

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

August 2004

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Online Consultation Is Growing Slowly

Consumers are slow to try online clinical consultations, according to a research report. Only 3% of adult Internet users participated in online clinical consultations with their doctors last year, even though 65% of the consumers who responded to a questionnaire in 2002 said they would welcome such a service, says Jupiter Media, a researcher in Darien, Conn. The growth of online consultations is likely to continue to be slow over the next two to three years, in part because 92% of consumers, in responding to a Jupiter survey earlier this year, said they were unwilling to pay more than \$10 for such a service.

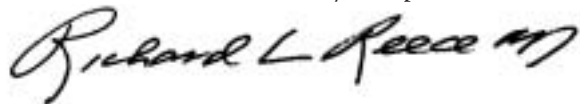
Maybe so, but some physicians are reporting anecdotally that patients who have had a preexisting relationship with them are generally willing to pay \$20 to \$25 by credit card for nonemergency advice. These patients prefer an online consultation to driving to the doctor's office, waiting to see the doctor, and having to make a copayment of \$10 or more.

Ed Fotsch, MD, CEO of Medem Inc., has developed free physician Web sites and an online consultation tool. Medem recommends that physicians conduct online consultations only with their existing patients, that they obtain an informed consent form from these patients, and that the consultations be for only nonemergency follow-up care. Medem also says fees must be clearly posted, e-mail communication must be secure, and the online consultations must be made a part of the medical record.

Medem has more than 100,000 physicians using its Web sites, and more than 10,000 doctors are doing online consultations with their patients, says Fotsch. For patients, there are several advantages to online consultations. The consultations save patients time and money, allow for frequent and complete communication and prompt replies to their questions, prevent unnecessary office visits, and improve care by making it easy for them to get reference sources and educational materials. For physicians, such consultations increase practice revenue (often by \$10,000 or so annually), decrease medical liability risk, and eliminate unnecessary office visits.

Although the Medem approach calls for payment outside of health plans, some plans are offering payment for online consultations. Beginning in August, for example, Blue Cross & Blue Shield of Massachusetts started paying primary care physicians at Beth Israel Deaconess Medical Center, Caritas Christi Health Care, and Baystate Health System \$19 for online consultations and patients will pay \$5 per consultation. Meanwhile, health plans in other parts of the country are conducting studies on the feasibility of paying for online consultations.

Online consultation is an idea whose time has come. Physicians need to get the word out to their patients that this type of physician-patient communication can save both time and money, two precious commodities in health care.



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Registry Helps Improve Care Efficiency

Many of the computerized chronic disease management programs vying to streamline physician practices are too new to have a proven track record. But a medical center in Concord, N.C., has been using a registry program for nearly a decade to cut costs and improve the quality of care it delivers to patients. Over the past 10 years, the registry has also helped NorthEast Medical Center become more efficient, a factor that is particularly important under managed care.

Earlier this year, the diabetes disease management registry program developed by Douglas Kelling, MD, at NorthEast, was introduced into a medical practice in Westchester County, N.Y. It was the first time it had been used outside of NorthEast and the first time it was used in a medical practice.

Improving Processes

Using a registry creates a radical break from how most physicians practice medicine, says Janet Sullivan, MD, chief medical officer of Hudson Health Plan (HHP), in Tarrytown, N.Y., which serves mainly low-income patients. Sullivan had heard Kelling speak about the registry, called CareFocus, and was impressed enough to visit him in his office in North Carolina. After seeing how efficiently his office runs, she recommended the registry to the Westchester New York Diabetes Coalition. The health plan is a member of the coalition, and, at the

time, the coalition was looking for a registry.

Sullivan is hoping that NorthEast's model can work in a community where many physicians are in private practice. Currently, HHP is offering the diabetes management program to participating primary care doctors in Westchester County and to Metro+Med, a primary care practice in New Rochelle, N.Y.

A joint project of the health plan and the diabetes coalition, the registry is funded, in part, through a three-year federal Healthy Communities Access grant, which pays for the hardware and software. Another coalition member, IPRO, in Lake Success, N.Y., the local quality improvement organization, is donating database assistance. CareFocus will be free to participating physicians.

To get the registry up and running, a team of professionals from HHP went to Metro+Med's offices, evaluated its computer hardware, and reconfigured its existing equipment to be compatible with CareFocus. IPRO staff reviewed all of the practice's paper charts, entering some of the data into the new system so that when the offices went online, some patient information would already be in the system.

Although the computer costs for adopting the registry involve not much more than buying and installing the necessary servers, printers, and related equipment, the consulting expenses are much higher. A computer consultant helped to

develop the software that allows the system to import patient data, and a registered nurse trains staff on-site on how to use the system.

Gaining Speed

While working with Metro+Med, the professionals from HHP are learning about the processes involved in helping the practice adopt the CareFocus system. They are learning what Sullivan describes as "an ongoing one-way transfer of information from their own practice management system into CareFocus."

Just as it is with any new process, adopting the registry added to the practice's workload. Implementing the first CareFocus system took Metro+Med six months. Currently, HHP is helping to bring CareFocus to four other private practice sites and hoping that the implementation will go a little faster each time, Sullivan says. "We now know some things to watch out for, and we can try to resolve issues ahead of time," she notes.

While the additional workload for a practice is difficult at first, the results will make the effort worthwhile, Sullivan believes. Combining the registry with how a practice is organized to handle information will improve disease management, she says. "Since no physician can remember everything about every patient, all medical processes need a system to improve the flow of information on past patient visits and current patient status," Sullivan explains. "An effective registry will do so simply and

(Continued on page 4)

"All medical processes need a system to improve the flow of information on past patient visits and current patient status. An effective registry will do so simply and effectively." —Janet Sullivan, MD, Hudson Health Plan

(Continued from page 3)

effectively.”

