

PHYSICIAN PRACTICE OPTIONS™

November 15, 2000

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

CONTENTS

Features

Strategy
Practice Built on
Patient Satisfaction 3

Practice Management
OIG Issues Final
Compliance Rules 10

Interview
Consultant Outlines
Seven Lessons for
Physician-Hospital-
Owned Health Plans 12

Departments

Editorial
Readers Offer Insight
Into Dr. Solomon's
Dilemma 2

Managed Care Theory
States Using Episodes
for Analysis 6

Information Systems
HIPAA Raises Patient
Privacy Issues 15

Physicians Find Quality CME on CDs and Online

One of the ways the computer is changing the practice of medicine is through distance learning. Using compact discs and the Internet, a physician can participate in continuing medical education (CME) courses while sitting at a computer. The development of CDs and online CME is based on the premise that physicians are acclimated to using computer-based technologies to enhance their medical practices and personal efficiency.

Online CME has grown in popularity because physicians quickly recognize its obvious benefits. "The use of online CME significantly increases the efficiency with which physicians can upgrade their skills," asserts David Selden, president of Enterprise Health Solutions, health care consultants in Salem, Mass. "One of the major commodities that physicians don't have enough of is time. Usually, physicians have to travel to a site to obtain CME, but the time spent actually learning is outweighed by the amount of time—and expense—required to get to the site. When provided online, CME is available to the physician when the physician has the time for it. So physicians can fit CME experiences into their schedules, rather than having to fit their schedules around obtaining CME." Many of the benefits of online CME are available via CD as well.

Rick Fulton, vice president of ArcMesa Educators in Tinton Falls, N.J., agrees, saying, "Medical professionals like the ability to go online 24 hours a day and take courses at their convenience, according to their own schedules. In addition, online users have a great variety of courses available to them."

ArcMesa offers CME both live and online (at www.arcmesa.com).

"Traditionally, physicians were required to travel to different locations to obtain CME credit," says Andrew Astrove, MD, an anesthesiologist with Broad Anesthesia Associates in Boca Raton, Fla. "Now, physicians can have excellent learning experiences by going online from home, at their own convenience. Physicians who don't have time to travel can still participate in CME, both for learning purposes and for meeting state relicensure requirements."

As a result of taking several CME courses online, Astrove can attest to the value of these programs. "Online CME is convenient and has allowed me more time to devote to my practice and my family," he says. "I also found the courses to be of high quality, providing valid information that helped me build my fund of knowledge."

Moreover, absorbing the information online is relatively easy, Astrove asserts. "Users can go at their own pace," he says. "They also can't miss any information or important points as they might when listening to a live presentation at a conference. They can just simply re-read the information if they need to."

To be sure, some online CME companies have struggled to survive as they wait for physicians to find the advantages of getting CME credits via the Web. Like other Internet companies, some online CME ventures have found financial partners to be more reluctant to lend money this year than they were in previous years.

In addition, not all physicians want to get CME credits online, of course. When

(Continued on page 8)

Readers Offer Insight Into Dr. Solomon's Dilemma

Recently, we have received several interesting letters from readers, particularly about our editorial, "Doctor Solomon's Dilemma Resonates Across the Nation," July 15. Readers identified strongly with Solomon. Earlier this year, the PBS news program *Frontline* aired a documentary, "Dr. Solomon's Dilemma," featuring Marty Solomon, MD, a primary care physician employed by CareGroup, a network of seven hospitals and 3,000 doctors in Boston. The editorial described how managed care was forcing Solomon to concentrate on the bottom line, and he struggled mightily to stay within budget and still deliver appropriate and timely care.

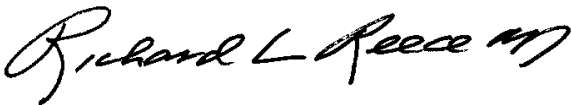
A reader from California wrote to tell us, "I decided a long time ago that I was never going to join an HMO, and as soon as I found out what an albatross Medicare was 18 years ago, I immediately resigned from Medicare. I did not have any doubts about the success of my leaving these methods of practice, since I had worked in physicians' offices in London. I saw 500 doctors in London who were busy doing private practice outside the government system and without benefit of the U.S. economy. I decided if they could do it, I could do it. It has worked out very well.

"Most of our patients are managed care and Medicare," the California reader continued. "These patients deal with us directly, however. All we do is give them a bill. I do not have a Medicare provider number. If patients want to get involved with the Medicare system, that is fine with us, but we do not think we can render the care we like to render under those systems. When I practiced solo, I had two full-time employees and my wife worked about half-time. Now that I have rid myself of the bureaucracy, my associate and I have one full-time employee and one high school student who works for us four hours a day. We keep our fees reasonably low because our overhead has gone down considerably."

Another reader from California wrote to say, "From my experiences in private practice's day-to-day trenches, I can tell you the ever-tightening vise of rising costs and heavy regulatory and liability costs will soon make it hard to justify medicine as a business or a career. Just where are physicians supposed to find the capital to invest in expensive information technology and electronic medical records and the professionals needed to improve customer service? One cannot provide the services consumers demand while at the same time getting \$33 to \$45 for an office visit or a \$12 capitation rate. It just doesn't add up. For what a family practitioner earns in California, Solomon's intensity of work just isn't worth it. Burnout isn't far away. Thanks for your newsletter, and keep it coming."

Another reader sent us this e-mail message: "Your editorial on not weeping for the past, but rather forging a new paradigm that accommodates the new realities for maintaining standards of care we all want to see was first-rate. I particularly liked your closing line, 'Put physicians and consumers in control and hold them accountable for the cost of care.' I get edgy when I see articles saying simply that physicians should be in control, because I know that to the consumer that sounds like a call for a return to 'yes, doctor' case management. I like the idea of an informed patient. But I like the idea of an accountable patient, too."

We encourage letters from readers and will to print the best ones in future issues.



Richard L. Reece, MD
Editor-in-Chief
Toll-free phone: 888/457-8800
E-mail: Rreece1500@aol.com

Neil Baum, MD
Urologist
New Orleans

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
Executive Vice President, Director
Center for Clinical Innovation
Premier, Inc.
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley
President and CEO
webEBM
Nashville, Tenn.

Peter R. Kongstvedt, MD
Partner
Ernst & Young
Washington

Richard Lilledahl, MD
Health Care Consultant
Milliman & Robertson Inc.
Seattle

Lee Newcomer, MD
Executive Vice President
Vivius Inc.
St. Louis Park, Minn.

James G. Nuckolls, MD
Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

Jacque Sokolov, MD
Chairman
Sokolov Schwab Bennett
Los Angeles

W.L. Douglas Townsend Jr.
Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

This newsletter is published by Premier Healthcare Resource, Inc., Parsippany, N.J.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Publisher
Premier Healthcare Resource, Inc.
888/457-8800
E-mail: publisher@premierhealthcare.com
Publishing Address: Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

Editor
Joseph Burns
508/495-0246
E-mail: editor@premierhealthcare.com

Practice Built on Patient Satisfaction

For many years, experts have extolled the virtues of building physician practices by improving patient satisfaction. Managed care plans also focus on satisfaction as an ideal, at least in their marketing materials. The reality, of course, can be quite different from what marketing materials or experts espouse.

But one multisite family practice group in Ohio has blended a determined focus on patient satisfaction with several strategic acquisitions of other practices to achieve a significant level of success. The practice has focused intently on satisfying patients' needs by extending the hours of operation and reducing patients' waiting times.

