

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Group Learns to Cope After Losing Capitated Contract

Many of the nation's largest health plans are moving away from prepaid, capitated payments to fee-for-service reimbursements. That may be good news for physicians who complain that capitation payments are too low to allow them to make a profit, but the loss of capitated contracts may not be good for physicians who have come to rely on prepayments as a steady and reliable stream of income.

One multispecialty medical group experiencing financial difficulties from the loss of capitation is Physician Associates of Florida, in Orlando. PAF offers family practice, internal medicine, obstetrics and gynecology, and pediatric services. The problems it faced as revenue declined and the solutions it put in place offer important lessons for physician groups nationwide.

Corporate Transition

"Some groups with a substantial amount of their income in capitated contracts want to stay with capitation," says David Gans, director for practice management resources for the Medical Group Management Association (MGMA) in Englewood, Colo. "Capitation can be very profitable for groups providing quality, cost-effective care, and it has the added benefit of predictable revenue."

PAF's troubles began in 1998 when

Prudential Insurance Co. of America, in Roseland, N.J., sold its Prudential HealthCare unit to Aetna Inc. in Hartford, Conn. The loss of the capitated contract with Prudential has been devastating to the lifestyle and damaging to the income of PAF's 80 physicians, says Dennis Buhring, PAF's chief operating officer.

The group's relationship with Prudential began in 1983. By 1998, its contract covered 130,000 commercial HMO members and 9,000 managed Medicare members. "All our services were exclusive to that one payer," Buhring says. "We were known in the community as the PruCare docs."

The relationship was lucrative, Buhring says. He cannot disclose the capitated per member per month (PMPM) payment the group received because of contractual restrictions, but the group was well paid during this time, he adds. A wide range of services fell within the capitation rate, including laboratory fees; X-rays; and mental health, hospitalist, and ob-gyn care. "We received bonuses for attaining medical loss ratio targets," he says. The medical loss ratio is the difference between the cost of delivering care and the amount of money taken in by a health plan. When a medical group saves a health plan money, its contract with a payer may call for bonuses and an increase in

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What Physicians Can Learn From Lawyers

As reimbursement rates decline, physicians may want to take a billing lesson from lawyers. Attorneys charge for telephone calls and e-mail, billing in 15-minute increments.

Michael Morris, MD, an ear, nose, and throat specialist in Washington, D.C., recently sent me a communication saying that physicians can legitimately charge for out-of-office phone consultations, using the following CPT codes: 99371 (phone consultations with a patient or with someone managing a patient's care), 99372 (phone calls to initiate therapy), and 99373 (phone calls related to coordinating complex services of several health professionals working on a total patient care plan).


Physicians should call their insurers to determine what they can charge for telephone conversations. It's also a good idea for physicians to inform patients that they will be billed for out-of-office phone consultations and to include the billing policy on patient registration forms, Morris adds.

Stephen Poole, MD, a professor of medicine at the University of Colorado in Denver and chairman of the American Academy of Pediatrics division of telephone care, says that about 1% to 2% of pediatricians currently charge patients for after-hours calls. A recent survey at the State University of New York at Albany found that only five out of 500 doctors were charging for some phone calls, but 70% would like to. The Albany study suggested, on average, a fee of about \$9 for a phone call; other studies have indicated parents would be willing to pay \$10 to \$20 to reach doctors at night. For most physicians, phone calls represent as much as 30% of patient-physician encounters, and in pediatrics the number can rise to 48%, says the American Academy of Pediatrics.

Neil Baum, MD, a urologist in New Orleans, has never charged for a telephone consultation but believes that some patients would be receptive to the idea. Several years ago, his practice did a follow-up study of 100 patients diagnosed with benign prostatic hypertrophy. Nurses followed up on 50 patients by telephone, while the other 50 patients returned to the office for follow-up care. Patients preferred the phone follow-up and would be willing to pay for it, Baum says.

Physicians may prefer to answer questions by e-mail. Some 15% of physicians communicate with patients in this way. Other physicians provide Web sites that offer patients the option of paying for e-mail consultation time.

The message is clear: As income declines, physicians are well within their rights to charge for the time they spend on the telephone and sending e-mail.



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Expert Explains How Practices Can Offer Health Promotion

By Richard L. Reese, MD, editor in chief

As the focus on health promotion and disease prevention continues to spread throughout health care, many physicians are seeking to offer these new services to patients. But too often discussions with patients about health promotion are ineffective or do not occur at all, since the time physicians have to spend with patients is limited and their medical training has emphasized treatment over prevention.

A new book can help physicians become more effective in dealing with the issue of health promotion. *Talking About Health and Wellness With Patients: Integrating Health Promotion and Disease Prevention in Your Practice* (Springer Publishing, New York, 2000), by Steven Jonas, MD, discusses 10 concepts of health promotion and wellness that physicians and other medical professionals should understand in order to help their patients implement the health promotion and disease prevention behavioral changes necessary to improve health.

"I hope the book will assist medical professionals in helping their patients and clients to become healthier," Jonas says. The author of 10 books, Jonas has edited or co-authored 12 others on personal health promotion, health policy, and national politics.

He is the founding editor of the Springer Publishing Co. series on medical education and associate editor of *Preventive Medicine* magazine. Jonas also is a triathlete and a certified professional ski instructor. He has been working in the field of personal health and wellness for more than 15 years.

Substantive Concepts

"There is a significant amount of sound scientific evidence proving that healthy behaviors improve health and extend life span by reducing health risks," Jonas says. The 10 most important health-promoting behaviors, according to Jonas, are regular exercise, weight management, healthy eating habits, not smoking, not using prescription drugs on a non-prescription basis, safe use of recreational mood-altering drugs, stress management, safe sex, personal safety, and periodic health risk appraisals.