As other practices gain experience in using the new system, the process will become less labor-intensive, speeding the flow of information as new patients arrive.

“The real key is acting on information the registry gives you,” Sullivan says. “For instance, knowing that a patient with diabetes needs an annual eye exam doesn’t require a physician to make the appointment; a clerical person can call the patient to schedule it.”

Better Information

Back in 1994, Kelling and his colleagues at NorthEast recognized that what they needed in order to improve patient care was better patient information. So, they set out to create a computer-based process to help them improve treatment outcomes. Narrowing their focus to the care of patients with chronic diseases, they chose to start with diabetes.

“Diabetes has objective, measurable outcomes, with national standards as to what our goals should be,” explains Kelling, who is board-certified in internal and pulmonary medicine. “Since we didn’t have to spend a lot of time on setting targets, we were able to spend more time on developing a system to see how close we could get to reaching those targets in a general population.”

Kelling headed a 25-member task force of providers at NorthEast, which included infectious disease specialists, endocrinologists, ophthalmologists, podiatrists, nurses, diabetes educators, nutritionists, vascular specialists, and other experts. Their first step was to write a protocol on how to reach the specific goals for blood pressure, blood sugar, foot

exams, and ulcers. The system was designed so that no medical education was needed to enter data and to allow updating to the system’s tracking, outcomes, and medication information.

Early in 1995, the task force gathered baseline data on the current status of NorthEast’s patients with diabetes, and along newly devised pathways, began to monitor these patients.

Kelling was the first NorthEast physician to use the registry. Within his own practice, he started with a database of 250 patients who had diabetes. Today, with a caseload of 950 such patients, he has four physician assistants and six nurses. All staff, including administrative staff involved with patient care, can use the registry.

Initially, registry data included typical patient chart information: age, insurance coverage, and specific conditions (such as other chronic diseases and whether the patient is homebound). It also included patient test results, such as hemoglobin A_{1c} levels.

Once the system is in place, physicians can use it to help avoid complications. “You’re going to try to find trouble before it finds you,” Kelling explains. “We’re trying not only to see how well the patients’ blood sugar is controlled, but also to determine whether their cholesterol is under control and if they show evidence of heart disease or nerve damage, especially to the feet.”

The registry shows other details as well, such as when a patient was last seen and when a patient should be scheduled for a nutritional exam. Such information serves as important reminders for the physician, staff, and patient.

Effects on a Practice

Usually, introducing a registry requires a physician office to change how it operates. Kelling therefore recommends that practices adopting registries establish a protocol for everyone in the office to follow, indicating which team member a particular patient should see on an office visit, and having staff direct various aspects of care. For instance, if a nurse practitioner notices that a patient has not had an eye examination for a year, that referral can be made without having to check with the physician.

Establishing a chronic disease registry can be revealing to a practice. “It’s a shock when you find out that you weren’t doing what you thought you were in treating a disease,” admits Kelling. In 1995, his new computer program showed that 26% of his patients with diabetes had hemoglobin A_{1c} levels below the recommended maximum of 7. Since tracking treatment outcomes is a significant component of the registry, the percentage of patients with the desired A_{1c} level has now risen to 65%. “Can we do better?” he asks. “Absolutely. The goal is 100%.”

One goal of any disease registry is to display data clearly so that any authorized user can read and understand it. Because the system prints out an easy-to-read, comprehensive chart before each patient visit, a glance at the graph immediately reveals whether the current exam shows any significant change. If so, the chart helps guide staff to identify the problem promptly. What’s more, patients benefit as well. “When I see a patient, I’m holding graphs showing how they’re doing,” Kelling says. “I can hand them to my patient. It

“Our system has helped improve care without requiring much time, effort, money, or paperwork,” says Douglas Kelling, MD, of NorthEast Medical Center.

The Next Step

Measurable care standards are the foundation of a computerized management program, says Douglas Kelling, MD, of NorthEast Medical Center in Concord, N.C. “If you can’t measure it, you can’t talk about the quality of care,” he comments. “In our program, if a complication occurs, we assume that we failed the patient before we assume that the patient failed us. We ask ourselves, why did this happen?”

“Managed knowledge is about getting the right information to the right people so they can do their job effectively,” Kelling continues. “In a system for treating patients with a chronic illness, you want to identify who can best help that patient. When we talk about an immunization, for example, the doctor should no longer be involved, since he or she has made the decision to go along with the national standard.” So, for immunizations, a physician will usually delegate the task of making the arrangements to a staff member.

The goal of an office visit, Kelling believes, is to quickly identify the patient’s risks and concentrate on the risks that the physician can most quickly decrease. As doctors learn to use the registry, their interest and focus in having more patients reach a goal increases, Kelling says. “Physicians want to do as well as or better than all the other physicians,” he explains.

The diabetes management program at NorthEast has been so effective that, once everyone had become comfortable with it, Kelling’s staff began adapting it for other chronic conditions. Today, his office uses a registry for patients with congestive heart failure, hypertension, osteoporosis, chronic obstructive pulmonary disease, asthma, and cholesterol problems.

At NorthEast, the next step is networking the diabetes registry so that it’s online and accessible to the entire medical staff and to patients as well. In order to do so, the medical center will need to install a firewall to prevent intruders from gaining access to the data and will have to develop methods to ensure that the data are useful while still complying with the federal Health Insurance Portability and Accountability Act.

The minimal investment in learning time, effort, staff hours, and equipment costs to implement a chronic disease management system is worthwhile, Kelling believes, because both patients and physicians benefit, if only because the system allows physicians to do what they do best: care for their patients. “Based on our experiences over the past nine years, medicine is a little more fun than it used to be, because we feel that we are finally trying to once again take charge of what is most important to us: the care of our patients,” he says. —CM

turns out they really like to be able to look at how well they are—or are not—doing.”

