

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

December 15, 2002

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Some Pursuing Alternative Careers

James Noble Hendrix, MD, was one of the most respected general surgeons in South Florida in 1990 when, at age 46, he stunned his partners by announcing his intention to stop practicing. The former physician now operates Hendrix Farms on 20 acres south of Miami where he grows lychees, a tropical fruit, that he ships all over the world.

While in medical school, Edward Schneider, MD, 56, dreamed of being an old-style country doctor. After 28 years as a family physician in Stockton, Calif., he sold his practice last summer to teach science at a community college. "I absolutely don't ever expect to go back to the practice of medicine," he says.

Lorne Weeks, MD, 50, practiced orthopedic surgery for 17 years in Colorado and Kentucky until four years ago. That's when he left medicine to become a consultant for Career-Lab in Englewood, Colo., helping physicians transition into new occupations as he did. "Medicine is a different game than the one I contracted for," he says. "There's a sense of betrayal. The bases have been moved."

Costs and Regulation

If you began practicing in the 1960s, chances are you expected to be wearing a lab coat well past age 60. But those expectations are changing due in part to an evolutionary and escalating exodus from medicine brought on by managed care, regulation, rising malpractice rates and lawsuits, and

economic and general dissatisfaction, verified by studies of doctors conducted in the last five years. As a result, researchers expect a dramatic shortage of 200,000 physicians by 2020, a time when the country's aging population may require more medical care.

Physicians who spent an average in today's dollars of \$136,000 on a medical school education and seven or more years of their lives intensively studying medicine are leaving in the prime of their careers, when their benefit to society is arguably the greatest.

The financial ramifications are enormous for America, which pays roughly \$2.7 billion in tax dollars to train approximately 100,000 residents annually. About \$300,000 is lost when a physician changes careers, estimates Richard Cooper, MD, 66, a former practicing hematologist and medical school dean who directs the Health Policy Institute at the Medical College of Wisconsin in Milwaukee.

Do self-exiled physicians feel a societal obligation to practice under any circumstances? "I gave away \$120,000 in charitable care every year for 15 years to patients who couldn't pay me," answers Hendrix, the South Florida farmer. "That's \$1.8 million. I paid my dues." Orthopedist-turned-career consultant Weeks says, "I don't remember promising anyone I would practice until I die."

While physicians are leaving, applications to medical schools also are declining. The Association of

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Geographic Options for Specialists in Demand

There could be as many as 50,000 openings for physician specialists by 2010 and 200,000 by 2020, according to Richard Cooper, MD, head of the Health Policy Institute at the Medical College of Wisconsin. This shortage can be partly attributed to the need for more specialists as hospitals care for the large numbers of aging baby boomers who demand new procedures. Low reimbursement rates, stagnant income levels, rising insurance rates, and high overhead costs are also contributing factors, as physicians retire early, switch careers, or relocate to other areas.

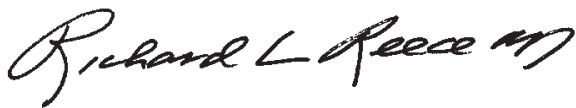
Boston is an example of a market already experiencing strong patient growth and such demand. Six Boston hospitals recently released figures on patient volume. From 1998 through the end of this year, the number of outpatient visits was expected to grow in the six hospitals from 2.26 million to 3.15 million, a 39% increase. In the same time, the number of inpatients was expected to rise from 152,537 to 175,097, a 15% increase.

Yet recruiting specialists to work in Boston is a challenge. The city's housing costs are among the highest in the nation, and the state's high concentration of HMOs means physician reimbursement rates are lower than they are in most parts of the country. Also, salaries in Boston's academic medical centers are low. Brigham and Women's Hospital recently lost a top heart surgery team to Mount Sinai Hospital in New York City, where physician incomes are higher.

An analysis by the Massachusetts Medical Society showed that from 1992 to 2000, the ratio of housing prices to median physician income rose from 1.14 to 1.83, the cost of running a practice rose by 61%, and median income dropped from \$140,000 to \$120,000. In the same period, the number of hours physicians worked in the Bay State climbed from 49.5 per week to 53. In other words, physicians in Massachusetts were working longer hours but losing ground economically.

California is having similar problems, in part because managed care enrollment and the cost of living in the Golden State are high, and physicians there are among the lowest paid doctors in the country. In West Virginia, 40% of the state's doctors are considering early retirement and are moving to other states. In Mississippi, many doctors are discontinuing obstetrical care to avoid high malpractice premiums.

Seeking the best conditions, many specialists are aware that hospitals are seeking their services, that salaries tend to be higher in regions with lower costs of living, and that the demand for specialists exceeds the supply in some markets. Specialists who are willing to relocate and know what hospitals are paying in salaries may soon have their pick of cities in which to practice.



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Billing Systems Boost Cash Flow

Good computerized billing systems can reduce billing costs, accelerate payment cycles, and improve collections, experts say.

“The processes of billing, collections, and accounts receivable management are crucial to the financial success of any medical practice,” says John W. McDaniel, president and CEO of Physician Management Group Inc., practice management advisers in New Orleans (at www.physician-management.com). “In an environment of declining reimbursements and delays in claims processing, it is crucial that medical practices have sufficient software to

the detailed information they need for smart financial decisionmaking and strategic planning. Billing software should allow some basic functions, including links between diagnoses and CPT codes, multiple modifiers and diagnosis codes, line-item payment posting, employer and referral sources, paperless collection modules, and the option to send claims and statements electronically, says Bever. Other basic functions to look for are extensive demographic data collection (such as multiple phone numbers and multiple e-mail addresses for insurers) and the ability to produce an array of management reports (such as accounts receiv-

The ability to check patient eligibility online can act as a revenue safeguard. “We are seeing systems in which the billing module can check for batch eligibility, meaning the system pulls all patients with appointments scheduled, say, within three days and sends out eligibility requests online,” Bever says. “A report shows which patients have confirmed eligibility and which ones the staff may need to check on.”

Systems also can help identify low payments by comparing payer schedules against fees during posting, says Sarah Wiskerchen, MBA, a consultant with KarenZupko & Associates.

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—John W. McDaniel, Physician Management Group Inc.