"Through what I've read, my own personal experience as an athlete, and my conversations with other recreational endurance sports athletes, I have formed hypotheses about how to achieve success in health promotion and behavioral changes that are included in the book," Jonas explains.

To be successful in helping their patients and clients become mentally

prepared for behavioral changes, physicians and other health professionals need to understand what Jonas calls the seven substantive concepts regarding health and wellness. "The medical professional needs to understand the principles of health and wellness," he explains. "Thorough mental preparation for change is the essential element of success that many contemporary simple behavioral health promotion programs leave out of their formulas. Certainly, physicians receive very little professional training on wellness and prevention, while some nurses do receive such training. Still, most health professionals focus on various aspects of sickness and how to direct or manage treatment."

First, health professionals need to understand the difference between "health" and "wellness," Jonas says. "The different definitions of health and wellness promulgated by various sources sometimes hide the fact that health and wellness are not the same," he explains. "The difference between them is crucial for health professionals to understand."

Health is a state of being that can be measured at any given time, Jonas says. "In other words, the state of a patient's health can be measured using various indicators, such as weight and height, body mass index,

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heart rate, blood chemistries, muscle tone, and mental status,” he explains. “Health is a condition at one point in time, and all of us go through different stages of health over time.”

Acknowledging History

In contrast, wellness is a process of being. “Wellness is the process of maintaining, improving, and promoting one’s personal health, which includes physical, mental, and social aspects,” Jonas explains. “A person can develop this process and, with opportunity, ability, and desire, can continue to develop it over the course of a lifetime.”

When physicians speak with patients about health promotion and behavioral changes, Jonas suggests they emphasize the importance of health-risk reduction rather than guaranteed outcomes.

The second concept for health professionals to understand is that multiple and varied factors affect each patient’s state of health. “In our society and in medical practice, if a patient comes in with an obvious health detriment—like obesity or a smoking habit—we focus solely on that particular aspect of the patient’s life,” Jonas notes. “But attention to other factors can lead to health improvements. For example, an overweight person can become healthier, even in the absence of weight loss, if he or she starts exercising regularly. Physicians should emphasize health improvements that relate to all aspects of a patient’s health.”

In addition, a focus on an unhealthy factor should not obviate the acknowledgment of healthy behaviors. “When a patient with a particularly unhealthy factor comes into a medical practice, the physician and the patient are both focusing on

that unhealthy factor,” Jonas says. “People tend to forget that almost everyone is doing something right. So if an overweight person is a non-smoker, the physician can acknowledge that positive behavior.”

Third, health has a natural history. “In medical school, we are taught about the natural history of disease, but virtually nothing about the natural history of health,” Jonas points out. “In most individuals, their state of health varies over time. Furthermore, their ability to make changes in their state of health—the changes that are under their control—also varies over time. Understanding this concept

enables the physician to say to a patient who resists change, ‘You are not ready to make a change now, but let’s revisit this issue in six months.’ People change over time, and their commitment to their wellness process changes over time as well. Just because someone is not ready to engage in a health intervention now does not mean he or she will not be able to do so in two or three years.”

Jonas cites his own story as an example. “I’m 64 years old, and in my 21st season of regular exercise,” he says. “I didn’t start exercising until I was 43 years old, and did my first triathlon when I was 46. Before that time, I was a thoroughly out-of-shape, moderately overweight, nonathlete. But the natural history of my own health led me in a different direction.”

The fourth concept is that many interventions can be considered when promoting wellness. “A smoker might not be ready to quit smoking, but he

or she might consider embarking on an exercise program to improve health,” Jonas says. “And, of course, by suggesting exercise to a smoker, a physician will be indirectly promoting smoking cessation, because an individual who gets hooked on exercise will eventually stop smoking for performance reasons.”

Keep It Simple

The key for health professionals is to find health-related interventions that an individual can embrace initially, and then move on to more difficult challenges. “Sometimes I see patients with many risk factors—they are overweight and out of shape—and they feel overwhelmed,” Jonas says. “So I start with something simple. Do they fasten their seat belts before they turn the key in the ignition every time they get into their cars? If not, then I prompt them to start with that health improvement intervention. If they do that already, then I try to find another aspect of personal safety that they can achieve.

“Have they installed nonskids under every movable rug in their homes?” Jonas asks. “Have they gone to the local fire department to get a list of where they should locate fire extinguishers in their homes? All of these interventions are health related. And they are under the patients’ control. Patients can be prompted to do something very simple. Then, once they have taken control of their health in a small way, they are more likely to want to try to change their behavior in larger ways.”

The fifth concept is that success in certain behavioral change endeavors must be conceived of as relative to what the individual can conceivably accomplish, rather than be based on absolutes. “For example, the physical abilities of individuals can range from those who walk three times a week to those who participate in triathlons,” Jonas states. “Similarly, success in losing weight is relative. If an individual

“Once patients learn the mental techniques for making one kind of behavioral change, they can transfer those techniques to other kinds of behavioral changes.”

—Steven Jonas, MD, State University of New York at Stony Brook

is 100 pounds overweight and loses 20 pounds, that weight loss is a success to be celebrated. So, while the desired outcomes for certain behavioral change efforts is an absolute—smoking or not smoking, or practicing safe sex or not—other changes, like weight management and regular exercise, have relative outcomes.”

Sixth, physicians should not guarantee that certain health outcomes will result from behavioral changes. “When physicians talk to patients about health promotion and behavioral change, they should emphasize risk reduction rather than guaranteed outcomes,” Jonas says. “As we all know, people who have never smoked even one cigarette may get lung cancer, and people who exercise every day may still die of a heart attack. At the same time, the two-pack-a-day smoker or the life-long couch potato can live to a ripe old age. The only thing that we can guarantee is a reduction of risk.”