A more efficient office and more productive staff can eventually lead to higher patient volume. But perhaps the biggest reward of using a registry is greater freedom to do

patient care, says Kelling. “We wanted a system that makes it easier to give quality care while, hopefully, spending less time on paperwork and more time with each patient to take care of his or her needs,” he explains. “Our system has helped improve care without requiring more

time, effort, money, or paperwork.”

The registry helps to improve care by triggering timely follow-up. Since patients are being monitored more closely, they are being sent for needed check-ups on a timely basis. With any new complication or problem, the patient benefits by being able to spend more time with the physician, who has been freed from numerous administrative chores. Most important, the diabetes management program has improved patient outcomes, as the A_{1c} numbers attest. And Kelling expects the registry to help an increasing number of patients reach their target level.

Broader Application

In 1999, the medical center took over the registry program, and it pays all of its operating costs. As other staff physicians chose to use it, a caretaker committee of doctors and other interested health care providers was formed to oversee the system. The full-service, 450-bed facility, 20 miles from Charlotte, serves a county of 125,000. Today, NorthEast has 8,200 patients with diabetes in its registry and offers the computerized program at no charge to any physician with admitting privileges.

Kelling is convinced that the system helps attract local patients who might otherwise go to Charlotte for treatment. Without advertising, NorthEast has seen a significant increase in the number of patients seeking care for any complication of diabetes. “We can cut the length of a patient’s stay, as well as improve the hospital’s bottom line,” Kelling says. Since taking over the registry, NorthEast saved \$400,000 on the treatment of patients with diabetes in one year and has seen no increase in mortality or patient readmissions, he adds.

—Reported and written by Carol Milano, in Brooklyn, N.Y. More information on physician practice strategies is available on our Web site (see page 16).

Plan Seeks Help From Physicians in Its Predictive Modeling Efforts

Predictive modeling is the new buzzword in health care. A tool adopted earlier by other industries, predictive modeling is just now coming to health plans that are learning how to use it for improving care and cutting costs. But many in health care who are adopting this tool are finding that it is not simply a matter of dumping data into a software program which spews out results that quickly lead to better outcomes and lower costs. In fact, some who have implemented predictive modeling, while enthused about its potential, are still learning about the best way to make it work.

Dennis Angellis, MD, is among those who is both encouraged and challenged by the potential benefits of predictive modeling (PM). The tool was implemented in April 2003 at Presbyterian Health Plan in Albuquerque, N.M., where Angellis is chief medical officer and vice president of medical affairs. PHP, which is part of the Presbyterian Healthcare Services integrated delivery system, is a 300,000-member, provider-owned health plan that offers four products: commercial (100,000 members), administrative services only (ASO) (50,000 members), Medicare (15,000 members), and Medicaid (135,000 members).

Risk Stratification

PHP's goal in implementing predictive modeling is to identify potential high-risk members and to intervene

before their health status deteriorates. But one problem with the strategy, Angellis has discovered, is finding a way of contacting the targeted hard-to-reach members so that these interventions can occur. One option PHP is considering to address this problem involves physicians.

Angellis spoke about PHP's experiences with predictive modeling at the 16th annual National Managed Health Care Congress held in May in Washington D.C. In a session entitled "Predictive Modeling: Lessons Learned for Successful Implementation," Angellis discussed PHP's experience with implementing predictive modeling, including the difficulties encountered and the challenges ahead.

Learning to Use PM

As it is with almost any tool, you have to know how to use it well to derive benefits from it, Angellis noted in his opening remarks. Predictive modeling, he said, is that kind of tool. Among the most important lessons PHP has learned in adopting predictive modeling is that having an effective implementation strategy is crucial.

Part of that implementation strategy involves choosing the appropriate predictive modeling software, Angellis said. PHP chose impactPro to meet its needs, but Angellis noted that all health plans have different needs and different patient populations and those factors should be

considered when selecting the PM software.

In addition to meeting its software needs, PHP's implementation strategy included

- Redesigning case management processes (by, for instance, decreasing concurrent review from all members to only members who met certain defined criteria)
- Helping staff adopt new ways of thinking about case management (from reacting after "trigger" episodes have occurred that cause members to be referred for case management, to attempting to intervene before the trigger episodes happen)
- Developing "motivational interviewing" techniques to encourage PM-targeted members to participate in the intervention.

Just 13 months after PHP implemented predictive modeling, Angellis had reason to be encouraged. In a plan in which 10% of the members account for about 60% to 70% of the costs, PHP had achieved \$1.8 million in savings (the total savings for all PHP products). It is still too early to obtain data on how predictive modeling has specifically affected outcomes, but Angellis says that is the next level of analysis.

Even so, in analyzing the data, Angellis realized that the results could be much better if at least one aspect of the tool's implementation could be improved: the process for contacting high-risk members identi-

Presbyterian Health Plan's goal in implementing predictive modeling is to identify potential high-risk members and to intervene before their health status deteriorates.

fied by the model who could not be reached by telephone.

Cold Calling

After potential high-risk members at PHP have been identified through predictive modeling, case managers telephone them to encourage their participation in case management. Some case managers who were accustomed to dealing with a member's "real" condition (as opposed to the potential high-risk one identified by PM) had difficulty adapting to this "cold calling" way of communicating with patients and decided to quit, Angellis said. "Calling a member who has coronary artery disease to engage that member, who hasn't yet had a heart attack or other major clinical event, was difficult for case managers who were used to dealing with a member about a defined significant clinical event," Angellis noted.

When case managers do connect by telephone with PHP's targeted members, the members are sometimes suspicious about the true purpose of the call. Some are fearful, thinking the case managers are calling to reduce their benefits, Angellis said. Others, he noted, think the caller is a telemarketer and hang up. To address these calling problems requires that case managers have carefully worded calling scripts, as well as training in motivational interviewing techniques, Angellis pointed out.