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Specialized Tools

Jennifer Bever, a consultant with KarenZupko & Associates, agrees. “Having billing software is critical for physicians today,” says Bever, MS, CHE. KarenZupko & Associates Inc., in Chicago, is a practice management consulting and training firm (at www.karenzupko.com). “Declining reimbursement and troublesome payment rules by carriers require that physicians have tools to help them effectively fight for every legitimate dollar due them,” she notes. “And just any old software won’t do.

Billing software must allow physicians to input data and then provide

able aging, payment analysis, and detailed adjustment reports).

What’s more, a system that allows electronic submission of claims will encourage a group to submit claims in a timely manner, which is important for physicians concerned about cash flow. “Many billing systems today have at least a front-line edit function for electronic claims submission that checks basic demographic information and format,” Bever observes. For example, the front-line editor will check to see if a Social Security number has nine digits, which helps practices submit clean claims the first time. Some systems offer a second coding scrubber that checks for bundling and for correlation between the diagnosis and the code, which can improve coding accuracy, she adds.

“Usually a claim denial will require staff to review the denial code on the explanation of benefits form and take action,” she explains. “Billing systems can be useful here if they allow for online claim editing.” With such a feature, staff can fix a mistake on the claim easily and resubmit it, she points out.

Finally, a good billing system helps track accounts receivable by using a paperless collection module. “Open accounts are pulled into files for employees to access on a regular basis,” Bever explains. “Special notes screens that have no restrictions on the length of note are key.”

Improving Documentation

Some billing systems will allow practices to track no-shows and recall

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patients for repeat tests or annual visits. "These activities can improve quality of care," says Bever. "However, most billing systems don't capture a great deal of clinical information because that gets into the realm of electronic medical records."

A billing system is unlikely to be able to assist physicians with proper documentation, but an electronic medical record could do so, Bever adds. "Some integrated EMR-billing system products are coming on the market now," she says.

The cost of such software varies. "Buying billing software is much like buying an automobile," McDaniel says. "If the customer chooses to have more options, the price increases. As with any purchase, physicians should consider which additional tools are

with each type of system," says Bever. "A subscription service can offer savings because there is no server on site, and there is less need for on-site technical support. However, the pricing models are so varied that each case must be evaluated individually."

Tangible Benefits

Summit Ophthalmology Group, an eight-physician single-specialty practice in Akron, Ohio, installed the Athena Health System billing program in September 2001. Athena Health (at www.athenahealth.com) is available as a subscription service over the Internet.

"Prior to adopting a new computerized billing system, we had significant problems with respect to making submissions to third-party payers, track-

of our insurers."

A large proportion of the group's patients—about 60%—is covered by Medicare. "Medicare typically has been one of the better payers overall," Ellison notes. "Therefore, in terms of timeliness and responsiveness, we have found that the improvement in claims payment of some third-party payers has been a bit more dramatic than it has for Medicare."

The billing system also helps to improve charge capture because it includes an integrated scheduling function. "The system makes the physicians and the staff aware of scheduled visits for which no charge entries have been made, so that we are able to track all patient visits and make sure they're matched up with a proper charge for that visit," says Ellison. "In many specialties, claims fall through the cracks, but computerized billing and scheduling systems can prevent this problem."

One benefit of the system is that it has allowed the group to focus on its clinical mission without being distracted by administrative problems. "As a result of adopting a computerized billing system, we now have a good handle on our financial picture, such that we feel we are in greater control of our economics," Ellison states. "We are now able to spend more time focusing on patient care."

The system has a direct clinical effect as well. "Since implementing the system, I have been able to track my patient population with respect to diagnosis codes much more effectively," Ellison notes. "Therefore, I can search for patients who have a particular diagnosis or I can quantify the numbers of people in a particular diagnosis who come in over a particular period of time."

A Positive Response

"Most billing software is relatively easy to learn, given a basic level of proficiency in using computers as well as an understanding of the billing

"In many specialties, claims fall through the cracks, but computerized billing and scheduling systems can prevent this problem."

—Richard Ellison, MD, Summit Ophthalmology Group

available in more sophisticated software and how these tools may assist the efficiency of the billing process and improve cash flow. Billing software can be purchased for as low as \$500 to run on a personal computer and as much as \$50,000 or more for a sophisticated billing software program that allows for the integration of electronic medical records."

Bever has found that the more robust billing systems cost \$25,000 to \$40,000, but cost depends on the size of the practice and which modules are purchased, among other factors, she says. "The less costly systems (between \$5,000 and \$15,000) tend to have some lower functionality and reporting capability," she adds.

Subscription services, which are available over the Internet, offer another option. "A practice should be able to compare actual expenses

ing accounts receivable, and managing claims overall," says Richard Ellison, president of Summit Ophthalmology.

Several features of the Athena Health System appealed to the group's physicians. "One important feature of the system is the ability to scrub claims prior to their official submission to the insurance company for payment," Ellison notes. "As part of that process, the system identifies reasons that claims might be rejected by the insurer, enabling us to make corrections and submit clean claims almost 100% of the time."

The group has seen some tangible benefits as a result of the computerized billing system. "There has been a significant decline in our accounts receivable outstanding," says Ellison. "In addition, we have seen improved payment turnaround time from most

“I do not recommend trying to save money by cutting training. The staff’s ability to use the system is critical to getting a return on the investment. Practices should be sure to allocate some training time at three months postinstallation to ensure that all valuable features are put into use.”

—Jennifer Bever, MS, CHE, KarenZupko & Associates

process,” McDaniel explains. “With the exception of software that is purchased off the shelf, all vendors provide a reasonable level of training.”

For an average person with some basic computer experience, these systems are not usually difficult to learn, Bever adds. “Vendor training is suggested for all staff unless the practice is very large, when a train-the-trainer or super-user approach is suggested,” he explains. “I do not recommend trying to save money by cutting training. The staff’s ability to use the system is critical to getting a return on the investment. Practices should be sure to allocate some training time at three months postinstallation to ensure that all valuable features are put into use.”

Implementing the system at Summit Ophthalmology went relatively smoothly, says Ellison. “It was really a twofold process,” he explains. “A lot of work was done by Athena Health System behind the scenes. We submitted information with regard to our payers and Athena validated and verified provider numbers and credentialing. In other words, we did some paperwork that Athena Health then processed for us. The second step was the training of our office staff to use the system. The training occurred over two days—on a weekend—prior to our go-live dates. We also held approximately three days of office training, during which Athena Health personnel were present to help our staff make the transition from the classroom to the live situation.”

