 50% short term gains, 6% state tax). Assume the pretax return of both investments are 8% per year. This individual would be able to withdraw $42,500 per year and face no taxes on policy withdrawals and loans and would have $1 million in life insurance protection.

Conversely, an individual who invests in mutual funds would be able to withdraw $37,000 per year after taxes and would have no life insurance.

In this situation, it is difficult to see how buying term insurance and investing the difference in taxable investments makes more sense than investing in tax-efficient life insurance for this highly compensated physician who is in a high tax bracket.

—DBM and JMO

Boost Revenue Without Breaking Rules

By Suzan Berman-Hvizdash, CPC, CPC-ED, CPC-E/M

On a typical clinic day, the physician may be able to see 20 patients. But by using a mid-level provider properly, the physician might schedule 40 or more patients.

The mid-level providers (MLPs) in physicians' offices can save physicians a lot of time at the end of the day. But, they can also help increase the practice's bottom line. Physician assistants or nurse practitioners can see patients, they can follow patients with chronic illnesses, and, depending on the state licensure rules, some have prescriptive authority.

The question regarding these staff is: How can physicians use these providers most effectively without spending more time supervising them than one does seeing patients, documenting, and handling other tasks in the practice?

Billing Directly

Mid-level providers can see patients on their own and bill Medicare directly with their own provider numbers. This can occur in the hospital as well as in an office. Medicare assigns non-physician practitioners their own numbers and it is highly recommended that physicians get a number for each nurse practitioner and physician assistant in the office. Their National Provider Identifiers (NPIs) will then be connected to your practice and their services can be billed out directly with a 15% discount to the reimbursable amount. This option might be worth considering depending on the availability of the physician.

So how can this be done to increase the revenue stream? Once an MLP is hired, the physician should have that individual shadow him for a while, make the phone calls to the patients, observe the office processes, and assist in carrying out the physician's tasks in the office. When the MLP is familiar with the practice's procedures and is comfortable seeing patients, the practice can schedule patients to see the mid-level provider alone.

These patients should be established patients with established problems, and thus would have established treatment plans. On a typical clinic day, the physician may be able to see 20 patients. However, now, there could be the potential for scheduling 40 or more patients. The physician would see the new patients, the consultations, and the patients with new problems. The MLP could then see all of the established patients for that day. As long as the physician is "directly supervising" the MLP all of the services for that day could be billed under the physician.

Proximity Requirements

Direct supervision means that the physician is present in the clinic area. This can be further clarified that if an office has two floors, the physician must be on the floor where the patients are being seen. If the clinic is in a hospital, but the physicians or group owns or rents space from the hospital, then the physician must be in that area and not in the hospital. The definition of direct supervision usually doesn't change by location; however, the type of supervision may change by state. The supervision requirement for billing "incident to" services involves "direct supervision."

The documentation must reflect the presence and availability of the physicians. And in his or her note for that service, the mid-level provider should indicate that the physician is available. If the physician saw the patient briefly or spent time with the patient, this information should be indicated as well.

The documentation guidelines for the evaluation and management services (dated either 1995 or 1997) are the same for the mid-level provider as they are for the physician. The history, examination, and decision-making should be documented in the office note in accordance with the guidelines for the selected level of service. But, any level of service can be billed for these patients (99211 to 99215).

In the event that the non-physician practitioner sees a new patient, a consultation, or an established patient with a new problem, the service might still be billable. In this instance, the mid-level provider can bill the service directly under his or her own provider number. This situation is an example of direct billing and will result in a 15% reduction to the fee schedule reimbursement.

There also may be opportunities in which the mid-level provider could see new patients and bill out under the physician, but these situations require physician involvement. The MLP could begin the visit and obtain the review of systems, the past medical and surgical histories, the social history, and the family history. It is not

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always necessary to have an NP or PA do this work because it can be done with a patient history form and NPs and PAs may find this chore demeaning. The physician would be responsible for seeing the patient and gathering the chief complaint, the history of the present illness, the examination, and then ultimately documenting the decision-making and the course of treatment. With a reference to the histories gathered by the non-physician practitioner, the service could still be billed out under the physician's provider number affording the practice the 100% fee schedule reimbursement consideration.

