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Doctor Finds Online Consults Produce Income, Questions

Two years ago, family physician Dean Tomasello, MD, of Walworth, Wis., began corresponding with his patients by e-mail. Today, he has a Web site that is becoming a profitable Internet business.

Like Tomasello, large companies are recognizing the market potential of filling consumer demand for online medical information, although most of them stop short of making consultations. For example, CyberDocs (at www.cyberdocs.com) reports an average of 3,000 daily online visits for general health information. Recently, however, CyberDocs began offering consultations with board-certified physicians for $50 to $100 a session.

Online Consultation

Medem, a company in San Francisco, started an online consultation service in June. Founded by the AMA and other professional organizations, Medem (at www.medem.com) offers free online practice-related services, including a secure online patient scheduling program, to its 83,000 participating physicians. Medem's new fee-based, online consultation service enables member physicians to charge for online consultations via e-mail.

In the past, most secure messaging between patients and physicians has been administrative in nature, such as appointment requests. Online consultation expands secure messaging to allow patients to pose clinical questions directly to physicians, who set the fees for the service. Medem officials say they expect the fees to range from $20 to $30 for an online consultation, and physicians who participated in an online consultation pilot project earlier this year report conducting five to 10 consultations via e-mail each week. Patients pay with a credit card.

"My patients love the idea of being able to use online consultation to communicate with me," says Karen Ilika, MD, a gynecologist in Kirkland, Wash., who has been using the service as part of the pilot project. "They think the cost is a bargain, especially single moms or working women who have difficulty getting time off from work to come in to the office."

More and more physicians who use the Internet to communicate via e-mail are recognizing the growing demand among patients for the service. A report in April by Harris Interactive, market researchers in Rochester, N.Y., shows that nine out of 10 adults (90%) of the 66% of all adults who have online capability would like to be able to communicate with their physicians online. "It seems safe to predict that within a fairly short space of time, many doctors will be communicating with their patients on the Internet," Harris researchers say.

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EDITORIAL

Doctor Visit Identifies Systemic Illness

Among the physicians who miss the more satisfying aspects of the way medicine used to be practiced is Joseph Fuller, MD, the senior member of a three-physician family practice in Old Saybrook, Conn. Three years ago, when Fuller was interviewed in this newsletter, he said that satisfying the bureaucratic requirements of HMOs and Medicare was not only irritating but was also consuming his time and energy, thereby distracting him from his ability to render care properly. At the time, he said he preferred a single-payer system to one that requires physicians and their staff to devote hours trying to determine what insurers would cover and how much they would pay.

Today, Fuller still experiences these frustrations and contends with other problems as well. For example, because Medicare pays him only $21 for a hospital visit—a trip that requires 70 miles of driving—he can no longer take two hours to visit a hospitalized patient, he says. Hospitalists help to fill the gap, but he misses checking on his patients, he notes.

Caring for patients in nursing homes has also become a problem for Fuller. Trained in geriatrics in Scotland, where the specialty is highly respected, he says the pay for such care in America is inadequate and the facilities so poor that it is difficult for him to practice medicine in these settings. Nor is he delivering babies anymore due to the high cost of medical malpractice insurance, he says.

A report from the American Hospital Association released in June shows that Fuller is not alone when it comes to facing high malpractice insurance costs. Since 2001, the AHA report says, many physicians have seen double-digit premium increases that are as high as 81% in some cases. High-risk specialties, such as obstetrics and gynecology and neursosurgery, have been the most affected.

Such dramatic increases have caused some physicians to relocate or to retire; made it difficult for certain communities to attract physicians; and forced the curtailment of services, the AHA says. The magnitude of the premium increases varies across geographical areas due, in part, to differences in legal practices, in the regulatory environments, and in the number of insurers serving the particular market.

Solutions to the frustrations and problems that Fuller articulates—and other physicians are dealing with as well—are not likely to come soon. But at least the frustrations and problems are being identified: cuts in Medicare payments, with HMOs likely to follow Medicare's lead with cuts of their own; rising costs; and, for some physicians, a diminishing level of the satisfaction they once found in the practice of medicine. Identifying the problems can be likened to diagnosing the disease: It's the first step to finding the cure.

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Physicians Face Increased Federal Scrutiny Under OIG Work Plan

Over the past several years, physicians have become increasingly concerned about federal fraud prevention efforts that target doctors. Many of them believe that these efforts have unfairly stigmatized all doctors for the fraudulent dealings of a few. But several sources of information exist for anyone who wants to know exactly what areas are being targeted for investigation.

One significant source is the work plan produced each September by the Office of Inspector General of the federal Department of Health and Human Services. The OIG's work plan outlines precisely where it will focus its efforts in the coming year, including the areas it will investigate rigorously. This year's plan, titled *HHS/OIG Fiscal Year 2002 Work Plan*, is available online (at www.hhs.gov).

"The federal investigators are looking at the work plan and so should physicians," says Charles E. Colitre, a compliance consultant who formerly served as a senior supervisory agent for the FBI in northern Ohio where he oversaw all fraud investigations for 14 years. The OIG's work plan is based on a statistical sampling of error rates, Colitre says. After analyzing these error rates, federal investigators target the areas they believe warrant close inspection. Physicians and the compliance experts in physicians' offices should review the plan each year, he adds.

Once a physician and his or her compliance expert have read the work plan, it would be prudent for them to review the group's compliance plan as well, Colitre advises. "If the new work plan shows new risks, the group should benchmark and audit them," he says.

Although the work plan is revised each year, many areas identified in one year are also targeted the following year, Colitre says. Of the total items listed in the physician's section of the work plan this year, for example, five were also identified as targets in 2001.

Scope of Activity

Few physicians are aware of the true scope of investigative activity directed against them by the federal government, experts say. One of the best sources for this information is the *Health Care Fraud and Abuse Control Program Annual Report*, which is published annually by HHS and the federal Department of Justice and available on the Web (at www.usdoj.gov/dag/pubdoc/hipaa00ar21.htm). The report outlines which departments are investigating physicians and the results these departments have reported. In addition to the OIG and the FBI, other federal agencies investigating physicians listed in the report include:

- Medicaid Fraud Control (a special investigative team overseeing Medicaid fraud in most states)
- Postal investigators
- Champus-Tricare (the U.S. Department of Defense's investigative service)
- Office of Personnel Management (the health care investigators of programs for employees of the federal government)
- U.S. Railroad Retirement Board
- U.S. Department of Labor (including unemployment compensation insurance investigators).