The system has changed the physicians’ practice flow. “Making the initial adjustment to using the system

was a bit disruptive,” Ellison admits. “However, once that transition was completed, the new practice flow was better than the original.”

Unquestionably, the automation of billing processes is a useful step, Ellison states. “There is great value in the cost savings that accrue from staff not needing to spend time tracking down paperwork or resubmitting claims,” he says.

Patients are largely unaware of the implementation of this system. However, patient satisfaction may have increased due to fewer billing and payment hassles, Ellison adds. “The staff in our insurance and billing department have commented that the number of questions from patients has decreased substantially,” he notes. “The staff did notice that the phone was ringing less often, and that they were handling fewer problems from patients.”

Tips for Providers

For physicians evaluating a number of systems for present and future needs, McDaniel suggests that each practice consider its needs depending on the size of the practice and the management reports the practice wants to review. “It is a waste of money to purchase a system to offer tools that the practice will rarely use,” he says.

Physicians seeking the best system should first understand what they want, Bever advises. “Many practices start by listing all the features their current system lacks,” she notes. “Finding the right system also means investigating many options so that the physi-

cians know what new features companies are offering. Sometimes a company offers a feature that physicians had never considered but may find appealing. Physicians also should involve staff in the decision. After all, they will use the system most and are likely to have insight into important details a physician might overlook. We also recommend visiting a practice using the system under consideration so physicians and staff can get a feel for the product in action.”

The pitfalls to avoid when implementing an electronic billing system include not getting system updates, cutting training short, not allowing enough time for the transition or implementation phase, adding “dirty” data to a clean system, failing to do file maintenance, developing duplicate accounts, not using the features available, not buying the vendor support, and experiencing poor vendor support but not failing to contact the vendor again for another solution.

While successfully implementing an automated billing and scheduling system solves a major business problem for physicians, Ellison cautions that it is not a panacea. “Given the health care system today, other business problems still exist, and new business problems will continue to develop,” he observes. “We will just move on to different challenges. But the computerized billing system prepares physicians to successfully tackle new challenges.”

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

Efficient Appeals Improve Income

By John W. McDaniel

The federal Centers for Medicare & Medicaid Services recently announced that it would reduce the time physicians have to file an appeal from six months to 120 days. At the same time, many insurance companies are often denying claims or refusing to pay them.

Physicians are increasingly frustrated by such practices on the part of insurance companies because resubmitting claims requires staff time and further delays payment. But there are strategies physicians can use to speed up the process of getting paid promptly and in full for each claim.

Submitting Clean Claims

This year, a review of Medicare denial rates by specialty shows that an alarming percentage of claims have been returned to physicians unpaid. But the review also shows that physicians can prevent most claim denials by submitting clean claims, since most denials are caused by administrative errors related to eligibility and authorization issues. The second most common reason for a claim to be denied is incomplete physician documentation and coding, according to CMS.

Successful claims recovery strategies involve persistence in appealing denials and an increasing awareness about the reasons for denials. Physician practices also need to be

diligent about establishing internal procedures that can help to focus on this important area of revenue cycle management.

Common strategies include developing a spreadsheet to track the status of denials and to provide feedback to physicians and other staff involved so that once a reason for a denial is identified, those involved can correct the problem so that it does not happen again.

The staff may also want to keep track of any trends in denials by CPT codes and revenue center. Identifying

improvement process and employee education program so that it can prevent such denials from happening.

Physicians also should track results of claims recovery by keeping a denial rate report and by recording the turnaround time from claim filing to payment.

An expert on billing and collections, Elizabeth Woodcock, FACMPE, offers several suggestions for physician practices seeking to improve their billing and claims processing procedures. For example, physicians should develop a system to follow up on

Although appeal strategies may not always work, most practices find that at least 50% of their appeals get paid. This kind of return is well worth the time and effort involved in pursuing appeals, particularly if the practice's appeal processes are efficient.

these trends can be a good way to prevent such denials in the future.

Before sending claims to any payer, the staff should make a duplicate copy of all paperwork and implement a package-tracking system (such as overnight delivery or certified mail) to ensure that the paperwork arrives on time and that the staff has a record of receipt. When sending claims to payers, staff should be sure to attach any reference paperwork that the payer may find useful, such as intermediary and carrier guidelines, standards of care, or a copy of the patient chart, if needed.

Process Improvement

When a physician group has received a specific explanation for a denial from a payer, it should develop an

appeals to avoid any wasted time in the appeal process, she says. Using the calendar function in most software programs (such as Microsoft Outlook) would be an easy way to establish such a system, she points out. Also, the group should develop standard appeals letters that can be easily customized with information about the particular patient and situation involved in every denial.

Physicians also should compare the money collected in appeal against the amount appealed for. If the group is doing better with some payers than it is with others, staff should try to determine why, she adds.

Staff should not appeal very low dollar claims by setting a minimum such as \$10 for first appeals, and \$20 for second appeals, Woodcock says.

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Physicians should use the appeal process when a payer has denied a payment and when a payer has made an underpayment, Woodcock advises. If an insurer routinely downcodes claims, they should appeal for the code that was submitted originally and include supporting documentation, she adds.

Getting a Return

Physician practices should group chronic denials together for a collective appeal, Woodcock says. For example, if an insurer consistently refuses payment for a certain code, staff should not keep sending appeal letters. Instead, the physicians should request a meeting with the insurer to discuss the situation and bring along supporting documentation.

Before signing any contract with a payer, physicians should make sure that the appeals process is explained clearly, Woodcock says. They should determine, for example, what happens if an initial appeal is denied. What additional steps can the physician group take after a denial? Is mediation allowed or would there be a grievance hearing? If a claim is denied for medical necessity, can the group request a physician peer review?

Although appeal strategies may not always work, most practices find that at least 50% of their appeals get paid. This kind of return is well worth the time and effort involved in pursuing appeals, particularly if the practice's appeal processes are efficient.