Customer Service

Today, Community Health Care (CHC), a 24-physician practice in Akron, Ohio, serves 125,000 patients (about one-third of the population of 300,000 in the metropolitan Akron area). In this group, the customer is king, says Rodney K. Ison, MD, CEO, who founded the practice. Early in his career, Ison was working at an urgent care center and learned an important lesson about customer service, he says.

"I was struck by the fact that the only reason the urgent care centers existed was that many physicians are not available to care for their patients at the times patients wanted care," Ison explains. "The world is an ever-changing place, and when patients' lifestyles had changed, medicine forgot to change with the environment. Therefore, we had an opportunity to provide urgent care."

In 1986, Ison purchased the family practice of Jeffrey Duffey, MD, in the small Ohio town of Canal Fulton. Duffey remained in the practice as an independent contractor, and the two made changes, immediately offering evening hours, staying open until 8:30 p.m. three nights each week and opening from 9 a.m. to noon on Saturdays.

The day Ison purchased the practice, Duffey had 1,000 patients. At the end of 12 months the practice had grown to 4,000 patients. After two years, the practice had 6,000 patients, and within four years, it was

servicing more than 17,000 patients, the number it serves today, Ison says.

After buying practices in the surrounding towns of Green, Hartville, Massillon, Norton, and Stow, each practice experienced similar growth. Today, Ison has eight physician partners and employs 24 physicians in nine offices.

"This is a service business, and the decision to offer extended hours was a strategic decision," Ison comments. "I work three evenings per week and I'm here every Saturday."

Nights and Weekends

Other physicians may eschew extended hours. "Initially, they look at me like I'm out of my mind," Ison says of other physicians. "They think it's inappropriate or that it makes no sense. But after they see how well it works, they view it differently. Today, one of the first questions I have for my potential colleagues is, 'Are you willing to work evenings until 8 or 8:30 and on Saturdays too?'"

The office does not make appointments on Saturday, but handles patients with acute problems who would otherwise have to wait until Monday for care. The stated purpose of Saturday hours is to help patients get through the weekend.

"The customer wants us to be available, and not just at set hours," he says. "If you have an acute problem, we will see you even if we are not your physician. After two or three times where we've provided care to a patient when their own physician has chosen not to, they don't go back to their other physician." By Ison's estimation, about 30% to 40% of his current patient volume came to him in this manner.

By providing care for children, Ison recognizes that he can also build his practice by offering care for other family members. "The nice thing about a family practice is that if your child is cared for when no one else will, I have won your business for the entire family," he explains. "It's often difficult to fit everyone in the schedule, but when you see the look in a mother's eye when you've cared for her child, you know you've accomplished something that no marketing dollars could accomplish. You've won that mother's heart."

There are few mysteries about providing good customer service. "Other doctors look at us and think we have some kind of hidden secret to create our success," Ison explains. "Providing care after regular hours is not more difficult than caring for people at other hours. All we do is put our patients' needs in front of our own."

"Other doctors look at us and think we have some kind of hidden secret to create our success. All we do is put our patients' needs in front of our own."

—Rodney K. Ison, MD, Community Health Care

"We don't offer Sunday hours, which leaves 24 hours where patients don't have access to us, which seems to work fine for most of our patients," Ison says.

When they learned about the extra hours, patients from other physicians started coming to CHC for care in the evenings. It wasn't long before these patients changed physicians, Ison explains. "We are available when the cus-

tomers want us to be available, and not just at set hours," he says. "Extending the office hours was just one of the steps CHC took to help the practice meet patients' needs. "We also made on-time service a priority, not just a slogan," Ison says. "Patients value their time, but we quickly forget this fact. Physicians are acutely aware of the time they spend and how they are being reimbursed for the time they spend with patients. But having patients wait 30 to

(Continued on page 4)

(Continued from page 3)

60 minutes routinely is disrespectful. If you respect patients' time, they will remember to call you first. Therefore, if a patient's wait was prolonged, we often told the customer that we would not charge for the visit."

"I don't feel like a piece of wood when I go into his office," says Lenora Rupe, a patient of CHC who along with her husband has run the general store in Canal Fulton for the past 10 years. As a result of being satisfied with the care she has received, Rupe estimates that she has made more than 1,000 referrals to CHC. "I think he's wonderful," she says of Ison. "He is a compassionate human being, and a patient is not a number with him, and I've told him that."

Time Management

As part of his effort to minimize wait times for patients, CHC developed a time management approach to patient care. He describes practice dynamics as akin to walking a tightrope, as physicians attempt to balance the need to provide appropriate care for each patient and stay on schedule at the same time.

"Here's the problem: If a patient comes into your office, the physicians will try to address his or her primary concern, which was the reason the patient called for an

appointment initially," Ison explains. "But then if you add three or four other health issues in a small time slot, it throws everybody's schedule off and makes all the other patients late. Then you have upset patients."

The key to success in time management of patients is to set another appointment or a series of appointments to address any additional concerns.

"We have learned to go in with the patient and address the primary concern he or she came in for, being very careful not to ignore the other complaints, explaining that the other problems are important and deserve the proper amount of time," Ison explains. When the office staff explains these issues, patients generally are comfortable with this approach, and the office stays on schedule.

When addressing patient satisfaction, CHC began considering every aspect of how the practice relates to its customers. When Ison was buying a physician practice that just happened to be located in a house in Barberton, the Barberton Citizens Hospital was planning to build a new expanded facility next to the practice. Ison decided a new approach to design was required.

Fearing that the expanded hospital facility would make it difficult for Ison's

patients to find the new house-based practice, Ison worked hard to ensure that patients would not miss the practice from the road. "We want our patients to be able to easily identify our practice from the road," Ison says. "So we were careful to provide optimal visibility to drive-by traffic. Also, parking can be difficult at some practices. So we made ours easy to drive into and park, and we have designed the front entrance in such a way that there is no question of where you should enter. We believe the facility should be open, colorful, and well lit. The entire experience should be as easy and comfortable for patients as possible."

Such attention to detail is not unlike that of the most successful fast-food chains, Ison says. "Look at the major hamburger chain," he adds. "Nobody will tell me that they've been successful because they sold the 'best hamburgers.' What they did do was to do it quickly, cleanly, and they are there when the customer wants them to be there, and it doesn't take a whole lot of time."

Acquiring Practices

As many physician groups have learned, multiple operations can cause cash flow problems. To date, Ison has managed to avoid losing money by focusing on the

Physician Offers Views on Practice Success

Community Health Care (CHC), a 24-physician practice in Akron, Ohio, that serves 125,000 patients in northeastern Ohio was built by focusing on patient satisfaction, says Rodney K. Ison, MD, the founder of CHC. Ison believes there are many ways physicians can position their practices for success. Among them are the following:

- Look at all problems as opportunities.
- Remember that medicine is a customer-service business, and patients have a choice about where they can get care.
- Be flexible when negotiating with hospitals. In other words, be willing to give and take.
- Take care of other physicians in

need. As a member of a profession, all physicians should be willing to help other area physicians if needed.

- Consider all constituents as customers and offer them your respect: patients, employees, fellow doctors, the community, insurers, and hospitals.
- Maintain relationships with representatives of insurers and hospitals. This is one area in which it is best not to delegate. Meet with as many insurance managers and representatives as possible, particularly those who are the highest-ranking executives in the companies.
- Stay away from offering medical advice over the phone. Physicians should try to maintain personal con-

tact with patients at all times as a way to maintain quality. Offering advice over the phone should be used only occasionally.