Each of these investigating agencies is independently funded by the federal government. For example, the FBI operates autonomously from the OIG, and it has its own congressional-appropriated annual budget that is augmented by funds through the federal Health Insurance Portability and Accountability Act (HIPAA).

Each year, the federal government reports on which activities it will target for investigation in the coming months. Physicians should review the report each year, experts say.

In 2000, more than $1.2 billion in health care fraud fines and settlements was collected by the federal government (which is about 1% of current annual spending for Medicare); prosecutors filed 457 criminal indictments in health care fraud cases (an increase of about 23% from 1999); and 233 new civil cases were filed (in addition to the 1,995 civil cases that were pending). As a result of the civil investigations, the government excluded some 3,350 individuals and entities from participating in Medicare and Medicaid or other federally sponsored health care programs due to perceived wrongdoing, government reports show. Also in 2000, HHS and OIG opened 14 new offices in 47 states; today, these agencies have 1,003 full-time

(Continued on page 4)

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employees dedicated exclusively to investigating and preventing health care fraud.

Investigative Apparatus

The principal national organizing structure for investigations of physicians falls under the national Health Care Fraud and Abuse Control Program, which was created and funded by Congress under HIPAA. The program's supervisors are permitted to coordinate federal, state, and local law enforcement activities against health care fraud; and the government can assist in investigations, audits, and evaluations of physicians and other health care providers, as well as educate agents and government employees about fraud. The program has an electronic national database, called the Healthcare Integrity Protection Data Bank, which is shared among investigative agencies. It receives 20,000 to 25,000 queries per week from investigators nationwide.

Federal investigative agencies also are using technology called data mining to uncover patterns of fraud. The software identifies billing patterns and flags those considered suspect.

While the government's efforts are extensive, federal officials also recognize that most physicians are not guilty of wrongdoing, experts say. In fact, the Health Care Fraud and Abuse Control Program's annual report says that "audit results also show that the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and documented properly. For both 1998 and 1999, HHS/OIG estimated that over 90% of the fee-for-service payments met Medicare reimbursement requirements."

"Only a very few physicians are committing fraud," says Judy Holtz, public affairs officer for the OIG. "Most are billing the program correctly. We have about 3,000 ongoing cases at all times, but that number is for the entire provider community, including medical laboratories, hospitals, carriers, and beneficiaries. In fact, we have more closed cases than open cases, and the vast majority of those cases never go anywhere.

"I'm not saying there isn't fraud," Holtz continues, "but when you look at the physician community, the numbers are small. Because the Medicare program is so large, it's getting lots of dollars. There's a lot of misunderstanding of what law enforcement is among physicians. Sometimes, the way news reports are written gives an erroneous perception to the provider community."

While the government's efforts are extensive, federal officials also recognize that most physicians are not guilty of wrongdoing, experts say.

Investigative Funding

The money used to fund federal investigations of physicians comes from several sources. Under HIPAA, Congress directed that money from the Medicare Trust Fund be transferred to the newly created Health Care Fraud and Abuse Control Program. In 2000, $158 million was allocated from the trust fund to this new account, and most of this money goes to the investigative efforts of the HHS. Of the $158 million allocated in 2000, HHS received $119 million, U.S. attorneys received $23 million, and the Civil Division investigations of the federal Department of Justice received $10.7 million. The remaining $5.3 million was spread over various other categories of HHS and DOJ. For comparison, $137.23 million was allocated in 1999 from the Medicare Trust Fund to the Health Care Fraud and Abuse Control account.

In 2000, the FBI received an additional $76 million under HIPAA to pay for 651 new positions, including funding for 380 new agents to form fraud teams dedicated solely to health care investigations. The number of FBI agents involved in investigating health care fraud has climbed from 112 in 1992 to 520 in 2000.

The program is self-funding in that the government gets a return of about $8 for every dollar invested in health care fraud enforcement, according to *Reducing Health Care Fraud,* a report by Taxpayers Against Fraud, in Washington, D.C. HIPAA stipulates that the funds collected in fraud investigations, which reached about $577 million in 2000, be deposited into the Medicare Trust Fund.

Personal Risk

While the government has allocated significant resources to investigating fraud, physicians may be at more risk of being investigated by a health insurer and Medicare carrier that represents the government than by the government itself, experts say. Carriers contract with the federal government to administer federally funded health care programs, such as Medicare, in a given geographic region.

"A carrier that contracts with the government to manage the Medicare system is obligated to assist the government in investigations," says Colitre. The OIG asks carriers to identify patterns of possible improper coding on the part of health care providers, and the reports are sent directly to the OIG, he adds.

Amy Woodhall, a health law attorney with Walter & Haverfield in Cleveland who represents physicians nationwide in Medicare audit

2002 Work Plan Targets

In the *HHS/OIG Fiscal Year 2002 Work Plan*, the government says that it will closely monitor the activities of physicians in specific areas. Available online (at www.hhs.gov), the plan says that the government is investigating inpatient dialysis services, bone density screening, and services and supplies incident to physicians' services. In addition, it says it is reviewing the following:

Evaluation and management codes. The OIG will assess whether carriers identified instances of incorrect coding and what corrective actions they took, meaning the government and Medicare carriers will be checking for instances of fraud. In this area, physicians would face fines under the federal False Claim Act.

Beneficiary access to preventive services. Investigators will evaluate beneficiaries' access to the expanded preventive services offered by Medicare since the passage of the Balanced Budget Act of 1997.

Advance beneficiary notices. Physicians must provide advance notices before they provide services that they know or believe Medicare does not consider medically necessary or that Medicare will not reimburse.

Physicians at teaching hospitals. Physicians must ensure that claims accurately reflect the level of service provided to patients.

Billing for residents' services. Physicians and hospitals must ensure that hospitals have properly used residents' physicians identification numbers to bill Medicare. Residents may bill Medicare only when they are moonlighting.