When payers shorten the time physicians have to file appeals, it creates a significant demand on the staff of most practices, particularly for the collection of claims that might take longer than four months to appeal. Typically, such claims involve getting documentation from another physician or practice that was involved in a consultation or pre-operative exam, or assisted in a surgery, for example. The billing physician may need documentation from a physician who

Reasons for Claims Denials

The top 10 reasons CMS and other insurers deny medical claims are as follows:

1. Beneficiary not covered
2. Medical necessity
3. Service provided not covered
4. Duplicate billing
5. Unbundled code
6. Modifier not provided
7. Diagnosis procedure code does not match service provided
8. Procedure code inconsistent with modifier used
9. Procedure code inconsistent with place of service
10. Diagnosis is inconsistent with age, sex, or procedure.

Source: Centers for Medicare & Medicaid Services, Baltimore, 2002.

has already been paid and may therefore not feel an urgency to respond to the request for supporting documentation. In these cases, practices may lose money on these claims if they cannot persuade other physicians to forward documentation in a timely manner.

Steps to Success

Deanna Holmes, MPA, a consultant in Mesa, Ariz., has developed the following four-step process for physicians to review pending claims.

First, physicians or staff should check aging reports around the 15th of each month to avoid the month-end crunch. Any Medicare claims outstanding after 31 days should be examined closely.

Second, staff should print any problem transactions and look for medical necessity errors. Also, the staff should review the explanations of benefits (EOB) as they arrive, a step that can help identify problem claims immediately and shorten the time before an appeal goes out. They should look at each line of the EOB to determine if diagnosis codes match the service. Also, they should determine if the patient's address and Zip code are missing, since these details

may trigger a claim denial.

Third, the telephone appeal should be planned. Staff should take advantage of the first level of appeal by calling the insurer's appeal line. They should have the original EOB denial in hand and know the correct diagnosis for the procedure. Also, they should have the patient's identification number (for CMS, they should use the HIC number), the physician's pin number, the date of service, and the patient's name. Staff should also know the patient's date of birth. This information is not required but insurers often request it during a telephone appeal.

Fourth, staff should make the call. Armed with these documents, staff should read from the EOB, not from the corresponding documents in the physician's billing system. The EOB is the record the insurer's representative will have. Staff should know the limit on the number of appeals that can be requested during a phone call but should not mention this number in the conversation.

While these methods offer no guarantee of success, the investment of time in a claim denial management process may yield a return that makes the effort worthwhile. ■

Expert Says: Focus on Chronic Care

An estimated 100 million Americans suffer from chronic illness, and that number is expected to increase to 157 million by 2020. In response, practices that want to remain effective are shifting their focus from reactive to proactive care. The benefits of this strategy are not only clinical: The associated reductions in utilization can save money as well.

Chronic illness is costly. Patients diagnosed with at least one chronic condition incur costs at least twice that of the population without chronic conditions, according to research reported in *Health Affairs* (November/December 2001). The

pital admissions within a year.

But not everyone is ready to support disease management. Critics claim the sample sizes in many disease management programs are too small to prove that the benefits of these programs are worth the cost. Physicians seem to be the most resistant: According to Forrester Research, 69% of health plan executives named lack of physician cooperation as the biggest challenge in implementing a successful disease management program.

Part of the controversy lies in the definition of disease management. "What you call disease management I might not," says Al Lewis, president of

MPH. Wagner is director of the MacColl Institute for Healthcare Innovation at the Center for Health Studies at Group Health Cooperative in Puget Sound in Seattle. He leads an effort called Improving Chronic Illness Care, a program funded by the Robert Wood Johnson Foundation, a philanthropy in Princeton, N.J. The ICIC seeks to improve the health of chronically ill patients by helping health systems improve the care they deliver to these patients.

Wagner advocates comprehensive system changes in response to the changing needs of American health care consumers. For decades, he says, the nation's health system has been delivering care to patients with acute needs; today, more patients have chronic needs, and the system must retool itself to respond appropriately.

"Our goal is to change the care of every patient, not to foster the isolated adoption of new practices in a few pockets of a health care organization," says Wagner. Statistics support this view. Robert Stone, executive vice president of American Healthways, says three of the most prevalent chronic conditions—diabetes, heart disease, and respiratory illness—represent only 8% of a typical health plan's population. To have a significant effect on the rest of the patient population, disease management programs would need to target a wide range of conditions, Stone explains. (American Healthways is a disease management company in Nashville that has contracts to provide services to 390,000 health plan members.)

For this reason, Wagner calls for systemwide change, not just change based strictly on specific conditions. Systemwide change should support the three elements that Wagner says are essential to good care of all patients with chronic illnesses:

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"Our goal is to change the care of every patient, not to foster the isolated adoption of new practices in a few pockets of a health care organization."

—Ed Wagner, MD, MPH, Group Health Cooperative

study's authors report that a diagnosis of a chronic condition results in an increase in costs of 80% to 300%, depending on the patient's age, sex, and condition.

Retooling Care Delivery

Increasingly, health plans are implementing disease management programs as a way to improve care and keep costs down. What's more, health plans are asking physicians to put such programs in place because there is evidence that this strategy works. At Harvard Vanguard Medical Associates, for example, a 550-physician group in Boston, a congestive heart failure management program produced a 92% drop in emergency room visits and a 40% drop in disease-related hos-

the Disease Management Purchasing Consortium and Advisory Council in Wellesley, Mass. While the American Association of Health Plans in Washington, D.C., claims that 95% of its member plans have some sort of disease management program in place, Lewis puts the figure closer to 30%.

However it is defined, disease management in many places doesn't go nearly far enough, says one of the country's leading experts on chronic care. "Simply tinkering around the edges by implementing guidelines or starting a patient education program without changing the fundamental clinical practice of the providers, or how patients interact with the health care system, will not have the desired effect," says Edward Wagner, MD,

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1. A prepared practice team
2. An informed, activated patient
3. Productive interactions.

Wagner defines a prepared practice team as one that, before and during the interaction with the patient, has the appropriate patient information, decision support, people, equipment, and time to deliver evidence-based clinical management and self-management support. It is the physician's job to get a patient to accept the role and responsibilities of being a self-manager every day, says Wagner, working as "a guide on the side, not the sage on the stage."