- Be willing to learn about the business side of medicine because physicians may not know everything about this aspect of practice.
- Delegate. You may be in charge, but physicians cannot be in control of everything in a practice.
- Run a multiphysician practice as a democracy, not a dictatorship.
- Never snub a person in a lower job. Many times, that same person will end up high in the chain of command years later.

—DK

purchase of the practice and allowing others to own the land and buildings.

"From the beginning, I was only interested in purchasing the practice, and had little interest in the land and building," the physician explains. "I paid \$10,000 for my first practice, and borrowed a total of \$65,000 for operating capital. But I did not buy the building, which was owned by Barberton Citizens Hospital."

This tactic substantially reduced the amount he needed to spend for the practice, and reduced operating expenses, allowing him to reach profitability much more quickly than he would have otherwise and freeing money to purchase other practices.

"It made sense to decrease the capital expenses up front," Ison explains. "Lack of capital and interest payments can destroy a practice. It was never my goal to be a property owner. I only wanted to own practices. My colleagues think we should consider the practice, the land, and building as one entity. But I think in terms of a unit, a practice without the land or the building."

This tactic also has cut the time Ison or his practice managers need to spend on building maintenance and accounting issues.

Vision to Reality

Ison's unorthodox ways have been well received by hospital administrators, in part because Ison focuses on patient satisfaction, says William Roderick, the chief operating officer for Barberton Citizens Hospital.

"Whether you're talking wait times, or how he deals with his patients, Rodney is a country boy," Roderick explains. "He talks to the patients on their own level and is devoted to them. One of the things that's unique about Rodney is that he wants to practice medicine personally. They have a large corporation now with many offices, but he devotes his time to patients. I think that's why he's successful."

What's more, Roderick believes that working with Ison and his colleagues has been good for the hospital as well. "There are many reasons why Rodney has been successful in working with the hospital," Roderick says. "Rodney had his vision from

"Insurance companies are in business to make money. When we accept that, when we make them money, they will give us what we want."

—Rodney K. Ison, MD, Community Health Care

the beginning to create a large multisite primary care practice. He brought his concept to the table and sold it to the hospital. That was 15 years ago, a time when most primary care physicians had solo practices."

In the intervening years, Ison has worked with the hospital as a partner, Roderick says. "We recognize Rodney as a dominant primary care force in the area, and he recognizes us as a good community hospital," he adds. "He has a track record of recruiting quality physicians and getting them busy right away. My observation is that he is unselfish with his new physicians, giving up his business to help them get started."

Accepting Change

While CHC has been successful in keeping its customers satisfied, it has also viewed managed care plans as customers as well. For many physicians, managed care has changed the physician-patient relationship and created such animosity that many physicians today are questioning their career choice. Ison professes not to struggle in his relationships with managed health plans.

"Many physicians have difficulty with managed care, but we don't," Ison explains. "Insurance companies are in business to make money. When we accept that, when we make them money, they will give us what we want. That's how I look at them now, as a business. We allow them to make a profit, but don't let them interfere with the quality care of patients."

This approach has helped CHC to extend its reach into managed Medicare. "Years ago, one health plan asked us to consider participating in a new Medicare contract," Ison says. After studying CHC's spending, the health plan said the practice was spending about 75% of what the health plan would have predicted. Unlike most plans, "They asked us what we want-

ed and what we needed," Ison says.

When asked to identify the factors that are most responsible for the group's success, Ison says there are three. First, he believes the practice needs to have a positive outlook toward change. "Our attitude is pretty simple: We've learned that every change is an opportunity," Ison says.

Capitation is a good example. "When insurance companies got into managed care, they started to move toward capitation," Ison relates. "Our competitors were looking at this as a problem. But from our standpoint, it was a golden opportunity. For the first time, we knew what our income would be, and all we had to do was manage within that income."

Patient expectations are another example. Over the past few years, expectations among patients have been raised. "They wanted more availability," Ison says. "It was another golden opportunity. We just readjusted our time to theirs, and made ourselves available. We are in a service business."

The second factor that helps a practice succeed over time is that all business managers—physicians included—need a vision, Ison believes. "We looked at what others had done, and found that those who survived over the long term in business have a core competency, and a vision that they keep alive," he says. "Instead of being pulled one way and another, they have central goals. Just like them, we have central goals that focus my partners and my employees' effort."

And the third factor that helps a practice succeed is a focus on patient care. "Most physicians want an employee to be loyal to them," Ison says. "We want our employees to be loyal to the company, not to be loyal to us personally. That way, they'll put patient care first."

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

States Using Episodes for Analysis

By Douglas W. Emery, MS

When the episode of care (EOC) was proposed back in the 1960s, it was nearly impossible to implement on a wide scale even though it was compelling as a sophisticated unit of analysis. At the time, a standardized diagnostic and procedural coding system was not available for medical and pharmaceutical claims and the computing power was far too primitive to do the job even if reliable databases for storing claims information existed. It has taken more than 30 years for technology and standards to catch up with the concept, but the capacity for wide-scale implementation of EOCs has arrived.

In the past, payers in the public and private sectors relied on ad hoc reports generally drawn from raw data. While often useful as way to develop actionable information, these reports tended to be of limited value.

Grouping Episodes

Recently, however, powerful new EOC systems have come to the market to take advantage of several cumulative advancements. Among these systems are Episode Treatment Groups (or ETGs), offered by Symmetry Health Data Systems, in Phoenix; the Practice Review System (PRS) from Medecision, in Wayne, Pa.; Clinical Episode Groups (CEGs) from HealthShare Technology Inc., in Acton, Mass.; and Diagnostic Clusters (DCs) from Practice Patterns Science Inc. in St. Louis. With these programs, it is possible for payers to perform sophisticated statistical analyses that make much more clinical sense to physicians than did the previous data-mining methodologies.

Consequently, payers are beginning to use episode technology to measure the performance of health care networks

more effectively than they have in the past. Among these payers are directors and staff members of Medicaid programs nationwide, who have contracted with EOC experts who offer advice and consulting on EOC. Such experts typically work for consulting firms that specialize in systems development, data processing, and administrative services for Medicaid programs.

Episodes of care, population modeling, and detection of fraud and abuse are becoming more prevalent in Medicaid requests for proposals, consultants say, and once one state is successful with a program, other states copy it. Consultants use EOCs to integrate data on hospitalization, ambulatory visits,

that the individual had a difficult year, experiencing 16 discrete episodes costing the state Medicaid program \$145,765. The report may show a number of cost drivers, including three hospital admissions for asthma or related pulmonary disease and two visits to the emergency department for a viral respiratory infection. A high number of reports like these would indicate that the state Medicaid program has an opportunity to improve the quality of care and save money by moving treatment sites for these episodes from a hospital setting to community-based care. By reviewing the provider identification numbers, the EOC analysis may show that Medicaid care is fragmented and that the child in question had not

By comparing the incidence of asthma episodes with hospital admission rates for children ages one through nine on a county-by-county basis, Medicaid administrators can obtain a wide view of disparities in practice patterns.

ancillary services, and pharmaceuticals across multiple service sites into clinically homogenous, patient-centered treatment categories.

EOCs serve as sophisticated units of analysis to measure and compare resource utilization and financial performance for physicians and patients. EOCs take into account such case-mix indices as patients' diagnoses, age, complicating conditions, comorbidities, and major surgeries. Aggregating these data is essential for directors of Medicaid programs because they use EOCs to measure and report utilization data to participating physicians.

Using EOCs for Medicaid clients, consultants can produce extensive reports on utilization. After examining a one-year patient profile for a five-year-old Medicaid patient with pulmonary disease, for example, a consultant could report

seen one physician twice.