Consultations. The government is studying the appropriateness of billings for physician consultation services and the financial effect on Medicare from any inaccurate billings. —DK

and investigative cases, believes that physicians are more likely to have a carrier audit than any other kind of audit or investigation. Woodhall serves as special counsel for the physician rights organization, the Association of American Physicians and Surgeons, in Tucson, Ariz. A carrier audit is serious, she says, but other actions can be more so. "More serious is a government investigation by the OIG or FBI," Woodhall comments. "However, a carrier audit may be a precursor to a government investigation if the error rate is high because carriers have been instructed to refer any audit where there is a reasonable suspicion of fraud to the government.

"The chance of a given physician making an error, on average, is roughly 7%, based on the last Medicare error rate review by the OIG," Woodhall continues. "Therefore, a physician should respond to audits appropriately to manage the risk of a case being referred to the OIG."

Marc Raspanti, a health law attorney in Philadelphia, says that a carrier audit can be especially problematic because it can result in a carrier action that would mean no payments from a particular insurer if errors are found. "Unlike a government dispute, where a physician can try to resolve the matter while still being paid for claims, carriers can immediately stop paying claims, and carriers are starting to do just that," Raspanti comments.

A federal investigation can be the most problematic in terms of penalties, which can be extensive, and in terms of a criminal indictment, which is possible in the most severe wrong-doing cases.

Compliance Efforts

"A physician who is not doing anything that sends up a red flare is unlikely to be singled out by the OIG for investigation," Raspanti says. But many physicians have trouble seeing the risks clearly, he notes. "Physicians say, 'It'll happen to somebody else, but not to me,' " Raspanti explains. "They may tell me something bad about one doctor in their town, while they might be doing something different but that is equally egregious. Unless a doctor's been hit by a fraud suit and has had to pay money and retain a lawyer, he or she doesn't see the threat."

A physician's best protection from problems relating to an audit is to have a compliance program. "Time and time again," says Colitre, "the ones who get into trouble in these investigations have the attitude that the system is unfair, or that it's too complicated, or that they are being picked on when all they are doing is trying to provide good patient care.

"Having a compliance program can act as a legal shield in the event of a federal or a carrier audit," Colitre adds. "Such a program will result in fewer errors, and the very fact that there is such a program in place and is functioning means that the investigators are likely to go easier on you."

In fact, Justice Department internal guidelines direct U.S. attorneys to weigh heavily the existence or lack thereof of a compliance program when they are determining how aggressively to pursue a health care provider, experts say.

—Reported and written by David Kettlewell, in Akron, Ohio. More practice strategies are available on our Web site (see page 16).

Strategies to Promote Growth

By John W. McDaniel

High-performance physicians use a number of different strategies to promote growth in their practices. One of their most effective strategies involves raising patient volume by increasing both patient satisfaction and physician productivity through improved patient access and continuity of patient care.

In fact, the number one factor that contributes to high patient satisfaction is giving the patient access to the provider of his or her choice at a time and in a manner that are convenient for the patient. Access is also the key factor in attracting patients to a practice in the first place and then retaining them after they have visited the practice at least one time. In this regard, access is directly linked to a practice's ability to capture sufficient revenue to ensure its financial success. Access encompasses not only the traditional face-to-face visit between patient and practitioner, but also access to information, medical results and records, medications, and educational material.

Access and Continuity

A practice should link a patient's access to care with continuity in how that care is provided. The best continuity of care comes from a process that allows a patient to see the provider of choice as much as possible. A practice that focuses on improving both a patient's access to, and continuity of, care is almost guaranteed to garner a solid patient base that contributes to the viability of the business.

For the average primary care practice, providing excellent patient care combined with a system for recalling patients on a periodic basis can help to ensure practice growth. Specialty physicians, on the other hand, must understand the importance of referrals from physicians to the viability and growth potential of their practice. Specialty physicians should continually analyze the nature of their referrals by tracking the number and type of referrals they are receiving and from which physicians. Developing relationships with potential referring physicians and cultivating the referral relationships they have already formed are key steps specialty physicians can take to help ensure practice growth.

Another strategic planning tool for practice growth involves conducting a patient origin analysis. By using this planning tool, a practice can determine where its most promising growth opportunities lie. This process involves determining both the number and type of patients categorized by primary Zip Code area in order to ascertain the demographic and socioeconomic mix of patients within the practice and to analyze areas for targeted growth.

To illustrate: Suppose an obstetrics and gynecology practice would like to target Zip Code areas where 18- to 35-year-old females who have annual household incomes in excess of $20,000 reside. By conducting a patient origin analysis, the practice would be able to determine whether it makes sense to locate its primary office in this geographic area or whether a satellite office would be sufficient to meet the needs of this targeted population.

Ancillary Growth

Given the continued decline of reimbursement for the average medical practice, every effort must be made to improve the utilization of ancillary services within the practice to provide additional sources of revenue as well as to increase patient care and convenience.

One ancillary growth strategy involves preventive medical services. Depending on the type of specialty, physicians can profile the types of patients whom various providers see, making sure to pay particular attention to the types of preventive medicine services that patients are receiving. In this way, a practice can ensure that patients are seen on a basis defined under their health care benefits program. This step not only promotes appropriate patient care but also ensures that the practice receives continued revenue for providing preventive health care services.

A focused growth strategy for any medical practice should involve

Access is a key factor in attracting patients to a practice in the first place and then retaining them after they have visited the practice at least one time.

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Improving the utilization of ancillary services can provide additional sources of revenue and increase patient care and convenience.

e-business opportunities, particularly regarding information technology solutions. While the average practice does not have such a strategy in place, developing one is necessary to ensure the appropriate technological growth of the practice and to avoid technological obsolescence. What's more, technology solutions help to increase the efficiency and productivity of physicians and their staff.

Survey Data Needed

Very few medical practices survey their patients, physicians, and employees with any regularity. The Medical Group Management Association, in its *Performance and Practices of Successful Medical Groups: 2000 Report Based on 1999 Data,* reported that 71% of high-performance practices conduct patient satisfaction surveys, while only 57% of other practices survey their patients on satisfaction. Interestingly, only 31% of high-performance physicians routinely engage in employee satisfaction surveys, while 27% of other medical practices survey their employees regularly.