Seventh, physicians should understand that achieving balance is the essence of healthy living and the wellness process. “We are looking for balance rather than perfection,” Jonas emphasizes. “We can never be perfect, but we can always get better. This is an important framework upon which to build health promotion efforts.”

Process Concepts

In addition to the seven substantive concepts, Jonas emphasizes three process concepts that are also important for health professionals to understand.

“The first process concept is that there is a common pathway to suc-

cess for most personal behavioral change efforts,” he says. “Physicians do not have to learn different mental routes for their efforts to encourage patients to exercise regularly, to attempt to lose weight or to stop smoking, to manage stress, to practice safe sex, to maintain personal safety, or to adopt other health improvement efforts. Once patients learn the mental techniques for making one kind of behavioral change, they can transfer those techniques to other kinds of behavioral changes.”

Getting Motivated

The second process concept is that motivation is a mental—not a physical—process. “One of the common phrases heard among health professionals with regard to health promotion is, ‘I’ve got to motivate that person,’” Jonas says. “But motivation is not some substantive object that can be implanted in a person’s brain. Motivation is a mental process that links a thought or a feeling with an action. When we say that a person is not motivated to do something, we mean that the link between the thought, ‘I’d like to lose weight,’ and the actions that are necessary to lose weight, does not exist. ‘Motivating someone’ means activating the motivational process; that is, helping patients to remove the barrier to that activation that exists in their minds, and helping them to maintain the connection between thought and action once it has been established.”

The third process concept is that a patient needs to undergo certain mental steps in order to become motivated to make a true behavioral

change. “These mental steps can create motivation—the link between the desire to change and the actions taken toward that change,” Jonas says. “Physicians should understand what needs to occur in the patient’s head if motivation is to be activated.”

Setting Goals

The most important mental step is goal setting, Jonas adds. “Goal setting is a process that is essential for mobilizing motivation,” he explains. “If a person understands what he or she wants to do and why it is important to do that, the chances of success increase significantly.”

It is also important that patients and their physicians acknowledge that making behavioral changes will require some sacrifices. “When regular, long-term exercise is the goal, for example, patients are giving up time previously spent on other activities on a permanent basis,” Jonas says.

“With weight loss goals, patients will be giving up certain foods that are very tasty,” Jonas continues. “With smoking cessation goals, patients will be giving up the tranquilizing effect of nicotine. These sacrifices are inherent in behavioral changes, and patients have to decide through self-assessment whether those sacrifices are worth the benefits of better health. As health professionals, we will be much more successful at health promotion if we help our patients and clients go through that process of honest self-assessment.”

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

Physicians Address Revenue Processes

By John W. McDaniel, MHA

All physicians want to improve their practice efficiency and reduce their costs while also improving the quality of care they deliver. In reaching for this goal, many have become what some observers call high-performance physicians. These professionals continually review, develop, and implement improvement opportunities in five key areas of financial and operational performance: reimbursement systems, billing and collections processes, accounts receivable management, operations improvement, and practice growth.

A previous article in this series on high-performance physicians discussed how these high-performers are constantly exploring ways to enhance practice reimbursement, particularly through coding compliance and managed care contracting. But in addition to coding compliance and managed care contracting, high-performance physicians focus on revenue management techniques that involve billing and collection processes. For underperforming group medical practices, patient billing, collections, and accounts receivable management are among the most common areas of poor performance.

Office Operations

Managing information during the patient visit is important for every

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practice. In the front office, physicians and office staff need to collect accurate and timely information so that they can submit the data promptly for patient billing. The patient billing cycle involves patient scheduling and registration; insurance verification and eligibility; over-the-counter collection of copayments, deductibles, and outstanding balances; coding validation; charge entry; and referral management.

In the business office, physicians and office staff are involved in initial billing and rebilling. Initial billing includes prebilling edits, electronic claims submission and validation,

done timely and accurately.

When seeking to improve their billing and collection processes, high-performance physicians use the 80-20 principle. In most medical practices, approximately 80% of patient revenue comes from 20% of the major payers of the practice. Following this principle means that physicians and office staff may want to put most of their efforts into the 20% of payers that represent 80% of practice revenue. At the same time, physicians cannot neglect the other 80% of payers. For all payers, physicians and office staff must constantly review various key financial and

For underperforming medical practices, patient billing, collections, and accounts receivable management are among the most common areas of poor performance.

and claims review procedures (both electronic and hardcopy). Rebilling includes account follow-up, secondary insurance verification, rejections, and denials. The staff also does payment posting, which includes tracking payments from insurers and monitoring and managing claims denials and rejections.

Physicians and staff in the business office also monitor payer contract compliance and manage patient self-pay accounts and patient payment plans. In addition, they manage accounts receivable. Managing accounts receivable involves monitoring the performance of collection agencies, as well as reviewing and approving write-offs for charity, physician and administrative requests, and aged accounts receivable reconciliations. They also must ensure that filings with insurers are

operating indicators, such as gross and adjusted charge or collection ratios, to determine the efficiency of the office staff and the payment turnaround time for insurers and patients.

Ensuring Payment

Validating reimbursements received from managed care organizations is important, since personnel at these companies can make mistakes. In fact, practices that validate reimbursements often find they are not always reimbursed at the amounts for which they have contracted. To ensure that they are being paid accurately, physicians may want to consider getting an editing module that can be used with practice management software. The editing module can perform periodic audits to double-check reimbursement rates from all major managed care companies.

Another important aspect of billing and collections involves credit balances. The Office of Inspector General of the federal Department of Health and Human Services strongly encourages that physicians refund patient balances within 60 to 90 days. Failure to do so may subject the practice to problems in the event of a government audit.