Further analysis can show how data can be extrapolated to a geographical and population basis. By comparing the incidence of asthma episodes with hospital admission rates for children ages one through nine on a county-by-county basis, Medicaid administrators can obtain a wide view of disparities in practice patterns among participating physicians and other Medicaid providers. Since the EOCs can adjust for case-mix disparities, it is possible to compare practice patterns in a way physicians can see clearly. The system itself does not tell physicians and other providers how to practice medicine nor does it reveal the underlying causes of disease. But it does make information available in a clinically relevant format that previously was either nonexistent or difficult to obtain. These systems allow Medicaid officials and participating physicians and other providers an

Douglas W. Emery is the editor of Global Fees for Episodes of Care: New Approaches to Healthcare Financing (New York: McGraw Hill, 1999).

EOCs provide information about how much was spent on various disease categories, the frequency of care within categories, and the average costs per episode.

opportunity to cooperate in finding solutions. Systems that use EOCs represent a quantum leap over previous methodologies, consultants say. Medicare's recent expansion into global fee payment for EOCs may help to accelerate the movement by state Medicaid programs into episodic payment, but the movement is likely to be extremely slow, experts predict. Many states are likely to continue with what they have done in the past simply because they tend to resist change, these experts say.

Precise Reporting
Using EOCs, consultants can break down all of one state's Medicaid budget into major practice categories. This type of analysis gives Medicaid managers a wide view of state health care spending. They would have a precise idea, for example, of how much the state Medicaid program spends on various disease categories, the frequencies of care within categories, and average costs per episode. The EOC systems also allow managers to look closely at discrete episodes, individual physicians or other providers, and geographic areas. It is possible to understand how much was spent by each physician treating patients with a particular condition, such as asthma, and separate those costs from the costs required to treat these patients for other conditions.

This is precisely what Jerry Solon, an expert in episodes of care, and his colleagues had in mind when they introduced the episode concept in 1967. After explaining how episodes could be used to plan and manage care with the goal of measuring actual outcomes against anticipated results, Solon and his colleagues had an expansive vision for the use of episodes. "A frame of reference transcending the individual care is further suggested," wrote Solon and his colleagues in an article, "Delineating Episodes of Medical Care" in the *American Journal of Public Health*, Vol. 57, No. 3 (1967): 401-408. "Medical experts might well formulate standard episodes of care for certain conditions, specifying how they would ordinarily be managed most effectively and economically....The anticipated natural history of the medical care would be outlined in a longitudinal profile to provide norms of identifiable episodes of care. Medical practice, clinical investigation, and population studies could all relate to such norms in useful ways."

Although it took more than 30 years for technology and regulations to catch up to the concept, Solon and his colleagues are now being seen as prescient. Since the EOC is a patient-centric, physician-driven model of care production and analysis, many experts hope that physicians will begin to see the value of moving to an advanced managed care model. ■

Want to make certain that you receive each month's issue?

SUBSCRIBE TO PHYSICIAN PRACTICE OPTIONS

OUR ARTICLES FOCUS ON:

- Understanding the dynamics of managed care
- How to strategically position your practice for success in today's health care market
- Effective organizational options
- Maximizing your practice through health care informatics



1 year (12 issues) - \$110

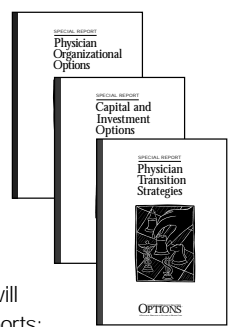
A 50% savings off the regular price. Act now and you will receive one free Special Report of your choice:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES

2 years (24 issues) - \$170

An additional \$50 savings off the special 1 year subscription rate. Act now and you will receive a complete set of three Special Reports:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES



Please call 888-457-8800 to order your subscription now, or fax this order form to 973-316-5989 or mail to:

Physician Practice Options
99 Cherry Hill Road Suite 300
Parsippany, NJ 07054

Name _____
Address _____
City _____ State _____ Zip _____
Email address _____

Payment method: Check enclosed Bill me Credit card.

If paying by credit card, please fill in the following information:

Credit Card (type) _____ Exp. Date _____
Credit Card Number _____
Name on card _____
Billing address _____
Signature _____

Checks should be made payable to: Physician Practice Options

(Continued from page 1)

physicians prefer to get their credits through distance learning and not go to the trouble and expense of attending a conference, they may choose courses available on CD. Edward A. Iannuccilli, MD, cofounder of CME Consultants Inc., a company in Providence, R.I., that develops, accredits, and organizes CME on CDs and at onsite conferences across the country, says a physician can get a CD on the topic of choice, view or print

the course material, take the test, and earn Category 1 credit.

"Specialists may prefer to attend conferences where they can mix with their peers and get a little rest and relaxation while away from their practices," says Iannuccilli, a gastroenterologist who founded CME Consultants in 1994. "It's a different matter for many primary care physicians. Under managed care, primary care physicians have enormous time and

money pressures and cannot afford to attend conferences across the country." In addition to being a member of a 13-physician group in Providence, Iannuccilli has directed medical education at a large academic medical center in Rhode Island.

CDs and online CME share two significant advantages: Both are more convenient and less costly than traveling to

(Continued on page 9)

Many Educators Offer Electronic CME Courses

Many educational organizations offer continuing medical education (CME) online. Physicians interested in finding such courses may want to begin with a search on the Internet and by seeking recommendations from colleagues and from specialty societies. The offerings of four online CME providers are listed below.

ArcMesa Educators. An AMA Category 1 provider of CME, this company in Tinton Falls, N.J., began offering CME online in 1997. ArcMesa offers approximately 150 courses, or 600 hours of CME. All courses are offered both online (at www.arcmesa.com) and in booklets that can be mailed to participants. Approximately 5,200 physicians have taken ArcMesa courses online. Course offerings include refresher courses on various diseases as well as detailed information about treating patients with specific diagnoses.

ArcMesa gives users the ability to preview courses for free. It also offers courses in the popular portable document format (PDF), meaning a user can download the material to a computer. "Users can print out the materials without being on the Internet," says Rick Fulton, vice president.

Medical Education Collaborative. MEC (www.cmegateway.com) is an independent, accredited, nonprofit company that provides CME for physicians and other health care professionals. The company offers live symposia, courses on CD, and online CME programs. Working with other organizations, MEC offers

courses in topics related to cardiology, oncology, psychiatry, and women's health and on such conditions as HIV/AIDS.

University of Wisconsin Medical School. Many universities and medical schools have begun offering online CME. "Our department has been offering CME credits primarily through conferences and seminars for 36 years," says Rhonda Dix, Internet outreach specialist in the CME office at the university in Madison. "In the last couple of years, however, survey returns showed an interest in CME Internet courses." Online education is attractive for many reasons, particularly to physicians who practice in outlying areas and cannot attend traditional courses.

The university began offering online CME (at www.cme.wisc.edu) this year. The university's first online CME course—"The Diagnosis and Management of Dyslipidemias"—became available in February. Four other courses—on post-traumatic stress disorder, an introduction to ECG interpretation, newborn screening for cystic fibrosis, and novel antifungal therapeutics—were offered in June. Five more will become available within a year.

The site also offers 28 nonmedical courses for which physicians can receive CME credit. Nonmedical online course offerings fall into several categories, including the Internet (such as establishing a Web site), computer courses (such as learning Microsoft Word and PowerPoint), and management courses (such as supervision, mar-

keting for small business, and starting a consulting practice).