A particularly telling statistic from the MGMA's report shows that only 13% of high-performance practices survey referral physicians and only 9% conduct internal physician satisfaction surveys. Medical practices have a long way to go in order to mirror successful businesses with respect to monitoring constituency demand, which is an effort that could open up many practice growth, efficiency, and productivity opportunities.

One of the most important steps practices seeking to become high performers can take regarding their future growth capabilities involves the development and implementation of a strategic plan. This process is undertaken by virtually every successful business. An essential component of any strategic plan involves the SWOT analysis. In a SWOT analysis, a practice makes a critical review of its strengths, weaknesses, opportunities, and threats within its market to position itself for future growth.

Differentiating their practice from the practices of their competitors is a strategic step many successful practices take to position themselves for future growth. Often this strategy involves the use of Web-enabled technology. High-performance medical practices use a number of the following information systems to increase productivity and efficiency:

- Internet-based patient registration and appointment scheduling
- Electronic charge capture tools using hand-held touch devices
- Medical practice management systems for scheduling, billing, collections, and electronic medical records
- Managed care transaction processing of online eligibility, referral and benefits management, and claims submission
- Online coding tools
- Electronic inventory management and supply ordering (called e-procurement)
- Electronic prescription processing
- E-connectivity with hospitals, other physicians, laboratories, imaging centers, and other ancillary providers
- Internet-based practice management benchmarking
- Online patient education
- Access to Web sites for regulatory and legislative information from federal and state sources and to medical business information from professional and online agencies.

As medical practices position themselves for future growth, it is also crucial that they implement a productivity improvement program, centered around patient scheduling and physician and provider work flow. Most high-performance practices have begun measuring physician productivity by using work relative value units. WRVUs reflect the intensiveness and resource utilization necessary to produce patient care based on the acuity of services offered.

Using various information technology solutions—such as computerized scheduling, electronic medical records, personal digital assistants, and voice recognition—can also lead to overall productivity improvement. In fact, one of the most beneficial uses of technology is the simple Dictaphone. By dictating progress notes while the patient is in the examination room, the physician not only saves time but also adds a personal touch. Since the patients can hear what the physician is saying about their care while they are being examined, this simple strategy can help reduce the number of questions patients ask at the end of visits.

In summary, high-performance physicians invest their money, time, and efforts in areas that offer the potential for the greatest return on their investment.

Editor's note: This series has focused on the characteristics that demonstrate the operational strengths of high-performance physician practices. In the series, we have examined reimbursement systems, coding patterns, practice fee schedules, managed care contracts, fixed-fee payer analyses, and compliance program management; revenue cycle management techniques to improve billing and collection processes and to boost cash flow; accounts receivable management, a process that is often unmanaged; operations improvements to improve efficiencies; and information technology to promote efficiency and productivity within the practice. Articles in this series are available on our Web site *(see page 16).*

Systems Will Ease Administrative Burdens, Futurist Predicts

By Richard L. Reece MD, editor in chief

When broadly adopted by physicians, information technology will have the power to ease the administrative burden of delivering health care and facilitate the acquisition of knowledge about a broad range of topics, says renowned health care futurist Jeff Goldsmith, PhD. Goldsmith is president of Health Futures Inc., health care consultants in Charlottesville, Va.

Currently, administrative pressure on physicians and other clinicians is causing professional burnout. "One thing that concerns me about our present medical care system is how rapidly our caregivers are burning out," Goldsmith says. "This is happening to physicians, nurses, and even senior and middle-level administrators."

Goldsmith has been following the health care industry for more than a decade. For 11 years ending in 1990, he was a lecturer in the Graduate School of Business at the University of Chicago, focusing on health services management and policy.

An associate professor of medical education in the School of Medicine at the University of Virginia, Goldsmith believes that administrative and time pressures hinder physicians in their efforts to continue learning as they practice, exacerbating professional burnout.

"After physicians go through many years of difficult education to get their training and professional credentials, they then seem to be systematically deprived of the ability to use their minds," he says. "And this is occurring in the midst of a renaissance in the science of medicine. Many important positive developments are taking place in medical science, so it's tragic that physicians who practice on a day-to-day basis can't participate in that excitement."

Within 15 years, information technology will ease the administrative burden of practicing medicine and the need for knowledge management, Goldsmith says.

Mired in Logistics

One reason this renaissance is not reaching physicians who practice medicine each day is that the health care industry remains mired in the logistics of medical practice. As a result, physicians face an overwhelming administrative burden in their practices.

"The health care sector is 20 years behind other major sectors of our economy in using information technology," Goldsmith says. "When I go into a physician's office, typically I see a blank computer screen because the computer's turned off and a desk is piled with medical journals and telephone message slips. To me, that scene symbolizes the reality of and the problem with most medical practices today: The important processes in medicine are still supported by paper and telephone calls." Such administrative inefficiency has a negative effect on workflow, physician and office staff productivity, and revenue.

Goldsmith refers to this state of affairs as Dickensian. "Until outmoded methods of operation change, we will continue to waste a huge amount of professional time," he says. Optimizing business practices and professional satisfaction is nearly impossible under such conditions.

The time pressure problem is exacerbated by the sheer amount of medical knowledge that is produced and disseminated each workday. "Compounding the pressure of this absurd and inexcusable administrative burden on physicians is a huge knowledge management challenge," Goldsmith says. "Each month, about 31,000 new citations are entered onto the National Library of Medicine's Medline service," he says. "Physicians recognize the progress in their own fields, but too often view this knowledge as they would the lights on a receding train. 'I'd like to be on that train,' they say, 'but I just don't have the time.' "

Goldsmith expresses optimism that such problems can be addressed through the use of information technology. "Both the administrative burden of medicine and the need for knowledge management will be solved in the next 10 to 15 years by applying modern information technology solutions," he predicts.

These solutions will occur as new computer technologies are adopted by physicians for use at the point of care. "Right now, powerful tools exist that physicians can use to support clinical decisionmaking and to communicate with their patients and their colleagues," Goldsmith says.