But it was not the targeted members whom case managers were able to contact that caught Angellis' attention; rather it was the targeted members they couldn't reach. The

PM call data from April to December 2003 showed that 21% of the targeted members did not answer the telephone and 9% were unreachable because of disconnected telephone numbers.

PHP claims data showed that, for the plan's commercial population, the average actual cost per case of those "no call contact" members was more than \$21,000 for the "no answer" group, and \$14,000 for the "bad phone number" group. The members of these groups were more costly than the members of other groups: no needs (\$10,000 per case), case management referral (\$12,500 per case), and refused intervention (\$4,000 per case). To Angellis, these data show that case managers were unable to reach the members most likely to benefit from intervention.

Calling on Doctors

Currently, PHP's strategy for contacting PM-targeted members is by telephone only, and case managers make three attempts to reach them. Complying with the patients' rights regulations under the Health Insurance Portability and Accountability Act is only one hurdle hampering PHP's calling efforts. Since the plan doesn't sign up its members, it must rely on others, such as employers, for member information (telephone numbers, for example), Angellis said. In an attempt to address this problem, PHP is seeking help from physicians.

PHP plans to start a pilot study involving physicians in its predictive modeling effort, Angellis noted in a telephone interview. That pilot study will begin with informal luncheon

meetings with physicians to educate them about what predictive modeling is, as well as how the tool can benefit both them and their patients. "In informal conversations with physicians about predictive modeling, I discovered none of them knew much or anything about it, and many had never even heard the term," Angellis said.

Ultimately, Angellis hopes that after bringing the physicians on board, PHP will be able to send them a list of their patients targeted by the predictive modeling software as having risk factors that could lead to a potential adverse clinical event within the next year or so. The physician can then contact these patients, suggesting that they visit the doctor's office to discuss their condition and any interventions that might be appropriate. "This effort won't increase the physician's workload," Angellis noted, "since it will likely involve only five to seven patients per year even in the largest practices."

To critics who argue that such efforts as PHP's to enlist physicians in its predictive modeling implementation efforts are an intrusion on the doctors' clinical autonomy, Angellis pointed out that the tool will actually benefit both physicians and their patients. "As a clinician, I would welcome such information," he said. "It's another way to help me improve the quality of care I deliver to my patients and improve their outcomes."

—Reported and written by Paula Grant in Lincoln, Va. More information on physician practice strategies is available on our Web site (see page 16).

"As a clinician, I would welcome such information. It's another way to help me improve the quality of care I deliver to my patients and improve their outcomes."

—Dennis Angellis, MD, CMO, Presbyterian Health Plan

Harvard Professor Says Health System Should Pay More for Quality Care



*David Cutler, PhD, is dean of the faculty of Arts and Sciences for Social Sciences at Harvard University. Previously, Cutler served on the Council of Economic Advisers and the National Economic Council during the Clinton administration. Currently, he is a research associate at the National Bureau of Economic Research and a member of the Institute of Medicine. He is associate editor of the Journal of Public Economics and the Journal of Economic Perspectives. His book, *Your Money or Your Life: Strong Medicine for America's Health Care System*, was published this year by Oxford University Press.*

Q: What prompted you to write *Your Money or Your Life*?

A: I have spent a lot of time thinking about what is wrong with our health care system. Survey data indicate that no more than one in five Americans claims to be happy with the medical care system. That seems like an awfully small number of people who are happy with something that is so important in their lives.

Q: One of the principal points in your book involves preventive care. Why is that?

A: We ought to spend more money on appropriate care, and in particular on preventive care, which is a good investment because it will obviate the need for spending even more money on the treatment of acute conditions in the future. But there are two other important points as well.

One is that we need universal coverage of some sort. All individuals must be insured if the health care sys-

tem is to work efficiently. The other is that we need to measure the quality and value of care, so that we can be sure we are spending health care dollars appropriately. I believe we should implement quality-based bonus payments for physicians. This will encourage physicians to maintain their focus on quality of care and invest in technologies that will help them to provide this care.

Q: What do you think is the best method of achieving universal coverage?

A: We should allow the general public to purchase insurance the way that government employees do. In other words, I am an advocate of expanding the present Federal

Employee Health Benefits Program. This program is a tested model and has worked successfully for federal employees. It allows enrollees a good deal of choice. Participants have reported that they are satisfied with the program.

When insurance is purchased by large groups, administrative costs are much lower, choices are more numerous, satisfaction with the process improves, and there is more control over insurer pricing practices. The federal government is one such large group. It is buying health care for millions of federal workers, and peo-

ple outside of the federal government should be able to take advantage of this plan as well.

Q: When you talk about the FEHBP, you point out that one of its deficits is that it does not pay for quality. Is that true?

A: Yes, that is true. However, it is important to remember that this is true for the medical system as a whole.

Q: Why is it important to pay physicians based on quality?

A: It is simply logical that people who do a better job should be paid at a higher rate. Health care is one of the few industries in which people who perform better do not receive higher payment. Public edu-

“We should implement quality-based bonus payments to physicians. This will encourage physicians to maintain their focus on quality of care and invest in technologies that will help them provide this care.”

cation is another example that comes to mind. Medicare reimbursement fees are the same for all doctors, regardless of skill, experience, or outcomes. As a result, physicians have no financial incentive to “go the extra mile” in ensuring the highest quality of care and the most appropriate care possible for each patient.