Business Operations

In the business office of a high-performance practice, physicians and staff frequently review and revise written financial policies. They encourage the practice to use information systems for appointment scheduling. They implement formal training programs for front-end clinic personnel. They develop performance monitoring benchmarks and procedures for following up on claims denials each month. And they conduct charge validation studies to ensure accurate contract reimbursement.

What's more, it is not unusual for high-performance practices to conduct quarterly in-training sessions on office practices for all physicians and appropriate clinic staff, as well as review their professional fee schedule once each year.

In the area of patient registration, these physicians monitor the reasons for rejections and denials, develop monthly targets for over-the-counter collections, initiate an effective patient recall system, and establish monitoring systems that track cancellations and patients who do not show up for their office visits.

Since all practices will be affected by the Health Insurance Portability and Accountability Act, all physicians should consider revising their patient registration forms so they comply with HIPAA.

In the area of billings and collections, high-performance practices develop systems that allow them to monitor the performance of collection agencies at least once each quar-

ter, as well as to track compliance with patient payment plans, monitor credit balances to ensure prompt refunding of patient overpayments, and implement formal training programs for front office staff to decrease error rates for claim rejections and denials. They also work to ensure consistent performance by office staff

make telephone inquiries to the appropriate insurers. They also may use the processes outlined by the state insurance commissioner to report delinquent insurers.

Physicians seeking to improve performance must develop internal control procedures. One procedure involves forming a chart audit com-

If claims remain unpaid after 30 days, staff make telephone inquiries and report delinquent insurers to state authorities.

on insurance verification and pre-authorization processes.

Physicians who want to adopt the procedures of their high-performing colleagues in the area of accounts receivable management should develop segregated aged trial balances by major payers. Doing so will help to facilitate follow-up with any insurer that has an outstanding account balance in excess of 30 days. Physicians also should develop monthly procedures for auditing accounts receivable and for following up on claims denials. Office staff should keep notes on each account in order to ensure that each one is reviewed properly each month. When delinquent account balances become excessive, they should consider using small claims court to ensure payment.

When payments are slow, physicians should use their state's prompt payment laws. To use these laws effectively, a physician needs to have good records on charges and collections from each payer. These records should show areas of low reimbursement or delayed payments from major managed care companies.

High-performance physicians take advantage of prompt payment laws by following up on claims after 30 days. If these claims remain unpaid, these physicians or their office staff

mittee that can perform quarterly random sample audits to ensure that the practice is in compliance with federal and state regulations on reimbursement and coding procedures and to ensure that the practice is capturing all appropriate charges.

In addition, all physicians should consider developing a compliance program that focuses particularly on proper coding, documentation, and medical necessity.

Benchmark Data

The better performing practices collect copayments and deductibles at the time of service from 93.55% of all patients, according to the Medical Management Group Association, in Englewood, Colo. Other practices do so at a rate of 71%, MGMA says. For the average primary care practice, as much as 20% of revenue results from such collections.

A review of the procedures high-performance physicians use for upfront collections, initial billing and rebilling, and claims denial and rejection follow-up makes clear why these physicians enjoy increased collection activity. While the common thread of poor performance in medical practices is usually a weak billing and collection process, this process is one of the strong practice areas for high-performance physicians. ■

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capitated rates. That was the case for PAF with Prudential. “We didn’t achieve our bonuses by rationing care, but by providing the appropriate care,” comments Buhring.

The Prudential bonuses allowed PAF to hire enough physicians to keep the group’s nine offices open evenings and on Saturdays. The doctors worked about 35 hours a week and had six weeks of paid vacation each year. “In terms of the hours worked, our physicians were in the MGMA’s 50th percentile,” Buhring says. “But in terms of compensation, they were in the 90th percentile.”

Declining Numbers

The Prudential-Aetna deal was finalized in August 1999. As Prudential’s contracts with employers ended, many signed contracts with health plans other than Aetna.

“Prudential had been the largest health insurer in the area, by far,” Buhring explains. “When it became time for employers to renew their contracts, Aetna didn’t offer the same services Prudential had offered, and some other HMOs were offering better services at a more reasonable price. We went from 135,000 to 35,000 Prudential lives by the beginning of this year.” Aetna continued to offer a Prudential product, but with significantly reduced and more costly benefits.

Two years ago, PAF began to develop new relationships with health plans serving employers in the area, negotiating with Aetna, Humana, UnitedHealthcare, and several other HMOs—none of which paid as well as Prudential. And many of the insurers, including Aetna, were moving away from capitated contracts to traditional fee-for-service contracts, paying for procedures after they were performed—sometimes months later.

The group went from a 100% capitated reimbursement system in 1998 to less than 40% by the beginning of this year. That figure is expected to

drop to 30% by the end of December, says Buhring. A sharp drop in prepayment led to several problems, Buhring says. Since it had been making a single PMPM payment, Prudential did not require medical procedure coding, for example. Therefore, the group had no experience coding insurance claims. “The physicians found it difficult to code,” Buhring explains. “They found it confusing, and we also found it hard to find the time to provide the necessary education they needed to code properly.”

Billing became critical to the group’s operation. “To get paid for the work we did, we found that we had to submit the claim within 90 days of rendering the service,” Buhring says. “Getting the complete critical information from our nine health centers to a central billing office was difficult. Our staff was overwhelmed, and it was overworked.”

Recognizing that it needed to cut costs, the group laid off about 50 staff members in 1998 and 50 more in 1999, saving about \$3 million each

Despite the longer hours, physician income fell. Morale was further damaged by poor communication.

“Our board of directors lacked key business training, many of the physicians lacked leadership training, and many did not trust management,” he adds. “Effective communication proved challenging. The practice lost some very good physicians who said they did not want to embrace an owner’s mentality.”