(Continued on page 9)

> **"Overall, hospital acquisitions of physician practices have created a serious political problem in health care that is preventing advancement of the industry."**
>
> ***—Jeff Goldsmith, Health Futures Inc.***

(Continued from page 8)

"The problem is that the legacy systems in physician offices, in group practice settings, and in hospitals are entrenched, and to change them would be difficult and costly."

Physicians can benefit greatly from Internet-based practice management services, which can give them access to subscription-based programs and services and can offer a return on their investment in these technologies. "Physicians do not need to buy a high-end server, put 20 million lines of code on each staff member's computer, and then teach them how to use the technology," Goldsmith says. "Subscription-based services are available over the Internet, and they make more financial sense. Furthermore, hand-held computers will increasingly support both the clinical and financial applications for physician offices."

A Slow Adoption Rate

Still, the availability of these services does not mean that physicians have been quick to incorporate them into their practices. "Mature technologies exist right now that can allow physicians to increase their revenue, decrease administrative hassles, and improve care," Goldsmith says. "But physicians are continuing to use systems that do not work. They find it difficult to create the time and space to convert to these new technologies."

Nevertheless, more physicians are changing their practice patterns to incorporate new technologies—and are finding rewards in doing so, Goldsmith says. "Recently, I've noticed in my interactions with physicians that many of them regularly use hand-held computers," he reports. "These physicians tell me that these devices are rapidly becoming indispensable to them, enabling them to manage both the business and clinical aspects of their work. They say that hand-held computers are useful in managing care, and for scheduling, checking drug interactions, and performing other clinical and administrative functions. I believe that physicians overall are on the cusp of widespread adoption of information technologies."

Goldsmith attributes some of the delay in physicians' willingness to adopt new technology to a lack of leadership. "There are not enough physicians who are willing to say to their colleagues: 'These are our problems. Let's get together and select a vendor that can help us. Then we can pool our resources so that we can manage the issues surrounding the training and systems conversion challenges,' " he points out. The sooner physicians take such a leadership role and begin to invest in and adopt new technologies intelligently, the sooner they will reap the benefits of greater administrative efficiency, Goldsmith believes.

Strained Relations

Hospitals are wrestling with similar technological issues, but the cultural and communication barriers between hospitals and physicians make collaboration on the selection and purchase of computer technology almost impossible. This result is unfortunate, given its negative implications for streamlining administrative processes and costs and improving the quality of patient care.

"Certainly from an efficiency as well as a quality of care standpoint, hospital and physician systems should be compatible," Goldsmith says. "Patient records should be equally accessible in the physician's office and in the hospital. But hospital-physician relations in most parts of the country are so strained that physicians tend not to trust the hospitals to provide the leadership or the funding for such initiatives. As long as that mistrust exists, patient records in different locations will remain separate, contributing to the administrative burden and hindering the development of optimal care processes. In the short term, the hospital-physician relationship will continue to be a barrier across which information does not flow, even though it is in both the patient's and the physician's interest."

In an article published in 1993 in the *Health Care Forum Journal*, Goldsmith highlighted the yawning gap between what he calls the "adminisphere" and the "clinisphere." "The relationships between hospitals and physicians are worse now than they were when I wrote that article," he says. "Relationships have become more strained because of the unsuccessful power grab hospitals attempted during the 1990s, when they acquired thousands of physician practices nationwide. Most community hospitals with more than 200 beds acquired physician practices, and a lot of them rue the day they did. In fact, many have divested these practices."

Likewise, physicians have been frustrated with the outcome of these deals. "Overall, hospital acquisitions of physician practices have created a

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An Entrepreneurial Effort

Subscribers to Tomasello's site (at www.netlivemd.com) pay $49 a year for the following services: evaluation of a medical history; a medication review; one online consultation; access to a database of medical information on specific diseases; and periodic preventive care reminders via e-mail. Consultations beyond the initial subscription price cost $19 each. Tomasello has about 200 annual subscribers, and he has hired three part-time physicians to answer client-member inquiries. The site is beginning to show a profit. "The cost is in the initial investment," Tomasello says. "After that, the costs are negligible."

The people who find NetLiveMD useful, says Tomasello, are those who won't go to the doctor because they are paralyzed by the fear of not knowing what's wrong with them, those who can't communicate with their doctors, and those with no insurance. "We can't give patient care over the Internet, but we can give valuable information," notes Tomasello.

Confidentiality Concerns

While Tomasello is pleased so far with the results of his venture, some of his Wisconsin colleagues have reservations about giving online medical advice, for both medical and legal reasons. "My biggest concern is patient confidentiality and security of data," says Ayaz Samadani, MD, a family physician in Beaver Dam, Wis., and a past president of the Wisconsin Medical Society. "How can you trust the Internet to secure your personal medical history? Also, I believe a personal doctor-patient relationship is important when you have an illness. Sitting face-to-face with a patient is important in making a diagnosis."

State regulators are particularly concerned about physicians who write prescriptions for patients they have not examined and who request prescription medications over the Internet. California passed a law last year requiring doctors to examine patients or to have a valid physician-patient relationship in order to write prescriptions for patients online, and the California Medical Board has hired a full-time investigator to surf the Internet for violators of that law.

In April, the state medical board in North Carolina suspended for 60 days the licenses of three physicians who were writing prescriptions after diagnosing patients over the Internet. State regulators determined that writing prescriptions without examining patients or having a physician-patient relationship constituted an unauthorized practice of medicine in North Carolina.

Tomasello does not prescribe medications, nor are his online consultations diagnoses, he says, but simply offers of medical information. As stated in a disclaimer on the site, the purpose of NetLiveMD is to "help clients find answers to health-related questions. Being a member of NetLiveMD does not constitute a physician-patient relationship. We encourage users to maintain their current relationships with their own personal physicians. NetLiveMD physicians will not diagnose, treat, or prescribe medication, prescription or otherwise, to users of this site."

The site simply provides information, Tomasello says. "People tell us their symptoms," he explains, "and then we tell them what those symptoms could mean. We also advise them to share the information with their doctors."