The Virtual Lecture Hall. Medical Directions Inc. (MDI) in Tucson, Ariz., started offering online CME in 1996 in conjunction with Physicians Online (www.pol.net). In May 1998 the company began offering The Virtual Lecture Hall (www.vlh.com) as a free-standing CME site.

The Virtual Lecture Hall offers 72.8 hours of CME, and currently has 9,000 registered physician users. All courses are designed for primary care physicians, although they cover topics in most major medical specialties.

Other resources. A wide variety of other resources are available to physicians interested in electronic CME. The AMA's CME Locator (at www.ama-assn.org/iwcf/iwcfmgr206/cme), for example, is a database of more than 2,000 Category 1 activities sponsored by CME providers accredited by the Accreditation Council for Continuing Medical Education (ACCME) or approved by the AMA. Also, the ACCME lists all of its accredited providers on its Web site (at www.accme.org).

Other Internet sites that offer information and links to sites offering online CME include the following:

- HealthStream (www.healthstream.com)
- The Health Channel.com (www.thehealthchannel.com)
- CMECourses.com (www.cmecourses.com)

—DJN

(Continued from page 8)

take a course. "Another benefit that's not so obvious is that if done properly, online CME is more effective than conference-based or written CME," says John Harris Jr., MD, CEO and founder of Medical Directions Inc. (MDI) in Tucson, Ariz. A medical education company, MDI provides online CME at The Virtual Lecture Hall (www.vlh.com). "Online CME can more easily deploy the technologies that are touted by adult learning theory and the medical CME literature as being more effective, such as providing targeted information and problem-solving exercises," Harris says.

Improved Effectiveness

MDI research has demonstrated that online CME can result in improved quality of materials and ease of learning. Working with the American Cancer Society, MDI tested the effectiveness of online CME. Society experts translated their live CME offering, "First Line Defense Against Breast Cancer," into a case-based CME program now available through The Virtual Lecture Hall. In its first two months, the online program reached five times as many physicians as the live program had. But it was also more effective.

In a test of the program's effectiveness, 77 participants answered seven questions about the information in the program before and after the live presentation. The first 183 users of the online program were asked the same questions before and after taking the program. For the live program, the average number of correct answers was 56.4% on the pre-test and 59.0% on the post-test. The average number of correct answers among the online participants was 57.8% on the pre-test and 77.0% on the post-test. Thus, knowledge retained improved by almost one-third for the online participants versus only a slight improvement for those who participated in the live presentation.

The effectiveness of online learning obviously depends on the quality and presentation of material. Over the past few years, the quality of online CME has improved significantly, says Selden. "Newer software systems have been

developed that allow for a rich learning experience," he explains. "Users can watch a PowerPoint presentation and see the overheads just as they would in a conference room, they can hear the presenter's voice-over, and they can interact via e-mail or in a chat room with others who are taking the course at the same time. In addition, users can download the presentations and discussions for later reference.

"We're moving toward a whole new breed of online offerings," Selden continues. "Online CME used to be a point-and-click, multiple choice exam. Now interactive sites are being developed on the Internet so that physicians can interact with peers and the educators while they are obtaining educational information."

In fact, the quality of material offered online can be just as good as that offered at conferences, says Astrove. "It has to be," he adds. "To make these sites valid, online CME providers must contract

"Although online courses may offer interaction through chat rooms or e-mail, they still don't offer the camaraderie of conference-based courses."

—Andrew Astrove, MD, Broad Anesthesia Associates

with authors who are knowledgeable and ensure the quality of the courses." To help ensure quality, ArcMesa uses a medical advisory board, which reviews and edits course materials submitted by faculty.

An Impersonal Approach

While users and vendors tout the advantages to obtaining CME online, the impersonal nature of the Internet remains. In fact, the inability to interact with faculty and colleagues face-to-face may be the only major drawback. "Physicians who attend conferences to receive CME enjoy the ability to interact with colleagues and discuss what is happening in their specialty across the country," Astrove notes. "Although online courses may offer interaction through chat rooms or e-mail, they still don't offer the camaraderie of conference-based courses."

Fulton agrees. "One disadvantage of

online CME is that it's not live," he says. "The inability to ask questions and interact with faculty and other participants real-time is a downside. The future of CME online is true interactivity." ArcMesa and other vendors are developing technology to foster more interaction between users and faculty.

Another potential disadvantage of taking CME online is that it seems more suited to shorter courses. "Some of our courses are 300 pages, and some people find it difficult to review this much material on a computer screen," Fulton says.

Getting Comfortable

Of course, ease of learning online varies among users. "Not every physician is computer literate or prefers to learn this way," says Rhonda Dix, Internet outreach specialist in the office of CME at the University of Wisconsin Medical School in Madison. "Online courses will simply

increase the options for physicians to increase their knowledge bases."

For physicians seeking an online CME provider, Astrove offers several suggestions. "First, physicians should be sure that the site is accredited by the national Accreditation Council for CME," he says. ACCME (at www.accme.org) is a voluntary accreditation organization in Chicago. "Second, the architecture of the site should be such that the site is easy to navigate without problems," Astrove says. "Third, the physician should feel comfortable with the mechanics of the site, such as how payment is made and how certificates are conferred. Finally, physicians should find a provider that offers a good library of courses that satisfies their own intellectual interests and their CME credit requirements."

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

OIG Issues Final Compliance Rules

By John W. McDaniel

The federal Department of Health and Human Services Office of Inspector General (OIG) has issued final instructions to help physicians in individual and small group practices design voluntary compliance programs. The guidance from the OIG is designed to help physicians in solo and small group practices develop effective, voluntary compliance measures to prevent fraud and abuse in government health programs, such as Medicare and Medicaid.

A voluntary compliance program can help physicians identify erroneous and fraudulent claims and ensure that submitted claims are accurate, the OIG said when issuing the guidance in September. A program also can help a practice by improving claims payment, minimizing billing mistakes, and avoiding conflicts with the self-referral and anti-kickback statutes, the OIG said.

Known as the *Compliance Program Guidance for Individual and Small Group Physician Practices*, the guidance is voluntary, but it would be safe to assume that the OIG strongly encourages implementing a medical practice compliance program for any physician serving Medicare and Medicaid beneficiaries.

Since the guidance takes away any excuse physicians may have for not implementing a compliance program, the guidance may mark the beginning of the establishment of a standard of care for physician practices. In other words, the government may view the failure to have a compliance program in place to be below the acceptable standard of care.

The OIG has identified fraud and abuse as an important area of public policy. The federal Health Care Financing Administration (HCFA) has determined that fraud and abuse costs the federal

government more than \$20 billion per year. What's more, "insufficient documentation" and "no documentation" account for more than half of questionable claims.

Therefore, it is clear that at a minimum every physician practice should implement a coding compliance program that analyzes the levels of service utilization by physicians to ensure compliance with HCFA standards and to determine areas of potential undercoding and overcoding. The program also should require periodic reporting on evaluation and management coding by each physician and periodic documenta-

tion of chart audits for each physician to ensure appropriate documentation of procedural codes and medical necessity. The practice also should conduct individual educational sessions with physicians and office staff members to review the results expected of the coding compliance program and to establish a framework within which each physician may accomplish these tasks in order to satisfy compliance requirements.

Physicians should keep in mind that they tend to overbill for what they document and they tend to underbill for what they provide.

First Steps

Unlike other instructions from the OIG, the final physician guidance does not suggest that practices implement all seven of what it calls the standard components of a full-scale compliance program, the OIG said. While the seven components provide a solid basis for creating a compliance program, full implementation of all components may not be feasible for smaller practices, the OIG said. Instead, the guidance empha-

sizes a step-by-step approach for practices implementing a voluntary compliance program. Practices can begin by identifying risk areas based on a practice's specific history with billing problems and other compliance issues that might benefit from closer scrutiny and corrective measures.