Seeking Solutions

With both income and morale sinking, PAF took two critical steps to reverse course, Buhring says. First, the group began to raise operating capital, which had not been important under capitation. The group had never developed a relationship with a bank; and until its troubles began in 1998, it had not retained earnings.

The group considered selling the practice to a physician practice management company (PPMC) or affiliating with a local hospital, but neither strategy seemed attractive.

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year. But layoffs meant physicians had to work more hours and see more patients. The group did not want to end the Saturday and evening hours that were an important source of revenue, so physicians began working 45-hour weeks or longer.

“Our doctors had become used to the idea that good medicine could be provided only with a staffing ratio of six to one,” Buhring says. “They had to learn to provide the same level of care with less support and to raise their productivity.”

“Most PPMCs were facing serious financial problems of their own, and none of the discussions with the hospitals were productive,” Buhring says. “In the end, we decided to remain independent. We caught a break in that the Prudential meltdown happened over a two-year period, so we were able to retain some earnings for working capital, but the situation was, and remains, very tight.”

By the end of last year, the group had secured a \$3 million line of credit through Merrill Lynch, a brokerage

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and investment firm in New York. "We'd had a good relationship with Merrill Lynch for several years because it handled our retirement accounts, and it was familiar with our business plan and the quality of care we provide," says Buhring.

The second critical step was to increase patient membership—a pro-

blem that pointed to a serious identity issue. "Aetna at that time did not enjoy a good reputation in the Orlando market," Buhring says. "As employer groups renewed their insurance, other health plans were selected. This by itself should not have been a problem, because by the end of 1999, we had developed relationships with virtually all the regional payers. The problem was the patients who were members of those plans. We surveyed people at random and found that they thought we were part of Prudential, that we were actually PruCare. So did employers. They thought that if they lost PruCare, they had to find new doctors."

"The physicians found it difficult to code, and we also found it hard to find the time to provide the necessary education they needed to code properly."

—Dennis Buhring, Physician Associates of Florida

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Marketing Success

To combat the problem, Buhring began doing presentations for local employers to encourage them to recommend the practice to employees. "That was a successful effort," he says. "We began to see human resources department referrals from those companies." And the group began advertising on the radio, in newspapers, and even on billboards. Last year, it spent more than \$300,000 on such advertising and plans to spend about the same amount in 2001, says Buhring.

When a physician left the practice, the group often lost members. That physician turnover made changes in compensation methods more palatable, Buhring says. "We found that we could not meet our physician productivity targets with physicians being salaried," he says. "We knew a change had to be made."

The current compensation system calls for primary care physicians to be paid based on a fixed pool of dollars. "To provide an incentive for physicians who work harder, we developed a compensation system to reward higher productivity levels," Buhring says. "The pool is allocated among the PCPs based on 50% guaranteed salary and the rest based on the physician's share of relative value units."

The group's ob-gyns offer a stunning example. Because the ob-gyns lost money in 1999 and 2000, the group required them first to pay for all direct costs, indirect costs, and a share of the group's retained earnings. What remained was then divided among the ob-gyns. Several of them suffered reductions in pay of 17% to 25%. "Once the ob-gyns learned that their income was directly tied to their productivity, they made changes in the way they practiced," Buhring explains. "They increased their hours in the office and reduced their vacation time. In six months, they had increased their billings and restored their compensation levels to what they were before the compensation changes took place."

The changes have helped to turn around the practice. As of September

2001, the group's overall revenue was about 5% below the high point it reached before 1998. PAF now has contracts with 55 different payers, and it serves almost 150,000 patients.

"We are still being forced to look at every position in the company," Buhring says. "Reductions in force are again taking place. This year we reduced expenses by \$1.8 million." Primary care compensation is still evolving. This month, the group anticipates moving to a compensation system based on individual physician collections. "Each physician will be required to pay his or her portion of direct expense, indirect expense, and retained earnings out of his or her collections," Buhring says. "The monies remaining will belong to the physician."

Ancillary Services

At the same time, PAF will continue to focus on generating new revenue. It is developing ancillary services, such as physicals for company executives. Also, it is considering adding medical specialties, opening new offices to generate additional revenue and to spread fixed costs over a wider base, purchasing the buildings it now rents, selling management services to other physicians, and developing a new buy-in strategy for new physicians and a new exit strategy for retiring physicians.

Despite the changes, staff morale and compensation remain difficult issues, Buhring says. Nevertheless, he believes the group has weathered the worst and good days lie ahead. In-house patient satisfaction surveys show the group is getting very good and excellent responses averaging 98.2%. "We continue to focus on quality and access, and that holds us in good stead," he says. "It's been one hell of a ride. We're getting closer to full recovery, but we're not there yet."

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

Here's How to Get Ready for HIPAA

By Edward Blonski

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes three separate sets of regulations that will affect physician practices. These regulations cover transaction formats and content, security, and privacy of health care data. The transactions and privacy regulations have already been issued; the security rules are expected to be issued by the end of this year.

The HIPAA regulations apply only to information that identifies an individual, or in situations where there is a reasonable basis to believe that the information could be used to identify an individual. The regulations cover all forms of individually identifiable information, including paper-based and oral communications. The regulations also list identifiers that, when removed from the data, create "de-identified" information not subject to HIPAA regulations. The regulations do not preempt any state laws that are more stringent or more protective of consumers' security and privacy than the federal standard.

Every physician will feel the effects of having to comply with HIPAA's regulations, and some physicians will need to change their office practices

in more ways than other physicians in their efforts to comply. Because of the effect HIPAA compliance will have on office practices, all physicians would be well advised to begin familiarizing themselves with the law

tions. "In pharmacy today, it can take just 10 to 15 seconds to adjudicate a claim," Braithwaite explains. "Eligibility [verification] in a physician office setting should not take nearly as long as a claim."