> **"We can't give patient care over the Internet, but we can give valuable information."**
>
> ***—Dean Tomasello, MD, NetLiveMD***

Compliance, Liability Issues

Tomasello is seeking to develop the safeguards necessary to comply with the requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) that are scheduled to take effect next fall. "We'll have the degree of encryption necessary for compliance in place later this year," he comments.

Also, he has talked with his malpractice insurer about whether he and the physicians associated with his site are insured against liability claims. "I was told that as long as we keep to the criteria set forth in our site disclaimer, our individual insurance is sufficient," he says. "This type of activity is so new that the insurer doesn't have a policy for it, but is developing one because of increasing demand."

Medem's online consultation service will comply with the eRisk guidelines, a set of communication privacy and firewall standards endorsed by a consortium of medical societies and insurers calling themselves the eRisk Working Group for Healthcare. The standards fulfill the privacy requirements outlined in HIPAA.

Interactive Information

Given the growing interest in such communication, most observers believe the number of entrepreneurial efforts similar to Tomasello's will increase. "Physicians are realizing that the Internet and other information technologies will change the way they practice medicine," says James G. Anderson, PhD, professor of medical sociology at Purdue University in West Lafayette, Ind.

For Tomasello, the need for such communication was obvious. "I was receiving e-mail inquiries from my patients asking me for information about certain diseases or medications, and patients would tell me they sought medical information on the Internet,"

Physician's Site Offers Range of Services

NetLiveMD, a Web site owned and run by Dean Tomasello, MD, charges $49 a year for a number of services, including an online health assessment and medication review, consultation, reminders, and suggestions for leading a healthy lifestyle. Here's how Tomasello describes these services.

Online health assessment and medication review. This service consists of a review of a medical and surgical history, family history, social history, medications, and allergies.

Physician consultation. Client-members can get a health or medical question reviewed and answered by a board-certified physician or by a pharmacist within 24 hours.

NetLiveMD archive. This service consists of access to the archive of client-member questions and answers developed and written by physicians based on the more than 1,100 questions submitted to NetLiveMD physicians since the site opened in 2000. The archive covers more than 180 topics on disease processes, medications, and treatments.

Weekly health tips. Physicians provide advice on improving health and wellness, and ideas to help reduce prescription and nonprescription medication costs.

E-health tools. NetLiveMD offers 18 ways to help patients evaluate their health (such as a body-mass index) addressing such topics as preventive medicine, diet, exercise, sleep, and wellness.

Preventive care reminders. NetLiveMD physicians send e-mail reminders to client-members to let them know when they are due for health screens, such as a Pap smear or a prostate exam.

Current issues in medicine forum. Physicians review health and medical issues as they arise each week, such as new treatments that are becoming available for certain diseases.

"An important part of staying well is staying well informed," says Tomasello. —MS

Tomasello explains. "I realized that some of the information was incorrect or misleading, so I decided to create my own Web page that would contain what I knew to be accurate health information, and hired a friend to design the site." Establishing the site initially cost a few hundred dollars, Tomasello says.

Big Income Potential

Soon after, Tomasello discovered that patients other than his own were interested in the site. He got e-mail messages from patients across the country who had found his site by searching at Yahoo, Excite, and Google. It was evident after a few months that there was "a big potential for income," Tomasello says.

He hired an Internet consulting firm, High Gear in Brookfield, Wis., to design a professional site that had more links to other Web sites. High Gear also handles the back office operations for NetLiveMD by tracking the number of times a patient visits the site, where the visitor lives, and how many pages each visitor views on the site. In the past year, Tomasello has paid High Gear about $25,000 for its services.

Tomasello says he has recouped his initial investment and is beginning to show a profit. What's more, other organizations are considering an affiliation with NetLiveMD. For example, the Catholic Knights Insurance Society, an insurance and financial benefits fraternal society in Milwaukee, is urging its 80,000 members to subscribe to Tomasello's service. "It helps our members get medical answers from a board-certified physician," explains Allen Banoub, chief marketing officer at Catholic Knights. "The whole package complements the relationship between doctors and patients."

"Physicians are realizing that the Internet and other information technologies will change the way they practice medicine."

—James Anderson, PhD, Purdue University

At least one observer believes the shift to communication via e-mail marks a fundamental change in the physician-patient relationship. "The traditional emphasis of medical informatics has been to provide information and decision-support tools to professional health care providers," says Anderson. "Currently there is an increasing emphasis on consumer informatics, a new branch of health service that provides patients with direct online access to information to help them better manage their health decisions."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More practice strategies are available on our Web site (see page 16).

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serious political problem in health care that is preventing advancement of the industry," says Goldsmith.

Nevertheless, the evolution toward technologically supported medical practice will continue as long as it is promoted largely by physicians, Goldsmith believes. "Doctors are the obvious people to reform health care," he says. "When physicians push for something in our health system, it tends to happen. So I'm optimistic that the administrative and knowledge management issues will be solved."

—Edited by Deborah J. Neveleff, in North Potomac, Md. More practice strategies are available on our Web site (see page 16).

Thompson Sees Progress Coming

In a commencement speech in June to the Chicago Medical School, Finch University of Health Sciences, Tommy G. Thompson, secretary of Health and Human Services, told the graduates that the way the United States provides health is inefficient to the point of becoming archaic. But he believes the increased use of technology will improve care significantly.

"Today's patient almost always needs to see a primary care physician before getting advanced treatment and has to deal with multiple referral forms and other paperwork, as does her doctor and his staff," Thompson said. Today's patient is given care to remedy existing illness and disease and usually is not given the kind of preventive care that forestalls illness and disease. Preventive care becomes a low priority as caregivers struggle to fight the ailments and illnesses that bring their patients in to see them.

What's more, Thompson said, coordination and communication of care frequently are poor. "The patient has to go to multiple specialists, receives multiple bills for overlapping care, and sometimes gets the wrong prescription," he explained. "Today's patient often sees different doctors and nurses each time she goes in for an appointment, and the patient's records are kept in manila envelopes that are often inconvenient to store and use.

"We have wonderful technology, but some grocery stores have better technology than our hospitals and clinics," Thompson continued. "The bottom line is that our system of health care delivery has not matured at the same pace as our technology."

