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Physicians Need Resources at Point of Care

There's no doubt that physicians today are pressed for time. *The New York Times* recently carried a short report, "Insights: The Ticking Clock in the Doctor's Office," which cited a study in the journal of *Health Services Research* on the topic. Researchers studied video tapes of 400 visits to primary care doctors and found that patients visiting doctors have many questions but insufficient time to get answers, spend an average of 16 minutes with doctors, raised an average of six subjects per visit, and got an answer on one subject.

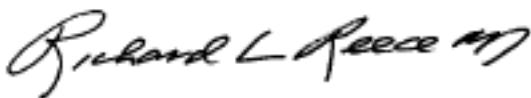
In the study, the physicians spent five minutes on one major subject but less than one minute on the other five, and devoted less time to secondary subjects so they could stay on schedule. Of course, rheumatologists, oncologists, allergists, pulmonologists, and physicians in other specialties have many similar challenges. Often, there are more patients to see than physicians can accommodate each day. For most physicians, "Time is always in exceedingly short supply," as the late management consultant Peter F. Drucker once said.

For physicians pressed for time, two of the best resources are books, both published in 1998. One is *The Successful Physician: A Productivity Handbook for Practitioners* (Gaithersburg, Md., Aspen Publishers) by Marshall O. Zaslove, MD, a psychiatrist in Napa, Calif. Zaslove gleaned the information in his book from hundreds of physicians, nurses, and other professionals who participated in his physician productivity seminars, he says.

The complexities of working as a physician today are leading physicians to quit, in part because there is too much work to do and too little time to do it, Zaslove says. There's also more risk, less pay, less job security, and more anger and depression, he adds. Therefore, Zaslove aims to provide guidance on how to make the physician's professional life easier, including ideas for ways that physicians can be more efficient, productive, and satisfied on the job. He offers more than 140 practical suggestions for reducing the hassles, pressures, worries, inefficiencies, and risks in one's professional life, he adds.

The second book is *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients* (San Francisco: Jossey-Bass) by Susan Keane Baker, a physician practice consultant in New Canaan, Conn. Baker offers practical advice on how to improve efficiency and productivity while also keeping patients satisfied. Her Web site (at www.susanbaker.com) offers a number of suggestions as well.

We recognize that the work of providing high quality patient care is demanding and time-consuming and that's why we include articles in this issue and every issue on how physicians can boost efficiency and improve productivity.



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Billing and Coding Strategies Crucial for Practice Success

Physicians can find it challenging to tend to practice management concerns while focusing on providing high-quality care to their patients. By spending some time each week on establishing processes to ensure careful billing, coding, and other practice management functions, however, physicians can ensure that their practices will run smoothly and successfully.

“Physicians today face a number of external pressures, including declining reimbursement, increased government regulation, an increasingly savvy patient base, and increasing costs,” says Kenneth T. Hertz, CMPE, a senior consultant with the Medical Group Management Association (MGMA) Health Care Consulting Group who has worked with many medical practices to improve their business functions. “All of these factors together are resulting in significant economic pressures on medical practices across the country. Focusing on the performance of the practice is necessary to ensure that the practice remains viable and able to serve patients into the future.”

Compliance Integrity

Improving practice finances is one of several reasons physicians should focus on management. “Practices must be very careful with regard to compliance,” Hertz notes. “Both governmental and private payers main-

tain specific rules and regulations about what services a physician practice may and may not bill for and how these services must be documented and coded. Furthermore, physicians also have an obligation to their patients in terms of providing an accurate recording of the clinical transaction that occurs between the practice’s clinicians and the patients. It is extremely important that physician offices operate with integrity with regard to their business functions.”

Medical groups face similar challenges and can consider similar solutions regardless of practice size, although the challenges may be on a different scale. “For a small practice, good business management is important because it means the ability to keep the doors open and continue to serve patients,” Hertz says. “A larger practice may have more flexibility, but at the same time it is more likely that business functions can escape control.”

There is no silver bullet in good practice management, Hertz continues. “Rather, it is a matter of being attentive to details, investigating, and paying attention to the group’s core business processes in the context of continuing to provide high-quality patient care,” he adds.

How practices structure their accounting and reporting is very important, Hertz continues. “All practices, regardless of size, need

accurate, meaningful, timely, and trended reporting of various performance indicators,” he notes. “For example, financial statements should be produced quickly following the end of the month. If they are excessively delayed, the opportunity for improvement is also delayed.”