To comply with HIPAA, some physicians will need to change their office practices in more ways than other physicians.

and the regulations well before compliance is mandatory.

Notwithstanding any cost savings that may be realized, Bill Braithwaite, MD, PhD, senior adviser on health information policy, office of the Assistant Secretary for Planning and Evaluation for the federal Department of Health and Human Services, thinks that the HIPAA regulations will have a significant effect on the way physicians do business. He cites a comparison between office visits as they are currently conducted and how they should occur under HIPAA.

Electronic Claims

Today, when a patient arrives for an appointment, office staff often need to confirm the patient's eligibility with the insurer via telephone, he notes. This process is especially true when the physician is not the patient's primary care provider. A standardized electronic claims system should allow eligibility verification within seconds or "at least as fast as by telephone," depending on how sophisticated the systems are in the physician's office, Braithwaite says.

The authors who drafted HIPAA used the model developed by the pharmaceutical industry in that industry's use of electronic transac-

In addition, under HIPAA, claims could be submitted to the payer before the patient leaves the office. Electronic transfers will increase practice efficiency, Braithwaite says. There will be more time for the patient and the physician to spend together, more time for staff to tend to other office tasks, and quicker payments for physicians.

Standards and Codes

The transaction standards include the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 transaction sets (version 4010) for claims-encounters, attachments, enrollment, disenrollment, eligibility, payment-remittance advice, premium payments, first report of injury, claim status, referral certification-authorization, and coordination of benefits. Under HIPAA, physicians can use a clearinghouse to comply with the ANSI ASC X12 transaction sets.

The code set standards for diagnosis and procedure codes include those defined under the ICD-9-CM and Common Procedure Coding System from the federal Centers for Medicare and Medicaid Services (CMS). Pharmacy transactions will use the code set specified by the National Council of Prescription

Edward Blonski is a consultant with Superior Consultant Co. Inc., in Southfield, Mich. He has more than 40 years of experience consulting on information systems and is an expert on strategies to comply with the Health Insurance Portability and Accountability Act. Readers may contact Blonski at 248/386-8300, ext. 8534 or by e-mail at edward_blonski@superiorconsultant.com. More information on HIPAA is available on our Web site (see page 16).

Drug Programs (NCPDP).

The entire health care industry will be moving from the UB-92 and the HCFA 1500 to the ASC X12N 837 for medical, dental, and institutional claims. The NCPDP telecommunication standard format version 3.2 will be used for retail drug claims.

Transaction Regulations

Currently, about 400 different formats exist for the online processing of health claims. The HIPAA transaction rules will require that everyone use the same format to transmit health-related information. Claims submission, claims status reporting, referral certification and authorization, and coordination of benefits will be affected. Practices will have to ensure that their software vendors have implemented the required HIPAA changes so that they can send and receive information using the standard formats.

Given that procedure coding is complex and ambiguous, many physicians are confused or concerned about how to transmit data uniformly. The AMA is updating the CPT (Current Procedure Terminology) manual and plans to release CPT-5 within about two years. The express purpose of CPT-5 is to eliminate ambiguity.

"CPT-5 will be inherently structured to support easy electronic interface and coordination with other computer-interpretable health care terminology systems, electronic medical and health records, other fields on the administrative record, and analytical databases of varying levels of detail," the AMA says on its Web site (www.ama-assn.org). Ideally, CPT-5 should result in fewer denials

of payment, which in turn will decrease accounts receivable days for physicians and hospitals.

Converting to the standard ICD and CPT codes will be mostly the practice's responsibility, and physicians will need to remember that using local codes (which some physicians have used with insurers) will no longer be allowed. Although physicians will find software vendors to offer assistance, most practices will need to determine the government's schedule regarding standard transaction formats. When using a clearinghouse, the clearinghouse will convert the formats for the practice.

The decision to use a clearinghouse is largely a financial one. A clearinghouse can ensure a practice's compliance with the regulations for standard formats, but there is a cost for this service, which is usually determined by the volume of transactions, and additional costs may be incurred for the clearinghouse to use the new formats.

Confidentiality and Security

The privacy regulations establish a basic rule: "Covered entities" may not use or disclose "protected health information" (PHI) except as permitted by the regulations. Any permissible use or disclosure must be of the minimal amount necessary to achieve the purpose for the use or disclosure. Covered entities must protect an individual's medical records for the life of the individual and for two years after his or her death. The privacy regulations cover all forms of clinical information, including electronic and oral communications, and paper records.

The draft security regulations are

broken down into four discrete areas:

- Administrative procedures—documented, formal security procedures for implementing security measures and oversight of personnel behavior as it relates to the protection of electronic health information
- Physical safeguards—safeguards that protect physical computer systems, buildings, and other related equipment from natural hazards, as well as intrusion from unauthorized personnel
- Technical security services—processes that are necessary to control and monitor access to electronic health information
- Technical security mechanisms—processes necessary to prevent unauthorized access to data transmitted over a communications network.

Determining Compliance

Physicians seeking to determine if their practices are compliant with HIPAA's regulations may need to take the following steps:

- Educate themselves and their staff about the extent of the regulations
- Evaluate their existing procedures and systems surrounding privacy and security
- Review their personnel security and privacy policies
- Assign a staff member to be responsible for security (such as a chief security officer) and privacy (such as a chief privacy officer)
- Determine whether the practice's software can comply with the internal audit trail regulations
- Examine the practice's physical requirements, ensuring that rooms or closets for equipment and records are locked

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Electronic transfers will allow more time for the patient and the physician to spend together, more time for staff to tend to other office tasks, and quicker payments for physicians.