Under the current system, physicians receive the message that the most important thing is saving money. This message is conveyed by the current incentives that underlie the reimbursement of care. We need some major reform of these incen-

“Suppose doctors got paid more when patients got the right diagnosis and prescription, and followed up with patients to ensure that their blood pressure was under control. These doctors would be prompted to set up systems, such as outreach programs, to ensure that their patients were getting the care they needed.”

tives if we want high-quality, appropriate care. We can't just plead with doctors to improve their quality. We must actually change the system so that physicians receive the proper financial incentives to offer high-quality care.

If the health care system structure is changed such that we pay more money to physicians who can demonstrate a better quality record, physicians will have a financial incentive to adopt electronic medical records and other technologies that enable them to track and improve their performance.

Q: *In your book, you note that large multispecialty practices have been measuring outcomes and rewarding doctors accordingly. Can this experience be replicated, given that most physicians practice in small to midsized groups?*

A: The structure and means for rewarding physicians based on quality of care will likely be different in different parts of the country. The health care structure in some areas, like Minneapolis, has developed in a way that facilitates payment based on quality. Other parts of the country have very strong physician groups, so the likely scenario is that the physicians will come together to negotiate with insurers based on quality. And in some parts of the country, the gov-

ernment will have to play a bigger role, because the insurers and doctors just can't seem to develop collaborative working relationships.

We have to create a situation in which people want health care incentives to be based on quality, and then they can determine the best way to make this happen. For example, suppose the federal Centers for Medicare & Medicaid Services reported that it will change its fee structure and will now reimburse physicians based on quality. Under that scenario, the physicians in each area would say, "How can we improve quality? Should we work with the government to do it? Should we work among ourselves? Should we work with the insurers?" Each region may come up with a different solution.

To be successful, however, in all cases this change will have to be driven by physicians. I also think it will be important to get the professional societies on board, so that the doctors do not view payment for quality as a bad, rather than a good, thing.

Q: *In your book, you often mention the great geographic variation in health care provision, which often translates into the misuse, overuse, or underuse of health care services. How can care be standardized?*

A: Because we do not pay providers based on quality, many providers reasonably follow the incentives that are embedded in our system, meaning those that dictate cost savings. This is what causes geographic variation in care. Health care providers should be able to learn what works well and what doesn't work well and always follow the path that leads to the best outcomes. In many areas, clinical guidelines outline the optimal treatment path. However, providers are not rewarded for following that path. The focus is rather on financial results, given the incentives of the system.

For example, the hypertension of only one quarter of the individuals with that condition in the United States is successfully controlled, even though hypertension medications have been around since the 1950s. Why is that? People have a hard time getting to the doctor regularly; they have a hard time filling medications; the doctor does not always prescribe the right medicine. There are a host of reasons. How can we do better? Suppose doctors got paid more when patients got the right diagnosis and prescription, and followed up with patients to ensure that their blood pressure was under control. These doctors would be prompted to set up systems, such as outreach programs,

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“Doing things that will ensure that clinicians take advantage of information to the maximum extent possible so that people are helped to the maximum extent possible will offer a very high return.”

INTERVIEW

(Continued from page 9)

to ensure that their patients were getting the care they needed.

The payer community must reimburse providers in ways that will encourage these changes. We must pay more for the best care. Doing so will encourage all providers to reach the standard.

Here's one possible structural change that could occur. Suppose that the government added funds to the current Medicare program such that reimbursement would be increased by 10%. The program would not increase payments across the board by 10%; rather, that money would be put into a quality improvement fund. That fund would dispense money to doctors on the basis of how well their practice met clinical guidelines. Every time a patient came in, the physician would see what, if any, clinical guidelines could be applied to that patient's care. Has this patient been referred for a mammogram? Has this patient received hypertension medication? Every time a patient is treated according to clinical guidelines, the doctor would earn points. At the end of the year, those points would be translated into a financial bonus, paid from the fund.

Q: Will this change require that physicians have a computer at the point of care so that clinical reminders can prompt the right care?

A: That would be optimal. The cost of both hardware and the software is dropping precipitously. Groups such as the Leapfrog Group and the Institute of Medicine are preaching safety. More physicians are realizing that computer systems enhance their practice efficiency, productivity, and profitability. But if

we ask doctors why don't they invest in these systems, they say they do not have the money to invest.

Health care information systems represent an extremely high productivity investment. Doing things that will ensure that clinicians take advantage of information to the maximum extent possible so that people are helped to the maximum extent possible will offer a very high return.

Of course, doctors need the money to invest in that infrastructure and need to be trained to use it. We must change the health care system to a structure that will hold providers accountable for quality, but this system must embody incentives for good care and provide the resources that will prompt quality improvements. This might require a government investment or it might necessitate an investment by private insurers or groups of physicians. The government pays for about 40% of medical care and the private insurers pay for another 40%. If we are really going to change the system, both of those constituencies must work together.

Q: You seem to be a bit dismissive of consumer-driven health plans because they require individuals to be more informed buyers. Is that correct?

A: For some people, consumer-driven health care is the right solution. Some people feel comfortable being in the driver's seat. But many other people need more help navigating through the health care system and making the best health care decisions.

Consumer-driven health care is a fad, just like all the other fads that we have tried. The whole structure of the industry has to change in a fundamen-

tal way. The idea that consumers on their own—without any changes on the supply side or any changes on the reimbursement side—will be able to change the system just isn't very likely. The system won't change significantly just because people have to pay more and make their own decisions.

A significant pitfall to avoid is a situation in which there is no flexibility. Consumer-driven health care will not work for everyone, just like not everyone is comfortable with managed care. We need a system that is more pluralistic, where some people can get insurance in one way but others can get it differently.

Q: What do you think about the Medicare reform bill that was recently passed?

A: The Medicare act was a big waste of opportunity. The drug benefit is really kind of silly. The cost sharing is such that while the government shares in the costs below about \$3,000, people are responsible for all of the drug costs they incur between \$3,000 and \$5,000. Then, government payment starts again. The act provides drug coverage to some people, which is good, but the coverage is not nearly as broad as it should be. While many extra provisions are packaged in that act, there is nothing that really addresses how the quality of the Medicare system is going to be improved. Overall, the package is much, much weaker than it should have been, and the act does not really address the central problems with the current Medicare system.