A productive interaction between a patient and a physician is characterized by a guideline-driven assessment that is tailored to each patient; collaborative goal setting; a shared care plan so that the patient and the physicians know what they want to accomplish; and active, sustained follow-up. "Follow-up is everything in chronic illness care," Wagner emphasizes.

The elements necessary to produce prepared practice teams; informed, activated patients; and productive interactions are combined in Wagner's chronic care model. The CCM contains six components:

1. Health care organization
2. Community resources and policies
3. Self-management support
4. Decision support
5. Delivery system design
6. Clinical information systems.

When improving the care of patients with chronic illnesses, there are no shortcuts, Wagner says. "You must make changes in all elements of the model if you want to improve outcomes," he explains.

The health care organization. "The single most important element in supporting the implementation of the CCM is the engagement of senior leadership," says Wagner. "There has to be an organizational commitment to improving chronic illness care." Champions in senior management should foster the creation of measurable goals for improving care and ensure that the goals are part of the organization's business plan, he adds. The organization also should adopt strategies that have proven to be effective. "Look at the literature and see what measures have worked for others," he advises. The organization should develop incentives for physicians that promote improvements in care. Health plans should design benefits that support effective care of patients with chronic illness.

Community resources and policies. Many communities have resources for patients with most chronic illnesses, and making referrals to those resources can complement care. Examples include senior centers that offer exercise programs for aging patients; state health agencies and national patient organizations, such as the American Diabetes Association, that can provide information and guidance on patient self-management; and school and day care nurses who can help coordinate and co-manage care.

Physicians and other providers should identify the most effective programs in their communities and encourage patients to access them. Also, health care organizations can form partnerships with community organizations to support or develop

evidence-based programs. By taking advantage of these resources, physicians can enhance care, improve patient awareness and compliance, and help health care organizations avoid duplicating efforts.

Self-management support. Patients with chronic conditions must be encouraged to accept responsibility for their own health and become partners with physicians and other providers in managing their illnesses. They must be willing and able to perform at-home monitoring each day, track trends, and share in treatment decisions. Physicians must create a collaborative relationship in which they work together with patients to define problems, set priorities, establish goals, create treatment plans, and solve problems. Such tools as goal-setting contracts and written action plans may be useful in this effort.

Decision support. The most important type of decision support a practice can create is to embed evidence-based guidelines into daily clinical practice, Wagner says. This step can be accomplished by developing easily accessible flow sheets, pathways, or checklists. There is growing evidence that describing and discussing guidelines with patients are helpful in this regard, he adds.

Specialists' expertise should be integrated into primary care, preferably by having the patient see a specialist. "There is some evidence that patients who see both primary and specialty providers do better," says Wagner. Also, of course, the primary care physician can consult a specialist. And finally, to support behavioral

(Continued on page 12)

After adopting a program to manage the care of patients with congestive heart failure, a 550-physician group in Boston produced a 92% drop in emergency room visits and a 40% drop in disease-related hospital admissions within one year.

“I am a doctor through and through, and I will die a doctor. Regardless of how much pressure and heat are put on us, my colleagues and I plan to stick it out and stay in practice. We’ll be the ones to turn out the lights. We’re not leaving.”

—William Harris, MD, family practitioner and geriatrician

(Continued from page 1)

American Medical Colleges in Washington, D.C., which represents the nation’s 125 allopathic medical schools, says medical school applications declined by 29% since 1996.

“All of us, medical educators and the public alike, should worry if a career in medicine ceases to be attractive to prospective applicants,” says AAMC President Jordan Cohen, MD. Today, one out of every two students who applies is accepted, compared with one in three in 1995.

“The real issue with medical schools is that the number of student slots has remained constant for the last two decades while the U.S. population has grown; so the schools have not kept pace with the population,” says Edward Salsberg, PhD, director of the Center for Health Workforce Studies at the State University of New York at Albany.

Disappearing Doctors

But perhaps the most serious repercussion of physician dissatisfaction is access to care. “We are already seeing the early signs of shortages and of public unrest,” says Wisconsin’s Cooper. He was one of only a few experts who challenged predictions of an oversupply of physicians that were made in the 1990s by the AAMC, the Council on Graduate Medical Education, and the U.S. Bureau of Health Professions.

In a report this year by the Pennsylvania Medical Society, *Pennsylvania’s Disappearing Doctors*, researchers reported that the high cost of malpractice insurance had resulted in the closing of medical clinics and

had caused hundreds of hospital employees to be laid off.

The AMA’s outgoing president, Richard Corlin, MD, addressed the issue at the organization’s annual meeting in June, saying, “Doctors are disappearing from America’s communities because of skyrocketing medical liability insurance premiums and an out-of-control legal system.”

Also, the Massachusetts Medical Society released findings in June from a study that showed the Bay State is facing a crisis in the number of physicians available to deliver patient care. “Many physician practices are already overwhelmed and unable to handle additional volume,” the society said. Last year, a report by the California Medical Association, *And Then There Were None*, said that by 2004, 43% of physicians planned to leave patient care in California, move out of state to a better practice environment, retire earlier than planned, or change to a career that did not involve patient care. In a report last year, *Keeping the Doctor Away: What Makes Arizona Unattractive to Physicians?* the Goldwater Institute in Phoenix drew conclusions about the supply of physicians in Arizona that were similar to those drawn about physicians in California.

One of the most frequently cited national reports was done in 2000 by Merritt Hawkins, a physician recruiting firm in Irving, Texas. In a survey of 300 doctors age 50 and older, about 40% said they planned to retire from medicine by 2003, and 10% said they expected to change careers.

Some have extrapolated from the Hawkins study that based on the total

number of U.S. physicians age 50 and older, an astonishing 100,000 could be retiring by next year, a “gray out” of one in seven doctors. “Admittedly, our survey size was small, and the results more likely reflect dissatisfaction than actual plans,” says Hawkins spokesperson Phillip Miller. “Plus, since it was completed, the stock market has gone south, which may inhibit some physician retirements. That said, we are nonetheless continuing to see a lot of doctors retiring prematurely.”

The problem may be larger still because exiting physicians do not report their departures to any central information agency and do not cancel their licenses. They simply don’t renew, which doesn’t show up in state or AMA records for several years. Also, many former physicians maintain multiple licenses so they can write prescriptions for family members but no longer see patients, which tends to skew the data.