The step-by-step approach is as follows:

1. Conduct internal monitoring by doing performance audits periodically
2. Write and implement compliance standards and procedures
3. Designate a compliance officer or person to monitor compliance efforts and enforce practice standards

Soon the government may view the failure to have a compliance program in place to be below the acceptable standard of care.

4. Train and educate staff members on practice standards and procedures
5. Respond appropriately to detected violations by investigating allegations and disclosing incidents to appropriate authorities
6. Develop lines of communication by discussing the issues of erroneous or fraudulent conduct at staff meetings and by keeping employees up to date on compliance activities
7. Enforce disciplinary standards by publicizing the practice's guidelines on these issues.

The final guidance identifies four specific compliance risk areas in which the OIG has focused its investigations and audits of physician practices. The four areas are proper coding and billing, ensuring that services are reasonable and necessary, proper documentation, and avoiding improper inducements, kickbacks and self-referrals.

1. Coding and billing. The following risk areas associated with billing have been among the most frequent subjects of OIG investigations and audits:

- Billing for items or services not ren-

John W. McDaniel is the president and CEO of Physician Management Group Inc., physician practice management consultants, in New Orleans.

To stay in compliance, a practice should obtain copies of all relevant OIG Special Fraud Alerts and Advisory Opinions.

dered or not provided as claimed

- Submitting claims for equipment, medical supplies, and services that are not reasonable or necessary
- Double billing
- Billing for noncovered services as if covered
- Knowing misuse of provider identification numbers that results in improper billing
- Billing for unbundled services
- Failure to use coding modifiers properly
- Upcoding the level of service provided.

Written policies and procedures concerning coding should reflect the current reimbursement principles set forth in applicable statutes and regulations. Also, written policies and procedures should ensure that coding and billing are based on medical record documentation and medical necessity.

Physicians should pay particular attention to issues involving diagnosis codes and individual Medicare Part B claims, including documentation guidelines for evaluation and management services. In addition, practices should institute a policy that all rejected claims pertaining to diagnosis and procedural codes should be reviewed each month. The practice should develop a monthly claim denial follow-up log to ensure that all claim denials are followed to conclusion.

2. Reasonable and necessary services.

Practices should provide guidance to staff members that Medicare will pay only for services that meet the Medicare definition of reasonable and necessary. Therefore, Medicare (and all insurance plans) should be billed only for services believed to be reasonable and necessary for the diagnosis and treatment of each patient.

3. Documentation. Timely, accurate, and complete documentation is one of the most important physician practice compliance issues. The rules on documentation relate to medical records, CPT-4 and ICD-9CM codes, and the HCFA 1500 Form from the federal

Health Care Financing Administration.

The medical record may be used to validate the site of service, the appropriateness of the services provided, and the accuracy of the billing. At a minimum, accurate medical record documentation should be complete and legible, of course. But documentation of each patient encounter also should include the reason for the encounter; any relevant history; results of a physical examination; the findings; any prior diagnostic test results; an assessment, clinical impression, or diagnosis; a plan of care; and date and legible identity of the observer.

If not documented, the rationale for ordering diagnostic or other ancillary services should be easily inferred by an independent reviewer or third party.

The medical record also should include support for the CPT-4 and ICD-9CM Codes. HCFA and private insurers should be able to determine who provided the services. These issues can be the root of investigations of inappropriate or erroneous conduct and have been identified by HCFA and OIG as a leading cause of inappropriate payments.

The guidance specifies that the HCFA 1500 Form is deemed to be properly completed when it links the diagnosis codes with the steps taken to perform an examination and record a personal history. It also must link a single most appropriate diagnosis with a corresponding procedural code, use modifiers appropriately, and provide HCFA with all information about any other insurance coverage a patient may have.

4. Kickbacks, inducements, and self-referrals. The guidance states that physician practices should have policies and procedures to ensure compliance with anti-kickback rules and with the physician self-referral laws and regulations. Whenever a practice intends to enter into a business arrangement that involves making referrals, counsel familiar with these laws and regulations should review the arrangement.

It is generally recommended that all business arrangements in which a physician practice refers business to an outside entity should be on a fair market value basis. What's more, physician practices should implement measures to avoid offering inappropriate inducements to patients, such as the routine waiver of coinsurance or deductible payments.

To help ensure that the practice remains in compliance, it should obtain copies of all relevant OIG Special Fraud Alerts and Advisory Opinions from the OIG's site on the Internet (see below).

Flexibility Stressed

Recognizing the financial and staffing limits in most physician practices, the final guidance stresses flexibility in how practices implement the voluntary compliance measures. Physicians can participate in the compliance programs of other providers, such as hospitals or other settings in which they practice, the OIG said. Such participation could augment the practice's own compliance efforts, the OIG explained.

The final guidance also provides direction for larger practices developing compliance programs. The OIG recommends that larger practices use the physician guidance and previously issued instructions, such as the Third-Party Medical Billing Company Compliance Program Guidance or the Clinical Laboratory Compliance Program Guidance, to develop an appropriate compliance program.

The final guidance includes several appendices on additional risk areas and information about criminal, civil, and administrative laws related to the federal health care programs. Physicians also will find information about the OIG's self-disclosure protocol and other useful resources, the OIG said.

For more information on the guidance, physicians can download the guidance from the OIG's site on the Internet at www.hhs.gov/oig/new.html. ■

Consultant Outlines Seven Lessons for Physician-Hospital-Owned Health Plans



William J. DeMarco is the president and CEO of DeMarco & Associates, health care consultants in Rockford, Ill., and has been involved in developing health plans since the

early 1970s. He helps physicians develop strategies to allow them to work more effectively with managed care companies and works with physicians and physician networks to reconfigure physician-hospital joint ventures. The author of *Physician Driven Health Plans* (New York: McGraw Hill, 1999), DeMarco has facilitated the development of physician-owned health plans in Connecticut, Illinois, Michigan, Minnesota, New Jersey, New York, Oklahoma, and Wisconsin. He has held several executive positions with health plans in Minneapolis and served as executive director responsible for the initial development of the Rockford Clinic-sponsored Clinicare Health Plan (now Rockford Health Plans Inc.). Richard L. Reece, MD, editor-in-chief, conducted this interview. An earlier interview with DeMarco, "Integrated Systems Fail When Partners Do Not Work Together, Expert Says," is available on our Web site (see page 16).

Q: You have been involved in the development of several physician-and-hospital owned health plans, and as a result you have many lessons to offer about where the pitfalls lie. In your book you outline seven mistakes made in building HMOs that eventually lead to the failure of these organizations. The first mistake is to create the HMO as a department or division of the hospital rather than as a separate strategic business unit. Why is that a mistake?

A: Setting up the HMO as a department of the hospital will guarantee failure. This structure leads to warfare among hospital departments, each of which believes that the money being set

aside for the HMO line of business is disproportionate to that being spent on other lines of business in the hospital.

Second, the physicians will have to contract with a unit of the hospital instead of a freestanding corporation or a joint venture. This creates the likely scenario that the hospital as owner or parent company of the physician-hospital organization (PHO) will take its expenses for administration, startup costs, and inpatient care out of the financial pool first and leave little to distribute to the physicians. A better arrangement is for physicians to form a medical staff IPA and pool the risk for professional fees such as Medicare Part B-related reimbursement. If they use a prospectively determined pooling formula in this arrangement, they can truly see whether they can afford to share in the risk. If physicians are going to be at risk, they should have the opportunity to develop pooled risk and not be at risk individually for unpredictable patient populations.