Benchmark Data

Practices also should track key performance indicators and benchmark the data both among members of the practice and externally as well, he says. MGMA performance and cost surveys offer excellent data for this purpose. “For example, practices should monitor their accounts receivable days each month,” Hertz adds. “If a trend analysis indicates that accounts receivable days are growing, then the physicians know they have a problem.” Physicians should pay particular attention to the portion of accounts receivable that are 90 days and older. “If accounts get that old, they are obviously not being worked,” he explains. “And the older an account gets, the more difficult it is to collect.” When accounts become older than 90 days, physicians can expect to collect only on about 10% of these accounts.

“The billing process needs to be systematized and calendarized,” Hertz asserts. “Practices should have a regular schedule for running credit balance and accounts receivable reports

(Continued on page 4)

Good practice management is a matter of being attentive to details and paying attention to the group’s core business processes while providing high-quality patient care, says consultant Kenneth T. Hertz, CMPE, of the Medical Group Management Association.

(Continued from page 3)

and other performance indicators. Furthermore, the practice should set goals and expectations for physicians and staff performance and then work toward those goals using carefully defined strategies that are communicated practice-wide.”

Practices also should monitor denied claims closely. “Many insurance companies believe that medical practices won’t work the denials,” Hertz says. “But practices should quantify denials, understand their causes, develop solutions to reduce them, and track them over time. Working denials must be done daily and constantly monitored.”

Coding and Documentation

Physicians face several challenges with regard to billing. “When physicians leave medical school, they typically have not received any formal training regarding coding and documentation,” Hertz notes. “Therefore, the physician will not know how to effectively and even properly code for services. Given ongoing changes to coding and coding regulations, even experienced physicians may code improperly.”

The next challenge practices face is the fact that most patients do not truly understand their insurance coverage, Hertz continues. “This means that the practice staff must understand each plan, and be ready to explain the plan’s stipulations to the patient,” he notes. “The practice’s billing staff must have detailed knowledge about all the payer contracts and plans that cover their patients. Furthermore, this knowledge must be kept up to date, given ongoing changes in coverage and contract stipulations. All of that information affects how the practice bills, the amount of the bill, where to send the bill, what services should be coded, which laboratories must be used for which patients, and a host of other factors.”

Such challenges exist for all groups, because all groups work with different

Dedicated Staff Specialists Boost Group Collections

Nephrology Associates of Kentuckiana, a 16-physician medical group in Louisville, Ky., dedicates specific staff to certain billing and collections processes. Doing so has helped the practice earn the designation of “best-performing practice” in accounts receivable and collections management. The Medical Group Management Association in Englewood, Colo., has bestowed the designation on the practice in its MGMA survey of Performance and Practices of Successful Medical Groups each year since 1999.

“For example, the sole assignment of one staff person in the billing office is to examine every claim that is rejected, and to collect it,” explains Janet M. Connell, the practice administrator and chief operating officer.

A second individual is responsible for working the aging list of accounts with insurers. “We often have claims that have not been rejected, but that have not been paid either,” says Connell. “Maybe payers want to see additional documentation, maybe they say they never received the claim, or maybe they are just slow to pay and need prompting. These claims can easily fall through the cracks if they are not vigilantly tracked and pursued.”

A third staff member enters and checks patient demographics and calls insurers to verify payer information, coverage, and claims submission processes.

Since these staff positions were designated two years ago, accounts receivable aging has been reduced from 72 days to less than 40 days.

Connell points out that identifying the right people to fill these positions is central to the success of this strategy. “The people who fill these positions should be extremely focused, detail-oriented, patient, thick-skinned, and tenacious,” she states. The group seeks to hire seasoned professionals with extensive experience.

“A third factor that contributes to success is that we work as a team,” Connell says. “Everyone in the clinical area, the billing office, and the front office understands that we have to collect payment to keep our doors open and continue to provide excellent access, service, and clinical quality.”

—DJN

payers and see patients in different plans. “However, the challenge can be especially acute for small practices, which have fewer administrative personnel,” Hertz says. Small practices with fewer than three physicians may not be able to dedicate staff to billing and coding. “In a small group, staff members are multitasking. For example, the office manager may be the person who files the insurance claims and posts the charges and payments, because there is no real billing staff. In

contrast, a larger practice has a dedicated staff to handle those tasks. These practices will have people who can focus on these activities and who will be much more knowledgeable and facile at handling billing and insurance issues.”

All practices must ensure that staff members involved in billing are trained appropriately. “Not only the billing staff, but all the physicians should be properly trained and coached so that they understand the

coding and documentation rules and regulations,” Hertz explains. “The staff should attend Medicare and Medicaid seminars and ensure that physicians and staff share information regarding coverage changes.”