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

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Antifraud Efforts Yield Savings

The Blue Cross and Blue Shield Association in Washington, D.C., reported this summer that antifraud measures yielded about \$240 million in recoveries and savings last year, an increase of more than 52% from what the BCBSA association saved in 2002.

"Americans spent more than \$1.7 trillion on health care in 2003, and the overwhelming majority of individuals who work in the health care system are honest," says BCBSA National Antifraud Director Byron Hollis. "But, according to experts, as much as 5% of that, about \$85 billion, was lost to fraud."

Fraud affects every health care consumer and practitioner because the amount lost to fraud could have been spent on treatment, to support federal health care programs, or for private health insurance for consumers. "Every dollar stolen by health care fraud perpetrators is a dollar not available for necessary life-saving treatments, drugs, research, or emergency services," Hollis explains.

While recognizing that fraud exists, some experts note that investigators sometimes view mistakes as fraud. "The large majority of coding errors are just that, coding errors, and not fraud, although at first it may appear that way to insurance companies," says Neil Baum, MD, a urologist and member of the clinical faculty at Tulane University and the Louisiana State University School of Medicine in New Orleans. Baum has studied physician marketing and business practices for many years.

"I have a problem believing that actual fraud is as high as 5%," Baum comments. "The billing system is currently so cumbersome that physicians make those mistakes all the time and sometimes the first thing a plan thinks is that the mistake is on purpose even though there's no real attempt to deceive."

Indeed, not all cases of suspected fraud are found to be intentional upon investigation, Hollis concedes. BCBSA members reported more than 20,000 cases of suspected health care fraud last year, and 606 of those cases were referred to law enforcement agencies. Among those 606 cases, 206 resulted in criminal convictions. In addition, nine civil actions were filed, and 475 cases were referred to regulatory agencies. The rest of the cases are still being investigated or no action was taken.

Last year, many of the 20,000 cases began when individual health plans that are part of the Blue Cross Blue Shield system received 66,117 telephone calls to its Antifraud Hotline. In addition, law enforcement agencies referred 941 cases and BCBS plan internal staff referred 13,232 cases to internal fraud units. An additional 3,886 cases came from external referrals from other public and private investigating agencies.

Types of Fraud

The most common types of fraud include performing unnecessary medical procedures, improperly prescribing drugs, impersonating a health professional, and billing for a more

expensive service than the one performed, according to BCBSA officials.

"False or altered billing codes, forged documents, and computer technology are powerful tools used to illegitimately collect billions of dollars every year from unsuspecting consumers and their health insurers," says Baum.

"That's how most fraud or alleged fraud is uncovered," says John McDaniel, president of Peak Performance Physicians, physician practice management consultants in New Orleans. "Plans carefully examine billing records to determine a pattern, and to determine which physicians are exceeding benchmarks. When they see that physicians are exceeding benchmarks, they investigate. It doesn't always mean fraud, of course."

The aggregate \$240 million BCBS plans recovered or saved represents money recovered from those who had submitted fraudulent claims and money saved because fraud was exposed before payment, Hollis explains. But the BCBSA report said that health insurance fraud cost BCBS plans, which insure more than 88 million people, about \$162 million in lost revenue in 2003 even after the \$240 million recovery. That reflects an increase of 66% from \$98 million in lost revenue in 2002. The increase may result in part from a more aggressive coordinated approach by the association, says Hollis.

But increases in health care fraud trends also reflect current health care

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"The large majority of coding errors are just that, coding errors, not fraud, although at first it may appear that way to insurance companies."

—Neil Baum, MD, Tulane University

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market conditions, Hollis adds. For example, prescription drugs represent a larger portion of total health care expenditures than they did years ago, so pharmaceutical fraud has increased. Specifically, there has been a rise in the number of cases in which pharmaceuticals are diverted for illegal use or street sales, according to Hollis.

Another trend involves an increase in cases that pose opportunities for potential patient harm, say BCBSA officials. In these cases, patients actually undergo unnecessary medical procedures, including invasive surgery. In the past, such activity was rare and the apparent increase in occurrence represents a growing danger to the public, says Hollis, although why an increase in unnecessary surgeries is occurring remains unclear. "Sometimes a physician will perform one procedure but bill for a more expensive procedure," says Hollis.

John Morris, manager of special investigations for Blue Cross and Blue Shield of Florida, says that some physicians use what he calls "rent-a-patient" schemes in which physicians recruit patients to undergo procedures they do not need and then share the reimbursement with them.

Other types of fraud committed by physicians that were uncovered by the association and its 41 members

include the following:

- Phantom billing—adding charges for services never performed or fabricating claims
- Upcoding—charging for a more expensive service, such as a visit to a specialist when the patient actually saw a nurse or an intern
- Misrepresenting services—performing uncovered services but billing insurance companies for different services that are covered
- Unbundling—charging separately for procedures that are actually part of a single procedure.

Fraud committed by consumers were primarily of two types:

- Identity theft—using another person's health insurance card or identification to obtain health care or other services or to impersonate that individual.
- Doctor shopping—going from one physician to another to obtain multiple prescriptions for controlled substances.

BCBSA officials said they will continue to pursue suspected fraud aggressively and have started a new national fraud telephone contact number and Web site (www.bcbs.com/antifraud), designed to increase the number of investigations by providing consumers with a central place to report alleged fraud. "This will help us identify national patterns and work with the

separate plans to coordinate the investigation of plan reports," says Hollis. "In order to keep up with an increased volume of information, Blue plans have invested in advanced computer software to uncover complex fraud schemes."