The documentation must illustrate that the physician not only saw the patient but also reviewed the note written by the mid-level provider. Just referring to the note without a clear indication that the note also was reviewed would be inadequate.

Hospital Settings

Physicians and MLPs also should be aware that "incident to" services are not applicable in a hospital setting when the mid-level providers are employed through the physicians or the physicians' group. Mid-level providers can still see in-patients and bill Medicare directly under their own provider numbers. Along with the physician, MLPs can see patients in a shared or split-visit situation. These shared visits can be billed under either provider's number and the reimbursement would be appropriately distributed based on the NPI used.

In such an instance, the mid-level provider would see the patient and document the service. At some point during that same day, the physician would see the patient. A reference to the mid-level provider's note is required and face-to-face contact with the patient also needs to be documented in the note. Once these two notes are part of the medical record, the documentation can be added together to support the appropriate evaluation and management code. The service could be submitted under the physician's provider number for consideration of 100% reimbursement. Shared visits, however, cannot be done for consultations or critical care services.

When physicians employ MLPs, they often find the value of these providers to be immeasurable. By implementing the "incident to" and direct billing processes, these providers can help physicians and physician groups to improve patient care and increase revenue.

—More information is available from CMS (at www.cms.hhs.gov/manuals/14_car/3b15052.asp#_15506_0). More physician practice strategies are available on our Web site *(see page 16).*

Requirements for "Incident to" Billing

In the Balanced Budget Act of 1997, the federal Healthcare Financing Administration (which is now the Centers for Medicare & Medicaid Services or CMS) allowed for the billing of services "incident to" physicians' services. Effective Jan. 1, 1998, this act helped to increase the billing opportunities physicians get from mid-level providers. It extended where non-physician practitioners could see patients, what types of patients they could see, and also afforded them the ability to request and perform consultations.

So with this act in place, mid-level providers free up physicians to see more patients, do more procedures, and provide more extensive therapy, knowing that their patients are receiving the same high quality care from their mid-level providers.

Keeping in mind that "incident to" refers to services provided to Medicare patients; there are specific rules governing these services. These are the services that can be billed under the supervising physician instead of under the mid-level provider.

1. The visit must be provided after a course of treatment has been established. Meaning, a physician must see the patient initially and establish an appropriate course of treatment for the specific problem. (The patient cannot be a new patient nor have a new problem.)
2. After the physician has established the course of treatment, the MLP can administer the plan. As long as one of the physicians associated with the mid-level provider is in the clinic, office, or suite when the service is rendered, the service can be billed under that physician and the reimbursement will be considered at 100% of the fee schedule amount.
3. The supervising physician during the "incident to" service does not have to be the originating physician. A practice can meet the employment requirement if a physician or the group hires the MLP directly. The MLP would need a connection to the physician, such as listing the physician as a supervising or substitute supervising physician on the license. There must be one supervising physician and an unlimited number of substitute supervision physicians is allowed.

Once the employment relation is there the connection is established, and the treatment plan is set, as long as one of the physicians stays actively involved in the care of the patient, the mid-level provider can be the one to see the patient, refill prescriptions, evaluate the patient's progress, and follow through with the suggestions the initiating physician has made.

—SBH

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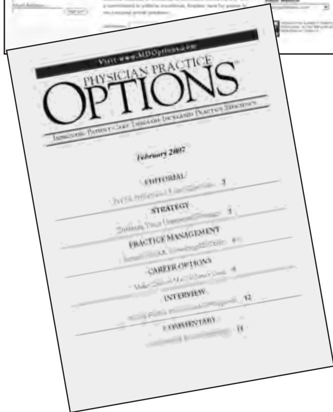

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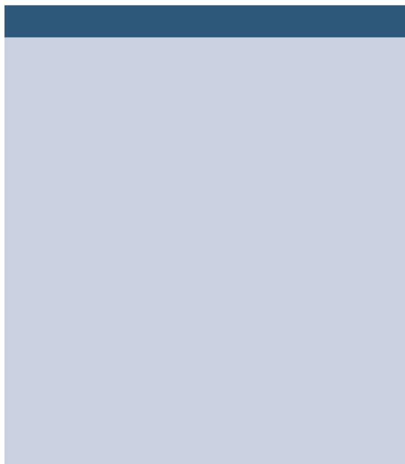

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