In addition, Hertz suggests that practices audit billing, coding, and documentation processes once or twice annually. “An external auditor can examine how charges align with visit notes to ensure that the charges and services billed accurately reflect the services rendered,” he explains.

Improving Collections

Many practices spend a large amount of time on billing but relatively little on collecting, Hertz comments. “The billing part is actually relatively simple, while collecting is much more difficult,” he says. “Practices must collect from several different insurance companies as well as from patients. Rather than treating insurers like the enemy, practices should develop a good working relationship with each one. Only through ongoing and civil communication can a practice understand the problems and issues regarding collections and increase its likelihood of collecting successfully.”

One important issue involves ensuring that the payment posted matches the contracted rate. “A common problem we see is that an explanation of benefits comes into the practice, the payment is posted, and the balance is written off,” Hertz explains. “But the practice never checks whether the amount that was paid equals the amount allowed under the contract.” Practice management systems can flag such discrepancies. “Many of the more robust

systems allow the practice to enter allowables for several payers, so that when a payment is posted, the system will flag that payment if it is less than the contracted amount,” he says. “Both large and small groups should actively compare these amounts so they can avoid significant losses.”

Collecting from patients also can be difficult. “Sometimes practices are unsure about how to communicate with patients, and how long to let delayed payments go,” Hertz says. He suggests that all practices collect copayments at the front desk at the time of service, and that staff fully understand each patient’s bill. “It is critical that bills be patient friendly, and that the balance due should be clearly allocated to the services rendered,” Hertz comments. “In addition, staff should be trained to understand insurance issues so that they can explain the bills to patients who have questions.”

Expense Management

Yet another business challenge for physicians is expense management. “It is hard to believe, but most practices do not have a budget,” Hertz marvels. “Their budget is their checkbook. But practices that do not have a budget do not set goals each month, and cannot plan for future needs. By managing expenses, practices can ensure that they make the proper investments in labor and technology that will enhance care quality and access for patients.” Practices should develop a plan first, and then design a budget to allow the practice to meet its planned expenses.

Most practices develop a budget by looking at their financial statements

from the previous year and making new estimates, but Hertz suggests taking a zero-based budgeting approach instead. “Physicians should start with a clean slate, and build a budget based on a careful consideration of what they really need to spend,” he offers.

Once practices design a budget, they can take steps to ensure that expenses are managed accordingly. “Physicians should compare their actual expenses to the budget and trend them over time, preferably graphically,” Hertz says. “They can benchmark their performance to outside statistics to get an idea what similar types of practices are spending in certain categories.”

Next, physicians and office managers should carefully assess each expense line item. “For example, consider health insurance for the practice’s employees,” Hertz poses. “Does the practice shop it around, and does it work with an insurance agent to determine the best plan? As the group gets larger, it will have more leverage in contracting for health insurance. The practice can also review its phone bills. Does the practice pay for any extra lines it is not using? Are long distance charges reasonable? Also consider journal subscriptions. Three physicians do not need to pay for the same \$800 journal subscription. Perhaps they can share the journal instead. Can the practice join a buying co-op for its office and medical supplies? Many of these items seem small, but when added together can be meaningful to the practice.”

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

“Physicians should compare their actual expenses to the budget and trend them over time, preferably graphically. They can benchmark their performance to outside statistics to get an idea what similar types of practices are spending in certain categories,” Hertz says.

Web Portals Facilitate Communication

By Michael Bihari, MD

The results of a poll published last year showed that more than half of the adults surveyed said a physician's use and investment in technology would influence their choice of a doctor to some extent or a great deal.

The Wall Street Journal Online/Harris Interactive Healthcare Poll published in September also showed that a significant majority of patients would like to receive e-mail appointment reminders from doctors, be able to schedule appointments via the Internet, and receive results of diagnostic tests online. In addition, a majority also said they wanted to communicate with physicians online, have access to medical information from an electronic health record, and be able to transmit information (such as blood pressure or blood glucose levels) from electronic monitoring devices.

Increasingly, health care organizations, including physician groups, are adding information tools to their practice management systems, most commonly electronic health records (EHRs) and the ability to order prescriptions electronically.

Early Adopters

More recently, some physicians have begun to adopt e-health portals, which allow their patients to interact directly with physicians and office staff using a secure Internet connection. Patients using these portals can get their health records, schedule

appointments, request prescription refills, get information about conditions and medications relevant to their care, and have a secure e-mail dialogue with health care providers.