But, in the not too distant future, technology of many various kinds will be available to improve care. "Patients of tomorrow will be treated on the basis of advanced preventive strategies," Thompson said. "Physicians will understand the genetic basis of disease and will incorporate it into their management of patients.

"Patients will be cared for through a home-based system, and the patient will routinely contact their physician through the use of telemedicine, the Internet, and other electronic technologies," he continued. "Prevention will be key to medical therapies and will begin in prenatal care and infancy. We will have computer chips that inform us of our genetic predisposition to illness, medication sensitivities, and the environmental risk factors that may trigger these problems. A coordinated team of physicians, nurses, and allied health professionals will work together through a paperless system to provide care to the patient, independent of where they are cared for."

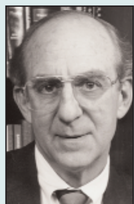
When a patient is admitted to a hospital, paper forms will be eliminated. "The use of telemedicine will allow one's whole medical record to be sent from one part of America to another within seconds," Thompson said. "We will carry wallet-sized cards that have our latest EKG, chest x-ray, lab tests, operative reports, and other critical data encoded in them. And to protect privacy we will use scanners that evaluate the unique features of the iris in a person's eye to activate these cards."

In addition, Thompson added, "Patients will have diagnoses made with noninvasive scanners and most surgical repairs will be performed through laparoscopic techniques using robotics. Medications will be tailored to our own genetic code and delivered safely through bar-coded systems. Billing will be processed at the time of care. Patients will know the costs and will be satisfied with the quality of care you provide, but will not be encumbered by mountains of confusing paperwork."

While his predictions offer hope for beleaguered physicians and patients, the processes needed to improve care are challenging. "We will have to fundamentally change the current health care delivery system in our country," Thompson said. "The myriad rules, regulations, and restrictions that make obtaining good health care difficult, if not impossible, have to be reviewed carefully and, when necessary, jettisoned like useless ballast.

"To make this kind of future real, we will have to bring systemic change to our health care system," Thompson concluded. "I'm not talking about tinkering at the edges. I'm thinking of nothing less than renewal and transformation."

Despite Predictions, Physician Work Force Will Grow, Researcher Says



Richard Cooper, MD, is a hematologist and director of the Health Policy Institute at the Medical College of Wisconsin, in Milwaukee. Previously, he was chief of the hematology division at Boston City Hospital's Harvard Medical Service (from 1969 to 1971), and chief of the hematology section and director of the Cancer Center at the Hospital of the University of Pennsylvania in Philadelphia (from 1971 to 1985). In 1985, he became executive vice president and dean of the Medical College of Wisconsin, and in 1994 he became director of its Health Policy Institute. Editor in chief Richard L. Reece, MD, conducted this interview.

Q: *What spurred your research into the physician work force?*

A: Early in President Clinton's first administration, there was a strong focus on health care policy. Some analysts believed then that the nation had an excessive number of physicians, particularly of specialists, and that half of all physicians should be primary care physicians—yet only one third were. These ideas did not ring true for me, so I began to examine previous studies and their conclusions.

I found that all of the studies were based on a "task and time" methodology that was totally vacuous. For example, one version assigned a specific amount of time to treat patients with a given disease and then multiplied that number by how many patients might have that disease. This figure was used to calculate how many hours would be required for physicians to treat all the patients with that disease. Using the same approach, calculations were made for hundreds of other diseases, eventually determining some total number of physician hours that would be necessary to care for the American public. How preposterous to think that there is a standard timeframe for any disease, that it will remain constant for decades, or even that the diseases and conditions treated will remain the same.

Variations on this methodology were used by the Graduate Medical Education National Advisory Committee (GMENAC) in the 1970s and 1980s and by the Bureau of Health Professions and the Council on Graduate Medical Education (COGME) in the 1990s. These variations pieced together time and tasks, and required many assumptions, since none were remotely related to reality. In fact, their complexity meant that each could create its own reality, which was convenient because this was not objective physician work force planning but philosophically based social engineering. The real purpose was to prove that there would be too many specialists because planners believed that science and technology should be squelched and that more care should be in the hands of PCPs. Should medical care be dominated by primary care with specialty medicine as a secondary component? Or should it be driven by technology, specialization, and innovation, with primary care serving as a point of entry and coordination of care? These are legitimate questions that need to be addressed forthrightly, not masqueraded as work force planning. Real work force planning is based on an understanding of what actually drives the system, and that is the economy.

Q: *Does physician-induced spending factor into measuring the optimal physician work force?*

A: Whether physicians determine health care spending is a bogus issue. Some economists have postulated that a larger number of physicians will generate a larger number of procedures, thereby increasing health care costs. The literature that refers to physician-induced demand is broad and hotly debated. A study in this area by Victor Fuchs, a health economist at Stanford University, demonstrated a correlation between the number of surgeons and the number of operations, implying that surgeons cause operations.

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"Should medical care be dominated by primary care with specialty medicine as a secondary component? Or should it driven by technology, specialization, and innovation, with primary care serving as a point of entry and coordination of care?"

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Subsequently, David Dranove, an economist at Northwestern University, used the same methodology to determine the correlation between the number of obstetricians and the number of births. The same relationship was found between obstetricians and births as had been found between surgeons and surgeries. Whatever can be said about surgeons inducing surgery, I do not believe that obstetricians induced births. So, the extent of physician-induced demand is questionable.

Everyone knows doctors who churn the system, but no one can argue that churning is the dominant mode of physician practice. The reimbursement system often places them in exceptionally trying circumstances, and they try to deal with the system on behalf of their patients. Very few physicians are trying to enrich themselves at the expense of their patients.

Q: *Economists predicted that by 2000 we would have a 15% to 30% surplus of specialists. What actually happened?*

A: Exactly the opposite: There was no surplus, and now there's a shortage. In 1981, GMENAC predicted there would be an excess of 145,000 physicians by 2000. Curiously, every government-sponsored study that followed arrived at the same general conclusion. They were wrong partly because the population projections they used were too low. But the major reason was that the basis for demand was not understood; it was by moving away from time-and-task measures and by focusing on macro trends that we were able to gain a better appreciation of where things were headed.