Finally, structuring the HMO as a department of the hospital does not permit the HMO to have retained earnings long term. Every year, the integrated system will take excess revenue after expenses instead of leaving it with the health plan to invest in systems or clinical improvement, or at least hold it in reserve for rainy days in the future. When the hospital folds excess funds back into the system and then accidents occur, the losses are exposed and must be subsidized by the hospital board. As a result, when the HMO needs additional capital for investment in information technology, physician education, or a broader product base, it does not have the money to do so. Enough of these subsidies will cause a hospital board to begin to question why the hospital supports this unprofitable department or product line.

Basically, a strategic business unit cannot run as a department of the hospital. It has to have its own profit and loss

accountability, its own staff, and the ability to go out in the marketplace and connect with employers to serve the long-term needs of patients in a changing market.

Q: You say the second way to kill a hospital-owned HMO is to staff the company with hospital executives whose schedules and budgets are already at risk. Can you explain why this would be a mistake?

A: Staffing an HMO with hospital executives creates inherent conflicts. The HMO must be treated as a separate, distinct entity. Just because an executive is head of a managed care department doesn't mean he or she also can run the HMO. The hospital training to fill beds and manage facilities is not easily transferred to an HMO environment to improve care and market services to employers.

In addition, hospital executives are already busy with multiple priorities; their budgets are at risk of being cut by the federal government or by hospital systems that shift priorities in an attempt to maximize institutional margins. Managing an HMO is not a part-time job; it requires full-time accountability to build an entirely new corporation that makes profit by reducing unnecessary admissions and length of stay.

Q: Why is the third way to kill a hospital-owned HMO to sell it to employers as an insurance product instead of a delivery system?

A: The original concept of an HMO was that it was an alternative to insurance. Insurance companies pledge to reimburse consumers for care following an illness or an accident. In contrast, an HMO guarantees consumers not just reimbursement of services but also a place to get the services. An HMO offers access to a delivery system and additional benefits such as preventive services. HMOs have operational procedures in place for marketing, utilization review, and quality

“Setting up an HMO as a department of the hospital will guarantee failure. This structure leads to warfare among hospital departments.”

assurance. Those elements make HMOs distinctly different from traditional insurance plans.

Unfortunately, ill-trained marketing staff members are telling employers that HMOs are just like insurance, yet better because they offer better benefits. HMOs that are presented that way get locked into having to bid for contracts against insurers instead of being able to leverage the true value of the delivery system. This value is the ability to do something that no insurer can do: improve clinical care.

Q: *Your fourth point is that hospital-driven HMOs fail if developers underfund the initial capitalization requirements in order to save money, and then become dismayed when a second round of financing is needed. What do you mean?*

A: In the old days, there was a state application fee of \$25,000 to \$75,000 to get an HMO started. We have seen a lot of disasters because of that low figure. We're finding that the price of HMO development can reach \$3 million or more just to meet state licensure reserve requirements. Adding another \$3 million investment in operations gives a closer approximation to the real costs of developing an HMO.

That type of investment represents a huge risk. Unless an HMO can get a level of enrollment to meet its break-even requirements, it will find itself adding more debt over time. Our advice to hospitals is that it is better to overestimate both the initial round of financing and a secondary round of capitalization in the original business plan than it is to invest only a minimal amount of money and then disband the HMO if losses rise and it goes bankrupt.

But the leading cause of death of HMOs is not undercapitalization. Rather, it is the things that drive the loss of capital, such as poor utilization review and unrealistic medical management tools that drive up medical expenses, such as too many admissions, and the inability to

market the hospital-owned plan as something different than the prevailing insurance products in the market.

Q: *You say a fifth mistake leading to the failure of a hospital-owned HMO is to continue to subsidize physicians' overutilization and practice difficulties and never have them share in the financial risk.*

A: Yes. Originally hospitals start on the right path by trying to negotiate a 50-50 ownership of the HMO and equal sharing of risk. Over time, many hospitals shift all the risk to the physicians, many of whom end up the financial losers because of capitation. They start with a high monthly capitation rate, but then suffer huge losses when treating people with chronic or catastrophic illnesses since these patients require more drugs, more inpatient days, and more sophisticated and expensive procedures.

The need for skillful case management, home care, and nurse follow-up can reduce the costs without putting patients at risk, but if physicians have no gain in

gave them no greater control than independent contracts. In addition, hospitals found that the physicians are more productive in independent practice, where they can see the economic advantage of working 10-hour days and keeping costs down. I tell hospitals that before they sell those practices, they should make sure that they've done everything to work with their physicians to try to make the venture a success, including creating an independent medical group that is managed by the physicians with behind-the-scenes support from the hospital. Faltering practices owned by the hospital will not help the hospital's reputation in the community and are targets for purchase by competitors.

Q: *Why is it a mistake to delay instituting serious utilization review, which is your sixth point?*

A: Sometimes health plans will delay a tough utilization review because their financial statements indicate that they are meeting their utilization targets after the first year of operation. First-year

“The leading cause of death of HMOs is not undercapitalization. Rather, it is the things that drive the loss of capital, such as poor utilization review and unrealistic medical management tools that drive up medical expenses, and the inability to market the HMO effectively.”

the outcome, then they have no incentive to try these cost-saving techniques. Eventually the hospital is awash in debt, and threatens physicians with lower reimbursement unless they improve care management practices. Physicians refuse to accept risk, and then the hospital has to subsidize the risk itself or extend it to the PHO, which takes the fall.

Many hospitals have divested their physician practices because of this cycle of events. They found that ownership

savings are real dollars, but they aren't necessarily what utilization for next year should be based on. In other words, this year's ability to bring admissions and days down 35% may be unrealistic next year.

Administrators may be delighted with initial utilization review efforts, because suddenly the hospital days start coming down. The reasons for the drop are not clear, however. For example, the drop may occur because the physicians aren't sure what the new rules are, or staff

(Continued on page 14)

“Instead of distributing first-year funds, physician-run HMOs should set that money aside to finance the risk pool for the next year. Only after the HMO has a track record of financial solvency should it distribute money to the physicians.”

(Continued from page 13)

members are trying to meet the guidelines through excessive preauthorizations. But as enrollment grows, the HMO will enroll its share of very sick and chronically ill people. This means active utilization review needs to be pervasive throughout the organization, and physicians and staff are empowered through the utilization review program to anticipate that as case mix changes, the benchmarks for good care become more important.

These efforts reduce overall medical expenses, which can be tied to savings that are fed back to the independent medical staff organization. This makes the organization as a physician-driven plan different than an insurance-driven plan. Instead of distributing first-year funds, physician-run HMOs should set that money aside to finance the risk pool for the next year. Only after the HMO has a track record of financial solvency should it distribute money to the physicians.

Overall, I've never seen an integrated care system that has not had to institute some sort of utilization review. But utilization review is best when it is physician-driven.

Q: Your seventh point is that once in trouble, hospitals try to limit their risk exposure by putting physicians at risk for physician and hospital care. Why is this a mistake?

A: Suppose a physician is in a PHO and has invested \$3,000 in stock. If the PHO is in financial trouble and the hospital says, “We’re going to have to cut costs and delay recovery on our initial investment. We’re also going to ask you as a physician to take a little bit more risk. We’ll pay you the same capitation rate, but you’re now going to be funding the reserve pools for specialty visits and for admissions.” The physician will say, “I don’t think I’m going to send patients to

my hospital, because it is not in my interest financially. In fact, I’m going to tell people not to join this health plan because I’m losing money.”