And in order to bolster individual plan efforts in fighting fraud, the association members have created the BCBS Antifraud Strike Force, consisting of investigators from 11 plans and designed to enhance the coordination of antifraud activities among members.

"This will provide a springboard for plans' efforts by enabling them to work together on complex, multi-jurisdictional cases," says Gregory Anderson, co-chair of the antifraud strike force and vice president for corporate and financial investigations for Blue Cross Blue Shield of Michigan. "We will help facilitate the sharing of best practices and improved detection of emerging trends across the country, and have a greater ability to respond quickly and forcefully when fraud is identified. We are also engaging consumers in fighting health care fraud."

In addition, the association works with the Federal Bureau of Investigation to eliminate such crime. "That's where the money is," said Tim Delaney, supervisor of the FBI health care fraud unit when asked why the FBI places an emphasis on health care fraud. The agency has 500 agents working on 2,000 health fraud cases open at any given time, he adds.

But McDaniel's take on where the money is differs from Delaney's: "If 5% of claims are found to be based on fraud, then 95% are completely legitimate," he points out. "The truth is most physicians are honest and are honestly trying to do a good job within a difficult reimbursement system."

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

Who Investigates Fraud?

In addition to health plans, such as those represented by the Blue Cross Blue Shield Association in Washington, D.C., and the Federal Bureau of Investigation, a number of public entities investigate purported cases of health care fraud:

- City, county, and state law enforcement agencies
- U.S. Department of Justice through the U.S. Attorney General's Office
- Postal inspectors
- U.S. Food and Drug Administration (FDA)
- Offices of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS)

—MS

Physician Tells How He Beat Addiction Brought on by Pressures of Practice

By Richard L. Reece, MD, editor in chief

Cardiologist Steven Farber offers an intimate and revealing view of the physical, emotional, and social pressures physicians face in his book, *Behind the White Coat: Intimate Reflections on Being a Doctor in Today's World* (www.booklocker.com 2001). Part memoir and part medical expose, Farber writes about his entire career, from his days as a nervous medical student to his work in large institutional settings and to the establishment of his own private practice.

The book is particularly instructive for physicians who are feeling burned out from long hours and feel they have little satisfaction from practicing medicine in a health care system dominated by managed care, one that offers little control and lots of pressure to work many hours each day and week. Farber built a successful solo cardiology practice over two decades, but the pressures inherent in the practice of medicine today exacted a high price. He became addicted to a powerful anti-anxiety medication and was divorced four times.

Among many of Farber's patients, the book has struck a nerve. They say they have gained an understanding of physicians as human beings. And physicians benefit as well because they may come to realize they are not

alone in experiencing the exhilaration, tension, and fear that is built into the practice of medicine in the early 21st century.

Farber, who beat his addiction, is currently happily married, has three young children, and practices in The Woodlands, Texas, outside of Houston.

"Writing the book was a labor of love," says Farber. "Over the 20 years of my medical practice I have had many successes, but I have also made a lot of mistakes along the way. When I went to medical school, I was not taught the realities of what the life of a doctor would involve. I was poorly prepared for the pressures I faced when I went into practice. Through my book, I hope to help other physicians avoid these mistakes, or at least realize that they are not alone in their problems."

The Emotional Toll

The book addresses the tremendous emotional pressure on doctors and the problems that flow from that pressure, including addiction and suicide. Farber himself has had four physician friends who committed suicide.

The problem of depression among physicians is well known. Last year, JAMA devoted an entire issue (June

18, 2003) to depression; in that issue, experts from the American Foundation for Suicide Prevention issued a consensus statement asserting that the medical profession must place a higher emphasis on clinician mental health in order to address the number of untreated mood disorders and reduce the number of suicides among medical professionals.

Research into the psychology of physician practice has shown that doctors can easily become isolated, a factor that leads to depression. Physicians give their time, energy, and care, but do not get much emotional gratification in return, and they are often deeply disturbed or depressed. "Going through medical school and the subsequent training can be a very isolating experience," Farber says. "It can be an extremely brutal process at times. During my internship at Baylor University, I never had a day off. At that time, interns were required to actually live at the hospital, and spouses would come in for conjugal visits. I am sure to many residents, this felt like a physical and psychological prison. The intense work schedules physicians and physicians-in-training face serve to isolate them from their family and friends, such that they cannot have a normal social or family life."

(Continued on page 14)

"When I went to medical school, I was not taught the realities of what the life of a doctor would involve," Farber says. "I was poorly prepared for the pressures I faced when I went into practice. Through my book, I hope to help other physicians avoid these mistakes, or at least realize that they are not alone in their problems."

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Heavy schedules continue after training and take a heavy toll. "For example, I typically work a 60- to 70-hour week, at least," he says. "My average day includes about 12 hours spent at the hospital and in the office, but obviously medicine is really a 24/7 profession because our patients may need us at any given moment. Physicians often go two, three, or four weeks without a day off. This schedule is very wearing on physicians, especially as they get older and have more family obligations."

Furthermore, a confluence of forces in today's practice environment exacerbates the pressures inherent in the job. Many doctors say that four main tensions in their lives are the fear of being sued for malpractice, the administrative hassles with insurers, inadequate reimbursement, and the complications of living in a society that is increasingly hostile to doctors. These issues resonate with Farber.

"These and other issues have made it harder and harder to practice medicine in the current environment," Farber comments. "For example, the 5% of physicians who are responsible for the majority of malpractice suits are the ones we read about in the newspaper. But we don't hear much about the 95% who are very, very good physicians. As a result, the profession has gotten a bad name."