Several large health systems, including the Cleveland Clinic in Ohio and the Beth Israel Deaconess Medical Center in Boston connect their stakeholders using portal communications. In both systems, patients have access to medical information and physician communication through a secure password-protected Web portal, system employees can use a corporate intranet to access documents, and staff physicians can engage patients in online e-visits. These systems allow patients to make appointments, refill prescriptions, get lab and test results, and, in the case of the Cleveland Clinic, receive customized health information.

The Beth Israel Deaconess Medical Center e-health portal, called PatientSite, has had steady growth in usage since its introduction. An article, "Who Uses the Patient Internet Portal? The PatientSite Experience," in the *Journal of the American Medical Informatics Association* (J Am Med Inform Assoc. 2006;13:91-95) said new enrollees logged in most frequently in the first month after registration, and as many as 77% of registered users continued to access the portal at least monthly. The study also noted that users most often examined laboratory and radiology

results and sent clinically-related messages to providers.

Customized Information

Information technology specialist Anthony Piccione is a patient at Beth Israel Deaconess Medical Center who uses PatientSite to track diagnostic testing that he needs for himself or family members. He is disappointed, however, with the portal's lack of health education capabilities and has noticed that customized health information relevant to a patient at the time the patient needs the information is not available on many e-health portals.

"Most products emphasize connectivity and interoperability but fail to include a robust educational component," Piccione says. "Every time a prescription is refilled, the patient should be offered an education piece about the medication and every time a patient accesses a diagnostic test result, a detailed description of the test and how to interpret the results should be immediately available." Piccione also asserts that every patient-provider dialogue should be coupled with health education modules relevant to the patient's specific condition.

Piccione speaks from experience. He is the vice president of product development at HealthBanks, Inc., a medical information company in Burlington, Mass., that provides a patient education portal linking patients, physicians, and provider

Physicians have begun to adopt e-health portals, which allow patients to get their health records, schedule appointments, request prescription refills, get information about conditions and medications relevant to their care, and have a secure e-mail dialogue with practitioners.

organizations. More than 5,000 physicians use the HealthBanks Patient Education Network. These physicians had more than 20 million patient encounters last year. The network is an expandable, database-driven patient education portal and practice marketing system. The system is password protected and secure

and provides customized information from a physician, including a newsletter that practices send to patients that includes announcements about when to get a flu shot, services the practice offers, and health news.

One of the best examples of an e-health portal belongs to Group Health, a managed care organization

in Seattle, says Piccione. Founded in 1947, Group Health serves more than 560,000 members, and is a nonprofit health care system that coordinates care and coverage.

The organization started its e-health portal, MyGroupHealth, in 2000. It offers an in-depth set of online services, including manage-

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Early Adopters Find Portals Save Time, Money

Encouraged by practice managers, several early adopter physician groups are implementing full service e-health portals for their patients. These comprehensive systems, connecting the practice with patients 24 hours a day and seven days a week, attract new patients, increase overall patient satisfaction, decrease medical errors, and save money by streamlining in-office systems, especially the need to manage a huge daily volume of phone calls. Most physicians find that once they communicate with patients via such portals, the time they spend online may be much less than the time they spent on the phone.

Patients prefer such systems because they can make appointments, get lab results and prescription refills, and collect information from their medical record at their convenience. The office can use the system to share medical records through a referral management process, manage the flow of information from health insurers about benefits and formulary changes, bill and receive patient payments online, provide automated health alerts, and most important, conduct a virtual office visit, when appropriate. All of these processes save time and money.

This certainly has been the experience of Atlanta Women's Specialists (AWS), an ob-gyn group with seven physicians and three nurse practitioners, in Atlanta. Paul Barry, executive director of the practice, says, "AWS implemented an EHR in 2001 and added a patient interface in the fall of 2004." This interface, or portal, the HealthMatic Access product from Allscripts, in Chicago, allows AWS patients to access their demographic information and lab results, and lets them communicate electronically with practice staff, he says. "Using the Internet portal, AWS patients can send secure messages to staff for making an appointment or refilling prescriptions, and to ask a question of their physician," he adds.

There was not a consensus about adopting an EHR or a patient portal, but since being implemented, both

have been successful, Barry says. Several physicians in the group have been champions of the system, and the group finds patients are increasingly using the secure messaging feature of the portal. Data from Allscripts show that AWS has been averaging more than 3,000 patient messages per month. "In a typical month, AWS patients view more than 3,000 lab results via the portal," Barry adds.

Maria Arias, MD, is one of the physicians who uses the patient portal at AWS. "I love the ability to communicate this way," Arias observes. "It's much easier than using the telephone. It has improved communications between my patients and me. In fact, I hardly ever talk on the phone any more and that's revolutionary. If I do use the telephone, it's generally with a patient who needs much more than a few sentences of explanation.