Physicians who do not feel they are in the driver’s seat will buck the harness and start sending patients to nonparticipating hospitals, making the argument that the sponsoring hospital cannot handle the case. These physicians will start referring to out-of-plan doctors so they do not have to “ding” the capitation pool. Pretty soon, utilization goes up, followed by cost increases associated with out-of-plan use. Unless there is strong utilization review and a clear understanding by the physicians regarding the plan’s predicament, this scenario will put the HMO under.

Hospitals can devise ways to minimize their capitation risk by shifting primary, specialty, pharmacy, ancillary, and hospital costs into the physician’s cap rate, but, for example, once the oncologist realizes that he or she is at risk for all chemotherapy patients, the plan begins to self-destruct. All the other physicians begin seeing costs rise sharply because there are no benchmarks or practice guidelines. The hospital has successfully transferred the risk of admissions to the physicians. This will destroy the plan.

Q: Given the above pitfalls to avoid, how can vertical integration succeed for physicians?

A: The real basis for successful health plans in the early 1970s was physician-driven integration. A number of the multispecialty group practices that integrated into health systems—such as DeanCare and Marshfield Clinic in Wisconsin, Scott & White Health System in Texas, Mayo Clinic in Minnesota, Geisinger Health System in Pennsylvania, and Fallon Community Health in Massachusetts—are still operating successfully today. They are still viable because the physicians were involved in the integration strategy,

guideline development, and cost-containment strategy long before HMOs even existed.

Q: But the types of groups involved in those physician-driven integration efforts represent maybe 1% of all physicians. Eighty percent of doctors are in groups of 10 or less, rather than in big groups. How can these independent doctors participate successfully in vertical integration efforts?

A: One of the reasons the large multispecialty groups are successful is that they can share some risk and some of the administrative burden of practice management. As practice models, they represent a small group of companies, but as to actual numbers of physicians, these large groups are representing more and more physicians either through affiliation or ownership.

More independent networks—either single specialty or multispecialty—are forming. For example, a primary care network in Allentown, Pa., broke out of its hospital-owned system and now has developed an organization for both specialty and primary care. These 500 independent physicians negotiate with care systems and share purchasing and other cost-reduction strategies.

In general, we are seeing the emergence of a new generation of IPAs and networks driven by physicians. Physicians can maximize their success in vertical integration efforts by not taking contracts at rates that are less than practice costs, not trying to manage risk without the appropriate infrastructure to support it, and seeking experienced network management. They also should be willing to devote the time and effort necessary to serve in a leadership role, thereby creating a true medical staff partner for the hospital.

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

HIPAA Raises Patient Privacy Issues

By Joseph Pokorney

The first step for any physician seeking to comply with the Health Insurance Portability and Accountability Act (HIPAA) is to understand the intent of HIPAA in regard to patient privacy. Congress passed HIPAA in 1996 with the intention of helping the health care industry achieve the benefits associated with the widespread use of standardized electronic transmission of information, such as claims, insurance verification, and referrals. With the increased use of electronic transactions and the potential for using the Internet in health care, the issue of privacy became paramount. Under HIPAA, the overriding concept with respect to patient information is to acknowledge that the patient has the right to determine how his or her personal and medical information will be used.

The privacy standard will directly affect the way in which physicians deal with patient information. The standard establishes a basic structure for protecting patient information. The regulation limits the use of individually identifiable patient information to three areas:

1. Patient treatment
2. Payment collections
3. Provider operations

Limiting Access

All other uses of this information are limited in various ways. The basic concept is that access to patient information should be limited to those who need to have the information, and their access is limited only to that information required to perform a particular job function. Under the law, there are limitations on how patient information can be used without a patient's permission and there are restrictions on disclosure of patient information to a "need to know" basis. Also, the law calls for establishing patient rights with respect to individual patient information, and penalties for improper use or disclo-

sure of information.

The implications for physician practices are many, and can be categorized into administrative and operational areas.

Administration. Physicians may want to appoint a manager to be responsible for patient privacy and information security. They may want to establish and publish policies and procedures to document

Multiphysician practices may need to modify systems so that only primary care or referral physicians can access particular patient records.

the organization's privacy and security programs. Physicians also should consider conducting a formal training program for all employees regarding privacy and security. Also, physicians may want to have all employees sign a statement that they have been trained on privacy policies and procedures and that they agree to comply with these policies. When establishing policies, physicians should consider that procedures must be established to ensure that computer passwords, keycards, and other control devices are removed or deactivated when an employee is no longer employed by the practice.

Operations. The practice should consider limiting access to patient information to those individuals who need to know such information. Doing so may include differentiating the billing and clinical functions and limiting the access to information by job function. Billing clerks, for example, do not need to see clinical information.

Also, systems must be modified to force users to change their passwords periodically—monthly is typical—and to ensure that users are logged off after a period of inactivity, typically 5 to 10 minutes. These steps help to preclude unauthorized individuals from accessing information at unattended workstations.

In large group practices, it may be necessary to segregate the billing clerks and clinical staff, so that employees not

directly involved in treating patients do not have access to clinical information.

In multi-physician practices, systems may need to be modified so that only those physicians listed as primary care or referral physicians have access to a particular patient's records. Physicians do not have the right to indiscriminately browse through all patients' records.

In some offices, physical changes may be required so that patients, family members, and others not involved in treating patients, cannot observe computer screens and see restricted information. Also, if patient information is communicated over open communication systems, then the information must be encrypted.

Applying the Standards

The regulations are inconsistent in that they apply only to patient information that has been entered into or processed by electronic systems. Patient information that is handwritten or typed and has never been electronically processed is not covered by the current regulations. In practice, however, providers should treat all patient information as though it is confidential. Within the next 12 months, experts expect the federal government to expand the confidentiality standards to include all patient information.

A key aspect of the HIPAA reforms is to allow for reasonable application of these standards within practices of all sizes.

The penalty for unauthorized disclosure of patient information for profit, sale, or barter ranges from fines to possible jail terms. Therefore, physician practices should initiate a comprehensive effort to comply with HIPAA. The regulations are being published through this year, and all practices must be fully compliant by the end of 2002. ■

Joseph Pokorney is a senior management consultant with Superior Consultant Co., Southfield, Mich., who specializes in HIPAA compliance.

MD OPTIONS.com



Our FREE online resource includes:

- ▶ A complete database searchable by keyword, subject, or issue
- ▶ Tools to develop and implement strategies to build your practice
- ▶ Interaction with experts on all aspects of the Business of Medicine™
- ▶ Links to business resources such as group purchasing, practice management, marketing, and CME
- ▶ E-mail updates on the latest developments in the Business of Medicine™

vpmanager.com is an interactive site providing free "first line" consulting services to the small and medium-sized physician practice.

E-MAIL UPDATES

Let **MDOPTIONS.com** come to you! **MDOPTIONS.com** can keep you up-to-date automatically on the latest developments in the Business of Medicine™. You can sign up at **MDOPTIONS.com** or fill in your name and e-mail address below and fax it to us at 973-316-5989.

Name: _____
E-Mail: _____


TOLL-FREE LINE **888-457-8800**

We are available to answer questions on the Business of Medicine™. This service is free to our readers.

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

November 15, 2000

 Premier Healthcare Resource
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

BULK RATE
U.S. POSTAGE
PAID
SMITHTOWN, N.Y.
Permit No. 15

Supported by
an unrestricted
grant from



U.S. Pharmaceuticals