At the same time, patient expectations about what they can expect from a physician are often unreasonable. "In the book, I point out that physicians are expected to have the competitive fire of Michael Jordan, the courage and heart of Lance Armstrong, the 'true grit' of John Wayne, the confidence of

Mohammed Ali, the ability to communicate like Dale Carnegie, the patience of Job, and the intelligence of Albert Einstein," Farber says. "The pressure of these expectations is astounding."

A Great Irony

All the many pressures of practice can lead to a great irony: While physicians are helping their patients achieve and maintain good health, they often ignore their own well-being. "I had a partner in the late 1980s who died about a year into our partnership," Farber says. "He was only 40 years old, but he was an asthmatic who needed to use his inhaler quite a bit during the day. I often told him that he should see a pulmonologist, but he never did. He just worked 12- to 14-hour days and never took the time to go. One day, we were seeing patients in the office and he had a fatal asthma attack. We found him on the bathroom floor. His face was blue and I performed CPR on him for about four hours, but he could not be revived."

"Writing the book was an act of bravery on Farber's part, as it is highly personal and required him to relive many painful experiences. At one time, he developed an addiction to an anti-anxiety medication, which alleviated his tension and conferred a pleasing, calm feeling, one he sought repeatedly throughout the day. While self-prescribing the medication, he also took the free samples that his office received.

"The fact is, many physicians need a crutch to get through the pressures of the job," he says. "It is well known that people who are depressed tend to self-medicate." And, Farber notes, it is very easy for physicians to

become addicted to alcohol or drugs because of their easy access to medications.

After some time, Farber and his friends realized that he had a problem. "Luckily, it didn't affect my patient care, but it could have," he says. "Eventually, the medication became something I felt I could not do without, and this in itself was very disturbing to me. In addition, my friends noticed and intervened. I knew my problem was bad, and I would need help to beat it. I went through counseling to help me overcome my addiction."

Farber has also been through four painful divorces. "Many physicians are workaholics by nature, and in fact the profession rewards workaholics," he observes. "That situation can weaken a marriage and lead to divorce. Ultimately, my work schedule probably hurt my marriages more than my drug addition did. In my book, I state that doctors deserve second chances as much as everybody else."

Managing Pressure

To weather practice pressures successfully, Farber advocates that physicians develop themselves spiritually. "I had a lot of difficulty accepting my mistakes when I went into practice," he says now. "The exhilaration when we save a patient's life is phenomenal, but we despair when we fail. I truly punished myself when I made a mistake, probably more than anybody else would. I took my mistakes very personally. But all human beings are fallible. I think if I had developed a closer relationship with God, that relationship would have helped me tremendously in negotiating life's difficulties."

"Unfortunately, it is very easy for physicians to become addicted to alcohol or drugs, especially due to the accessibility of medications."

—Steven Farber, MD

At a Glance

Steven H. Farber, MD, FACC, graduated Phi Beta Kappa with honors in English from Rutgers College before attending medical school at Hahnemann Medical College and Hospital in Philadelphia. After receiving his medical degree with honors in 1977, he became an intern and resident at Baylor College of Medicine in Houston where he completed a cardiology fellowship. Board certified in Internal Medicine and Cardiovascular Disease, Farber has twice served as chairman of the Department of Cardiology at Conroe Regional Medical Center. A fellow of the American College of Cardiology, he has a private practice outside Houston.

Intellectual development is also critical to having a balanced life, says Farber, who calls for a more broad-based liberal arts education for doctors. Physicians often attend medical school after being strongly science-focused. While they may have superb grades in biological sciences and pre-medical courses, physicians also can be stunted intellectually about the world at large, particularly about the arts and literature. Realizing this fact, Farber has tried to develop his intellectual creativity by becoming a fan of Shakespeare. He also started writing poetry, and includes some in his book. Physicians should also learn ways they can help themselves manage stress and recognize signs of burn out.

In each state, the board of medical examiners of the state medical association offers services for impaired physicians who want such help. For example, the Indiana State Medical Association's Physician Assistance Program addresses the needs of physicians impaired by chemical dependence, psychiatric disorders, and disability (www.ismanet.org). Farber's Web site, www.behindthewhitecoat.com, also offers a number of links that can help

physicians understand the challenges of the job and recognize signs of depression.

Sharing Online

On Farber's Web site, physicians can participate in the "Physician's Forum Bulletin Board," a mechanism by which physicians can share their feelings and personal experiences, vent frustrations, offer opinions, and ask the opinions of other physicians regarding how to address certain problems. All of these features are available anonymously. "This forum can help physicians learn from the experiences of others and allows them to take comfort that other physicians are facing similar problems," Farber says.

Often, other physicians provide suggestions that make a difference. "For example, I learned that I need to take the time to research things before I just jump into them," Farber adds. "I was relatively naïve when I graduated from medical school and other people, including patients, took advantage of me. Younger physicians need to learn this lesson early. I know now that there is the potential to

work very, very hard for 40 years and have very little to show for it financially."

Certainly, business support for physicians is crucial. Because many medical school programs focus solely on clinical information, new physicians do not know how to run a practice from a business standpoint. Gaining such understanding can make practice challenges more manageable. "Coming out of medical school, I had no training in how to run a business," Farber notes. Business courses—such as human resources management, accounting, strategic planning, and finance—geared toward physicians could help them manage their practices more optimally, he explains.

Ultimately, Farber hopes that his book will help physicians and their patients develop a stronger relationship. "Patients have come to me and said, 'Dr. Farber, now I understand what you're all about, the pressures you are under on a day-to-day basis,'" he says. "One of the intentions of the book is to strengthen the doctor-patient relationship, which has weakened over the years, in part due to shorter visit times."

Farber also hopes to offer comfort and a sense of community. "I want physicians who may have an addiction problem to know they can find the courage to seek help," he says. "Physicians are not alone in the pressures that they feel, and talking about these pressures with colleagues and family can help physicians manage their negative feelings."

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

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