Q: *Can you discuss why economic expansion is the dominant driver of demand?*

A: In general, the demand for health care services is created by the capacity to purchase, which is in turn created by the wealth of the nation or, as in the United States, by the wealth of a state.

Some people assume that factors such as aging of the population determine how much health care is provided. But Tom Getzen, from Temple University, was the first to show that there is no relationship between the rate of growth of the elderly population and the rate of growth in health care spending. Demand boils down to not how many elderly there are, but how much a nation can afford to spend on their behalf. The same logic holds true for technology. People say that technology will cause more health care spending. Yet the same technology is available worldwide. The availability of technology and the care of the elderly are functions of economic capacity, not of desire, need, or availability.

> **"The availability of technology and the care of the elderly are functions of economic capacity, not of desire, need, or availability."**

Health care purchases are different from most other purchases in that the decision to purchase and the allocation of funds occur before the actual services are purchased and depend on the state of the economy. Included are decisions of businesses to offer certain health benefits; of workers to accept benefits in lieu of wages; of voters to support Medicare expansion; of philanthropists to underwrite the costs of cancer treatment centers; and of individuals to purchase health insurance, to start medical savings accounts, or to budget more for conventional and alternative health care. These decisions are made at different times with respect to the actual services that may be received, and all are made mindful of economic circumstances, both personal and national.

There are both connections and lags to economic expansion. Wealth, as reflected by gross domestic product (GDP) or per capita income, translates into more health care because that's what people increasingly want. And health care spending translates into a demand for more physicians.

Another point: When we talk about cutting health care expenditures, we are talking about restraining the rate of growth, which is necessary in order not to exceed the natural relationship between GDP growth and the growth in health care spending. The question then becomes: What is the acceptable rate of growth in the tug of war between huge demand and the availability of fiscal resources, given competing needs?

Getzen and others have demonstrated that health care spending increases about 1.5 times as fast as the economy overall. If the economy grows 20% over a decade, then health care spending will increase by about 30% in inflation-adjusted terms. This general rule holds for developed countries. A rising standard of living is reflected in more spending on sectors such as technology, leisure, and health care—three categories that have driven economic expansion over the past 25 years.

Q: *Is this health care spending good for the economy?*

A: Two economists who have contributed thoughtfully to this subject are Uwe Reinhardt at Princeton University, and Mark Pauly at the Wharton School of the University of Pennsylvania. They have concluded that, for the most part, health care spending is neither good nor bad, but that if health care spending were to be less, something would have to take its place. Is there an

> **“Nonphysician clinicians clearly are playing a greater role. The question is: Where is the border between care that physicians can delegate and the care that is necessarily provided by physicians?”**

equivalent sector that will stimulate consumer and governmental spending to the extent that health care does?

We have seen how fragile the technology sector is. It crashed with little warning. And the leisure sector contracted after Sept. 11. Throughout this period, health care continued to expand. If it hadn’t, our economy would be in a deep recession. The main negative that economists see to be associated with health care spending is that much of it is through the government, which tends to be inefficient and therefore such spending creates a drag on the economy. Also, taxation supports much of health care spending, and some believe that taxes have a negative effect on worker incentives and therefore on productivity. These are theoretical concerns. In reality, every indication is that health care spending is an economic stimulus. Indeed, many small towns would be in trouble without their local hospital.

Q: *What is the implication for managed care, or even Medicare, to restrain that spending?*

A: In an article published in the Jan. 23 issue of *Health Affairs On-Line* (at www.healthaffairs.org), Drew Altman and Larry Levitt showed how interventions such as managed care had only transient effects on the growth of health care spending from 1961 to 2001. In fact, they had no effect. We have shown that these changes in the rate of growth of health care spending mirrored almost exactly changes in per capita income occurring four years previously. With a lag of about four to five years, changes in national wealth translate into changes in health care spending. Planners often attribute the changes to something else that is occurring, but, in fact, it is associated with economic expansion.

Q: *How does population growth affect physician demand?*

A: In two ways: First, we need an adequate number of physicians to care for people, so the larger the population, the more physicians we need. Second, because people engage in economic activity, the population size affects the amount of resources available in the economy. And economic growth drives health care demand. But population has to be measured and projected accurately, which has been a problem.

Q: *And what about the work effort of physicians?*

A: It has been declining, largely because there are more women physicians, and women tend to work fewer hours and to leave the work force periodically. Another reason is that the average age of physicians is increasing, and older physicians tend to work fewer hours. Also, younger physicians are working less than physicians in the previous generation worked, and residents’ hours are being limited. We’re also seeing more early retirements, and more physicians are following nonclinical career paths. Together, these factors result in approximately 10% to 20% less work effort.

Q: *What is the effect of nonphysician clinicians on physician demand?*

A: When talking about the physician work force, we are referring to the work force capable of providing physician services. Physicians have always delegated some of these tasks to others, and other professions have evolved to do what physicians do not do. As a result, we have seen the growth of nurse anesthetists, psychologists, nurse practitioners, and physician assistants. And we have seen the range of their licensed privileges expand.

Nonphysician clinicians clearly are playing a greater role. The question is: Where is the border between care that physicians can delegate or share with nonphysician clinicians and the care that is necessarily provided by physicians? We are close to maxing out on what can be delegated, which means that, as demand increases, more physicians will be necessary or what nonphysician clinicians are allowed to do will change radically.

Q: *What changes will occur to the physician work force in the near future?*

A: It will be impossible to train sufficient numbers of physicians over the next 15 years to meet the demand beyond 2020, and this lack of personnel will have a profound effect on the role of physicians in our society—forcing them into ever more technical roles and away from the traditions of medicine. The revered Harvard professor, Francis Weld Peabody, taught a generation of physicians that the care of the patient means caring for the patient and that caring requires that physicians lavishly dispense time, sympathy, and understanding. Lacking sufficient numbers, the physician described by Peabody 80 years ago will soon no longer exist.

—Edited by Deborah J. Neveleff, in North Potomac, Md. More practice strategies are available on our Web site (see page 16).

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