White Coat Blues

Some speculate that physicians may be leaving practice because there are more opportunities for those with a medical degree than there were years ago. While it is true that physicians today practice in a wide variety of management and executive roles that were unheard of before managed care, the fact remains that practicing physicians today are no longer autonomous as they once were. In the past, physicians made medical decisions without answering to insurers. They enjoyed the loyalty of lifelong patients who did not switch doctors because their employers

changed health plans. They set their own fees and usually were paid in full. And, typically, they worked into their late 60s or 70s.

"It's not the long hours," says Cooper about the practice of medicine. "It's getting beaten up and the fear of getting audited or sued that demoralizes physicians. Doctors don't want to retire. They love medicine. They hate the practice."

Karen Engberg, MD, an internist in Santa Barbara, Calif., agrees. "Why would someone want to work 80 to 100 hours per week when they can support themselves just as well in almost any other profession and with many fewer regulatory headaches, much less liability, and a forest less of paperwork?" she asks. "This year our reimbursements have shrunk by 5% while our overhead has gone up about 20%. It's a losing battle."

Not only have reimbursements declined, but what doctors call the hassle factor has risen considerably as well. In some markets, obstetricians have stopped delivering babies and surgeons have stopped performing risky procedures—both out of fear of malpractice suits. A patient on crutches is sent to a radiology center miles away instead of using his physician's own x-ray room because an HMO has negotiated a lower rate with a cross-town center or because of liability concerns. Pap smears that once took three days for results get shipped out of state as a cost-cutting measure and take 10 days to get back.

Rita Robinson, MD, 54, an internist and oncologist in Akron, Ohio, used to do 80% oncology and 20% internal medicine but had to flip those two because insurers would not pay her for the time she needed to spend with cancer patients or for administering chemotherapy in her office. Now, because her annual malpractice rate tripled this year to nearly \$25,000, she is considering leaving practice to sell cosmetics full time.

For Hendrix, the former South

Florida surgeon, several situations precipitated his exit from medicine. He became angry and despondent when an anesthesiologist he worked with committed suicide over a malpractice suit. Hendrix himself had been sued twice, though in each case the charges were dismissed.

A Silver Lining

But if physicians are leaving medical practice, the law of supply and demand may favor those who remain. "Doctors can be more selective," Cooper explains. "They can have boutique practices, turn down Medicaid patients, and say no to HMOs." Recruiters are reporting soaring starting salaries and offers of nontraditional working agreements, like job sharing. But a shortage of physicians means longer wait times for patients to get an appointment and longer search times for groups

titles physicians have assumed include securities analyst, actuary, quality assurance officer for a medical device manufacturer, and founder of a medical Web site, he says.

"Careers were once a lifetime investment," Weeks continues. "Now they are amenable to tweaking, redirection, and a midcourse correction." Doctors are discovering their value with the help of career counselors; some of these counselors are like Weeks: disheartened physicians who saw a new opportunity in medicine. Gigi Hirsch, MD, once worked as a psychiatrist and now is the CEO of MD IntelliNet, LLC, a research, consulting, and physician placement firm in Brookline, Mass. Peter Moskowitz, MD, once worked as a radiologist before he founded the Center for Personal and Professional Renewal in Palo Alto, Calif. Todd Pearson, MD, is a pediatrician who founded the

**"I don't remember promising anyone
I would practice until I die."**

—Lorne Weeks, MD, CareerLab

seeking new physicians for practices.

What's more, many physicians who remain in medicine are leaving heavily populated cities for rural areas where malpractice premiums are lower. Still others are shifting from one field of medicine to another, from direct patient care to academic or administrative work.

The most difficult shifts are to totally different fields. "It's much harder for doctors to move into new industries because they spend years training with a very narrow focus," says career counselor Weeks. "Then they spend more years interacting primarily with other doctors. It can be hard to imagine what else is out there."

Nonetheless, once doctors retire, they typically do not return to patient care, Weeks adds. Recent job

Center for Physician Renewal, in Bellevue, Wash.

Of course, most physicians will remain in practice, particularly those who believe medicine is still the most exciting and rewarding profession, even with all of the hassles common today. "I am a doctor through and through, and I will die a doctor," says William Harris, MD, 52, family practitioner and geriatrician in Charleston, W. Va., who has been in medicine for 25 years. "Regardless of how much pressure and heat are put on us, my colleagues and I plan to stick it out and stay in practice. We'll be the ones to turn out the lights. We're not leaving."

—Reported and written by Maureen Glabman, in Miami. More information on physician practice strategies is available on our Web site (see page 16).

More Information Available

More information on the chronic care model and examples of successful chronic care programs in a wide variety of practice settings is available in a report published in May, *Curing the System: Stories of Change in Chronic Illness Management*. The report is the second in the series *Accelerating Change Today: ACT for America's Health*, jointly published by the National Coalition on Healthcare, an alliance in Washington, D.C., that is working to improve health care quality; and the Institute for Healthcare Improvement in Boston. The report is available on the National Coalition on Healthcare's Web site (at www.nhc.org).

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change at the practice level, the model calls for the use of interactive provider education techniques (including case studies), which are more effective than traditional lecture-based continuing medical education, he adds.

Delivery system design. The CCM requires that the health care delivery system be transformed from a system that reacts to patient care needs to one that works to keep patients healthy. To achieve such a transformation, says Wagner, "it is critical to start with the team you have. Ask the team members how their roles can be changed to see that chronic disease management gets done." Roles and tasks should be assigned to a multidisciplinary team, which includes a case manager, and to ensure continuity, patient information must be available to all members of the primary care team. Physicians and other providers should see patients regularly, and regular follow-up must be ensured through standardized procedures, such as reminder systems and telephone calls.

Clinical information systems. As with many management programs, information systems are essential to track individuals and groups of patients. Creating a computer-based disease registry that includes clinically useful and timely information on all patients is the first step. The registry should outline recommended

care for certain chronic conditions (and subgroups of conditions) and should be capable of checking an individual's treatment to make sure it conforms to guidelines. In addition, the registry should measure outcomes; offer reminders for screenings or check-ups; and track, report, and communicate results and outcomes of care effectiveness over time and among physicians, other providers, and populations.

To avoid developing multiple registries with different forms and reports, physician practices should work to create systems that apply to all patients generically, Wagner says. "The patient, not the disease, should be the unit of analysis," he notes.