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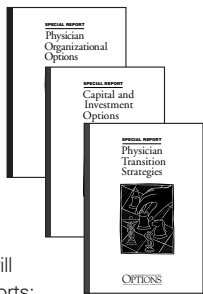
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- Create a training program for physicians and employees
- Determine whether there is a need for agreements regarding the "chain of trust" with business associates who help deliver medical care or process billing.

For small medical offices, the requirements appear overwhelming. HHS's Notice of Proposed Rule Making specifically addresses this concern in a section that explains how offices of one to four physicians might implement the security requirements.

CMS suggests that a consultant or the practice management system vendor evaluate and certify the practice's security compliance procedures during assessment and policy and procedure development. Even small offices will need to execute the items identified earlier: personnel

Whether there will be a net positive return on HIPAA compliance investments in health care remains to be seen.

security policies, assigned security responsibility, compliant hardware and software with internal audit trail capability, and physical plant changes. Employees must be trained and oriented to information security; chain-of-trust agreements with claims processors must be written; and each of these measures must be documented, maintained, and kept current.

Can HIPAA reduce or eliminate privacy fears? Ongoing and well-publicized virus assaults have demonstrated the vulnerability of information systems. Patients are worried about the effect of electronic transmissions on their ability to keep their medical information secure. The use of the Internet is becoming more prevalent, and e-mail communication with patients will continue to grow in the coming years. All of these trends pose potential threats to both privacy and security. When fully implemented, the privacy and security regulations are aimed at minimizing these threats.

Many physicians wonder whether they will ever get a net positive return on their investment in HIPAA compliance. This question has yet to be answered. To date, there has been no solid analysis of the possible financial benefits of HIPAA. Certainly, the regulations for standard transactions and code sets have the potential for reduced accounts receivables and significant reductions in claims processing costs. Aside from the financial implications, the privacy and security regulations, when fully implemented, will allow for a stronger confidence bond between patient and physician. ■

Physician-Author Outlines Plans for Workable Health Reform



George D. Lundberg, MD, is editor in chief and executive vice president of Medscape, an Internet medical information provider. Previously, he practiced as a pathologist before serving as editor of the *Journal of the American Medical Association* for 17 years. Lundberg is on the faculties of Northwestern University in Chicago and the School of Public Health at Harvard University. He is co-author (with James Stacey, formerly director of media and information services for the AMA in Washington, D.C.) of *Severed Trust: Why American Medicine Hasn't Been Fixed* (Basic Books, New York, 2000). Editor in chief Richard L. Reece, MD, conducted this interview.

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Q: Your career was in full swing in the 1970s, when the U.S. Department of Defense created the Internet and personal computers entered the scene. So computers have been part of your career for nearly 30 years, haven't they?

A: Yes. Actually, I've been working with some form of computers since 1963, but it wasn't until the mid-1990s that I became involved in working with the Internet by helping to create the "medical" Internet. So I have been a part of the medical Internet from the beginning.

Q: Recently, Medscape signed a contract with one of the country's largest employers, General Motors, to offer handheld computers with Internet connections to physicians who take care of General Motors' employees. Tell us about that project.

A: Outside of the federal government, General Motors is the largest employer in the United States. GM, which is self-insured for health insurance, has deep concerns about the cost of health care, particularly the cost of prescription drugs, which has been increasing rapidly. We worked out a deal with GM whereby 1,000 physicians in a pilot test in Shreveport, La., and in Oklahoma City, Okla., would receive Palm V handheld professional digital assistants free of charge.

GM's formulary was loaded into these devices. Using the handheld computers, physicians are guided toward selecting the best drug at the best price, at the right dosage, and with consideration for drug interactions. The doctors can transmit these requests to the pharmacy electronically, which would eliminate the errors that are so common in handwritten prescriptions. We have included control groups in the pilot study, because our goal is to create a prescribing system that is both cheaper and safer, and we want to prove that case.

Q: Why is this pilot project important?

A: Physician use of the Internet will be a large part of the future. Handheld computers may be

the path to that future because they will not interfere with a physician's normal practice style. These devices are mobile, so they do not tether doctors to desktop computers. Many companies have made the same prediction about the future of physician use of the Internet, which is why there are 160 companies offering handheld computers to physicians. Some of these companies will survive, and some will not.

Q: Medscape also has a clinical component with an electronic medical record. Do you view the electronic medical record as a worthwhile and useful productivity device for practicing physicians?

A: Yes. A recent addition to our company was MedicaLogic, an electronic medical record company. Its main EMR product, called Logician, has 19 million patient records on it, which gives it by far the largest EMR market share in America. EMRs are already a reality for the 11,000 clinicians who use our system, and use of EMRs will become the dominant way of life in a few years. The only questions that remain unanswered are the speed at which EMRs will be implemented, how complex the ultimate system will be, who will be the major vendors, and where the money will come from to

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"Physician use of the Internet will be a large part of the future. Handheld computers may be the path to that future because they will not interfere with a physician's normal practice style."

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get routine EMR use actually started.

There is no question that the Institute of Medicine reports—the 1999 report on patient safety and the 2001 report on the quality chasm—were powerful stimuli for EMRs, whether they are enterprise-based or Internet-based. Most were enterprise-based at first. The Internet-based ones have been slower to develop and more complex to implement, although they tend to be simpler in actual content.

Many people in the health care field have expressed concerns about security and privacy of information when connected electronically. Patients, as well as congressional representatives and physicians, have also expressed such concerns.

Medscape was pleased when the Clinton administration issued the final regulations for the Health Insurance Portability and Accountability Act (HIPAA). In the health care field, we all know that there are no secrets in hospitals, and technology will not uncover any. In fact, it is easier to have security with electronic records than it is with paper records because access to the electronic records can be monitored and password protection for information is possible. Electronic access to secure information, while maintaining privacy and confidentiality, is the solution rather than the problem.

Q: *The original HIPAA promised “administrative simplification.” Do you believe that HIPAA will simplify administration?*

A: There is nothing simple about HIPAA, and its implementation will cost a lot of money.

However, U.S. Secretary of Health and Human Services Tommy Thompson, in his recent clarification, inserted a significant dose of common sense into the HIPAA regulations.

Q: *What motivated you to write Severed Trust, and what responses have you received to it?*

A: The ideas for the book had been incubating in my head for many years while I was the editor of JAMA. When the AMA fired me in January 1999, a literary agent in New York contacted me and pitched a book deal. I was receptive and signed a contract.

Shortly thereafter I was offered the position at Medscape and became extremely busy, so it became clear that if I was going to write a book I had to get someone to work with me. By chance, James Stacey, a journalist with whom I had worked at the AMA, retired from the AMA about that time. He and I worked together on the book.

Severed Trust is not a personal memoir, but rather a medical memoir; it is not about what has happened to me, but rather what has happened to medicine in the 50 years since I started working in the health care profession. We developed the theme that the U.S. medical profession is in grave trouble. I have witnessed a disastrous severance of trust, one that has led to runaway costs, constrained access, skewed coverage, and diminished quality. We cannot fix the system until we restore trust in medicine. The hardback version of the book has been a success, and a paperback version will come out early next

year. New editions of the book will include an additional chapter, which will attempt to define the parameters of the next iteration of the U.S. health care system.

Q: *The May 23/30 issue of JAMA includes an article, “The End of Managed Care,” by James C. Robinson. In the article, Robinson says that the protagonists of managed care, particularly for-profit managed care, are in full retreat and that we are on the edge of a new consumer-driven system.*

A: Nonprofit managed care can continue to develop and do decent work. And I agree with Professor Robinson that for-profit managed care in America is in decline, but, in fact, the for-profit system is not gone. It’s like a decomposing corpse. It will get very smelly and messy until we figure out how to replace it with something that we hope will be better. And I believe that the Internet will be a central part of the new system empowering patients to take charge of their health.

Q: *There is a new concept in health care, called “point-of-care medicine,” that is emerging. Under this concept, the Internet will enable a physician and a patient to access scientific evidence during the office visit that will guide treatment decisions. Do you see this online care as a possibility?*

A: I see it as already existing in many settings, although it’s not simple. Many alert physicians already practice point-of-care medicine, while others are well on their way to doing so. Even now, up-to-date information is available at the point of care, sometimes on handheld computers but more often on

“The only questions that remain unanswered are the speed at which EMRs will be implemented, how complex the ultimate system will be, who will be the major vendors, and where the money will come from to get routine EMR use actually started.”

“Physicians should be guiding their patients to the better Internet sites so that patients can access the best information to help them in making proper treatment decisions.”

desktop computers. But much of that information is confusing, and Web site quality is uneven. Physicians should be guiding their patients to the better Internet sites so that patients can access the best information to help them in making proper treatment decisions.

Q: *You’ve served in the Army, in academia, and as an editor. Tell us more about your varied career.*

A: I served in the U.S. Army for 11 years and left as a lieutenant colonel during the Vietnam War. The Army paid for my senior year of medical school, and I served my intern year at Tripler Hospital in Honolulu, four years of pathology residency in San Antonio, two years of pay-back time in San Francisco at Letterman Hospital, and three years as chief pathologist at William Beaumont General Hospital in El Paso, Texas.

In 1967, I joined the faculty of the University of Southern California Medical Center in Los Angeles and stayed there for 10 years. My career at USC was fascinating. Drug-induced disease was suddenly widespread. We treated as many as 50 people a day in the emergency department for drug overdose or other drug problems. We built a large, sophisticated clinical toxicology laboratory so that we could handle the Southern California drug epidemic.

In 1977, the University of California at Davis beckoned with the possibility of my being chairman of pathology there, and I accepted. At UC Davis, we built a creative curriculum for medical students and created a residency program that was competency-based. From 1977 to

1982, I also served as director of laboratories at the UC Davis Medical Center in Sacramento.

Q: *What lured you away from academia?*

A: The American Medical Association courted me. I was on the editorial board of the *Journal of the American Medical Association*, a position I had held since 1974. I gave up a tenured professorship at the University of California to move to Chicago in the middle of winter to start work as an editor at the AMA in January 1982. I remained in that role for 17 years.

to republish them with up-to-date commentaries by current experts.

Under my editorship, JAMA expanded internationally. When I left in 1999, we had 18 international editions in 11 languages. And with that international circulation, we doubled the circulation of JAMA.

Q: *When did you join Medscape, and what is your role there?*

A: Within a month of leaving JAMA, I was offered my current position as editor in chief and executive vice president of Medscape. The company, which has been in business since 1995, provides evi-

“For-profit managed care in America is in decline, but, in fact, the for-profit system is not gone. It will get messy until we figure out how to replace it with something that we hope will be better. And I believe that the Internet will be a central part of the new system empowering patients to take charge of their health.”

Q: *What were your impressions of JAMA?*

A: It was certainly a long and interesting ride. Overall, the job was fabulous. It was a wonderful international opportunity for education, and a great showcase for science and public health. JAMA has been around since 1883. In my first year as editor, we celebrated JAMA’s centennial. It was great fun to revisit the landmark papers that had been published over the previous 100 years and

dence-based information over the Internet. Medscape users are required to register, but the service has always been free of charge. Medscape (at www.medscape.com) now has 3.7 million registrants in 249 countries. Of that number, more than 600,000 are physicians, and about half of them are in North America.

—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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