ICIC offers case examples on its Web site (at www.improvingchronic-care.org) of organizations that have benefited from the chronic care model. For example, the PeaceHealth Medical Group, a managed care organization in Eugene, Ore., developed a program for 290 older persons with frailty. After one year, the percentage of patients who had been immunized for pneumonia increased to 73% from 61%, and those for whom the group had a written care plan increased to 28% from none.

Gaining Control

There is a common response from physicians to the prospect of implementing new practice protocols or

redesigning systems, says Randy Vogenberg, RPh, PhD; that response: "I don't have time." And while sympathetic to physicians' plight, Vogenberg advises them to find the time. "If they don't, they are going to have more problems and even less time," he says. "Physicians have got to get out of that cycle and turn it around so they are more in control." Vogenberg is vice president and national practice leader at Aon Consulting, in Wellesley, Mass.

The trend is clearly moving in this direction, says Vogenberg, as more and better guidelines are produced and patient-centered care is pushed. "New guidelines and protocols are moving toward more aggressive earlier intervention," he says. "This might cost more at first, but physicians should be able to level out their spending by preventing more complex scenarios down the road."

A key to the success of chronic disease management, says Vogenberg, is patient empowerment. "If patients recognize symptoms and problems early on, it is easier and less costly to manage those symptoms and problems," he says. "It's a five-minute visit now rather than an hour visit later."

For physicians, there could also be a significant benefit to the practice from effective chronic care management, Vogenberg suggests. "It could reduce a physician's exposure to malpractice," he says, noting that lawsuits are often triggered by unexpected morbidity or mortality and are more likely when the patient does not have a personal relationship with his or her physician. "If physicians are doing good chronic care management, they are bonding with their patients," he explains. "Studies show that patients who have a positive relationship with their physicians are less likely to sue them."

—Reported and written by Ann B. Gordon, in Wayland, Mass. More information on physician practice strategies is available on our Web site (see page 16).

Online Consultation Seen Enhancing Revenue, Efficiency



Edward Fotsch, MD, is CEO of Medem, Inc., an e-health network in San Francisco. Founded by the AMA and the nation's leading medical specialty societies,

Medem is a physician practice communication network on the Internet (at www.medem.com) that provides secure communication and integrated Web services for physicians in practice. Editor in chief Richard L. Reece, MD, discussed online communication with Fotsch.

Q: How did your career lead you to your position as head of Medem?

A: I was a practicing emergency medicine physician for many years. While serving as head of the Department of Emergency Medicine and head of the Medical Staff Executive Committee at Doctors Hospital in the North San Francisco Bay area, I founded and ran a 250-physician independent practice association, which negotiated managed care contracts. During that time, I discovered how bad the physician communications infrastructure was—because we didn't have one. In 1997, I founded an Internet communications company that was called Metis with the goal of creating secure net-

works for communicating with physician offices.

In 1999, Metis was purchased by Healthcon in Santa Clara, and I served as the president of the Metis Division at Healthcon. When Healthcon merged with WebMD in 1999, the AMA and several medical societies asked if I would be interested in helping to create a secure physician network that would feature their medical information and allow physicians to communicate with patients. I helped to write the business plan, and when the plan was completed, the medical societies asked if I would run the new company.

When Medem was launched in 2000, we had seven founding societies, including the AMA, which had invested in the company. We now have 45 participating medical societies.

Q: What types of services does Medem offer?

A: The first service that we began offering was a customizable practice Web site that included information about a practice and featured clinical information from medical societies. In other words, each individual practice's Web site basically would have its own library, which would be, in fact, the information from the nation's medical societies aggregated into one library.

But the intention from the beginning was to move from Web sites, which are one-way communication between doctors and patients, to secure messaging. We launched our secure messaging service integrated into Web sites last year. With secure messaging, patients can go to their physician's Web site, get information, and communicate with the practice. Of the 83,000 doctors who use our Web site services, about 8,000 use the secure messaging service.

The secure messaging function facilitates administrative services. Patients can request an appointment or a prescription renewal, and they can pose a question about a bill. This function is used more often by the physician's office staff. Efficiency of workflow is an important benefit. Secure messaging can replace many patient phone calls to physician offices. Most patients call with basic questions. Secure messaging is quick and does not interrupt the workflow of office staff. It also adds value to a practice because it saves staff time and therefore saves money.

The service that we have just launched is the online consultation service, which uses the secure messaging function but allows for a charge capture function and additional tools and services. Whereas secure messaging is administrative,

(Continued on page 14)

“A physician's time is valuable, and it should certainly be compensated if the physician is providing a service, whether by e-mail or in person. But somehow when it comes to physicians, we've created a system that constantly increases demands on their time without increasing payment.”

(Continued from page 13)

online consultation has a clinical focus. Patients can ask the physician a clinical question, and the physician has the option of charging a fee for providing the answer online. The payment is based on a credit card feature. Physicians usually charge between \$20 and \$30 for information, and this is sometimes more than what they can net from a patient visit, which is subject to insurance company discounts, office overhead, delays in payment, and even nonpayment in some cases.

Q: Do online consultations represent a fundamental breakthrough in health care?

A: Yes, they do. E-mail, e-mail attachments, and all the capabilities of the Internet have transformed so many businesses. As an example, people used to call their brokers to get a stock quote, or they would wait for *The Wall Street Journal*

Q: Why are physicians reluctant to use e-mail with patients?

A: Physicians who responded to our surveys indicated two main reasons for their reluctance. The first reason is liability security issues, a concern that medical information shared online will not be secure. Physicians express a valid concern that private medical information communicated by standard e-mail may fall into the wrong hands. Physicians who wish to e-mail patients should have a system that incorporates some level of user authentication and data encryption so that messages are secure. The use of standard e-mail systems for physician-patient communication is very risky and is not endorsed by medical malpractice insurers.

The second reason is that they will not get paid for their time and expertise in delivering medical advice

Q: How have you addressed the security issue?

A: In 2000, we were contacted by two of the largest liability insurers that understood we were providing services for doctors involving clinical information and secure messaging. They wanted to know our security standards, if we had an informed consent form, the quality of clinical information on our network, and how frequently this information was being updated. We told these insurers that if they gave us their standards for online consultation, we would live up to them. And they responded that they didn't have any standards. So we invited them to work with us and the AMA to set the standards for online communication.

We quickly got 33 liability insurers representing more than 70% of insured physicians and many medical societies to participate in creating these guidelines to make sure that the liability issue was appropriate on both sides.

Q: Do patients welcome online consultation?

A: We receive a lot of positive feedback. Online consultation is convenient and saves money for patients, who do not need to take time off from work and drive to the doctor's office. And, of course, the system is optional. If patients do not want to use it, they do not have to. And when physicians offer the service, it does not replace office visits, but is an addition to office visits.

Q: Does the system eliminate the insurer as a middleman?

A: It clearly eliminates the insurer as a gatekeeper, since the insurer does not pay for online consultations and therefore cannot set rules and create obstacles to direct patient-physician communication. We have been contacted by a few large employers that are considering paying for online consultation as a way to keep their employees at their desks. Some health plans are considering paying

“Some health plans are considering paying for online consultation as well, but most health plans are not looking for new ways to pay doctors. They are looking for new ways to decrease their costs, including payments to physicians.”

to show up to find the price of a stock. Now people laugh at that idea. They can go online anytime and get that information. Another example is that we used to use fax machines or express mail services when we needed to share documents; now we regularly use e-mail attachments.

All kinds of transactions and information have moved online, but this has not affected the physician-patient relationship. In the most recent Medem survey conducted in February, 90% of physicians use e-mail but of those, only 10% use it to communicate with their patients.

over the Internet. In the current system, physicians get paid only when the patient comes into the office. A physician's time is valuable, and it should certainly be compensated if the physician is providing a service, whether by e-mail or in person. If you say to anyone, “I want you to do 10% more work but I'm not going to pay you a dime for it,” a reasonable person would respond, “That's not fair.” But somehow when it comes to physicians, we've created a system that constantly increases demands on their time without increasing payment.

for online consultations as well, but, frankly, most health plans are not looking for new ways to pay doctors. They are looking for new ways to decrease their costs, including payments to physicians.

From Medem's standpoint, we would prefer that health plans do not become involved in the near future. First, we know they are going to make patients contribute some of the cost of an online consultation—maybe \$10 of the \$25 charge. And then the physicians will be in the position of trying to chase the insurers for reimbursement of the balance.

Q: *How do physicians avail themselves of this service?*

A: Physicians can log onto www.medem.com. In 20 minutes, the system will be up and running, and there is no fee.

As far as notifying their patients about this new service, we have downloadable marketing kits with sample newsletters for patients, sample letters for the local television and radio stations (stories about the service have been picked up often by the local press), and placards that can be printed and placed in the office waiting room. Marketing can be very effective. For example, I heard from an ob-gyn in Seattle who said she planned to price the consultations at \$30, but was going to start by running a two-month special for \$15 in order to prompt patients to try the service.

In addition, all of the guidelines for liability insurers and payer guidelines are all available on the site.

Q: *Does providing online consultation services produce new revenue for physicians?*

A: Certainly. In a physician survey we conducted in February, we asked physicians what they intended to charge and how many patients they believed would use the service at a price range of \$20 to \$30. The average physician believed that five to 10 patients per week would use the online consultation service. If

they do, that service would represent \$5,000 to \$10,000 of annual incremental revenue. These are indeed the levels of online consultation use that we are seeing. For primary care physicians, an extra \$5,000 to \$10,000 a year is real money.

Not only is online consultation

from their own doctor, but it is inconvenient to do so. Interestingly, these patients will spend an hour or two on the Internet, searching for an answer. With online consultation, they can ask their own doctor the question, and not only get the physician's answer, but appended informa-

“The average physician believed that five to 10 patients per week would use the online consultation service. If they do, that service would represent \$5,000 to \$10,000 of annual incremental revenue.”

producing revenue, it also enhances patient satisfaction. One of our doctors e-mailed me that an article in his local paper about the service resulted in him picking up two new patients in one week purely because they wanted a doctor who would provide that kind of service. This story is repeating itself every week.

Furthermore, half of the doctors said they are considering leaving the office early and providing online consultations without the overhead of office expenses. They are planning on closing their offices an hour early at least one day a week, thereby decreasing their cost in terms of hourly staff time and enabling the generation of revenue without the overhead costs.

Q: *Some observers have said that there are some simple or even trivial questions that can be answered online, with no detriment to health care quality. Do you agree?*

A: Yes, and the flipside of that is that there are many times that a patient would ask a physician's advice if there were a more convenient way of accessing the physician. One of the top reasons people go to the Internet to do a search is to find medical information. Most patients would rather get this information

from a credible source. This provides a very complete answer in a shorter period of time. Online consultation fulfills patient demand.

Q: *Another barrier to seeking care is psychological. Patients may believe their doctors are too busy, so they don't want to bother them. Does online consultation minimize this barrier?*

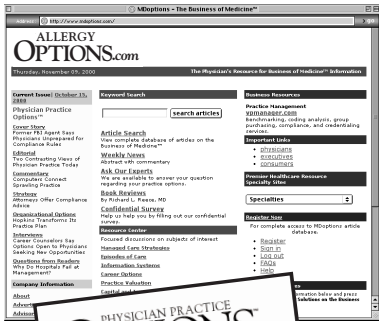
A: Yes. Patients know that when they call the doctor to ask a quick question, the doctor is being interrupted from seeing patients and is not going to earn any money for the call. That's why they feel it is a bother. But, with online consultation, patients know that physicians are going to be compensated for their time.

Q: *Will online consultation be a fixture in the future?*

A: As online consultation use by physician practices grows nationally, patients will begin to expect online communication with their own physicians. Soon, it will become a standard business practice for physicians. It's no different than the use of the telephone or the fax machine, although the Internet is much more pervasive and powerful.

—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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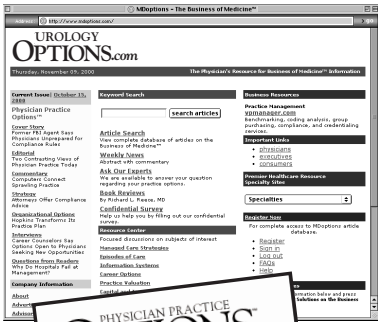
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