"Phone messages are inconvenient," Arias adds. "To answer them, I must either personally make every phone call or write a long note to my phone nurse. It also means that many of these phone calls cannot be done from home. It's different with messaging. I no longer feel guilty when I leave at the end of the day because I can review my messages later."

Use of the EHR and patient portal has saved the practice money and has been a valued tool to differentiate AWS in the Atlanta area. "Our operating expenses per full-time physician have decreased by 25% since the EHR was installed in 2001," Barry says.

Divan Da've, CEO of OmniMD, an information technology company in Tarrytown, N.Y., recently launched an e-health portal for physician offices. "These functions empower the patient with information available any time of the day, while at the same time reducing the workload of the practice," he says. "In addition to enhancing online community presence, many practices with portals have reported substantial savings in staff time and administrative costs."

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ment of prescription refills with access to a database of drug information, a secure messaging service to e-mail the health care team, and parental access to children's health information. It allows patients to make appointment requests and gives them full access to online medical records and health profiles with suggestions on how to improve one's health status and lower the risk of certain diseases and conditions. Patients also can review their health coverage and check what services and benefits are covered under their plan. The system also includes a searchable database of more than 5,000 articles on diseases, conditions, medications, and medical tests.

Additional online services include access to chronic disease condition centers, which provide in-depth health information, products, and services; discussion groups with other MyGroupHealth members, hosted by Group Health staff; the ability to choose or change a primary care physician; and interactive health tools and quizzes to help users understand and manage their health.

In 2006, Group Health integrated an updated version of the Healthwise Knowledgebase with its electronic health record. Healthwise is a widely respected developer of consumer health content in Boise, Idaho. Using the Healthwise database, Group Health physicians can show patients information during a patient exam, and can link to a patient's EHR in their MyGroupHealth after-visit summary and add health education links to a secure message.

Net Results

Few physicians use the Internet to its full potential. Many practices, espe-

Resources

The following is a list of Web sites for the companies mentioned in this article:

- AllScripts: www.allscripts.com
- Atlanta Women's Specialists: www.awsphysicians.com
- eCleveland Clinic: www.eclevelandclinic.org
- Group Health of Puget Sound: www.ghc.org
- Healthbanks: www.healthbanks.com
- OmniMD: www.omnimd.com
- PatientSite: www.patientsite.org

cially larger ones, have implemented Internet sites, which offer only information about the providers and office staff, office hours and directions, and some basic health care information. But while smaller physician practices may recognize the benefits of sophisticated clinical software such as electronic health records and e-health portals, the costs and technology resources needed to implement and maintain these systems may be a barrier to implementing them.

In a report published in August, *Electronic Medical Record Use by Office-based Physicians, 2005*, the federal Centers for Disease Control and Prevention (CDC) documented that 23.9% of physicians reported their medical records are either fully or partially electronic, while only 9.3% reported that they used additional features, such as computerized prescription ordering, computerized test ordering, electronic results, and electronic physician clinical notes.

Also, experts estimate that fewer than 10% of physicians with EHRs are using e-health portals to link their patients to the EHR and other practice systems. Stephen Ura is not surprised by these figures. Ura is the chief technology officer for the HealthMatics division of Allscripts, a

company in Chicago that makes EHRs, patient portals, and other software. Of the 900 small to medium-sized physician practices using the HealthMatics EHR, only 80 have installed the patient portal and only about half of those have actually implemented some or all of the product's features, Ura says.

Although many potential patient users of e-health portals are concerned about security and the privacy of their health information online, one of the biggest obstacles to widespread adoption of patient portals is physician resistance. Some older physicians are uncomfortable with technology and others do not want to spend the money and time needed to implement a system, especially if they are not far from retirement.

Many physicians are also concerned that once implemented, a patient portal will require more of their time to respond to messages and to address messages that are inappropriate or irrelevant. Physicians who are uncomfortable with an e-health portal system are not likely to encourage their patients to use it.

—Michael Bihari, MD, is a writer and editor in Falmouth, Mass. More information on physician practice strategies is available on our Web site (see page 16).

One report showed that 23.9% of physicians reported their medical records were either fully or partially electronic, and 9.3% reported that they used additional features.

Satisfaction Surveys Can Boost Volume

A patient satisfaction survey can help physicians learn much more about their practice than they can gain from almost any other source. “It has been said that the guest sees more in an hour than the host sees in a year,” notes Susan Keane Baker, a practice management consultant in New Canaan, Conn., and an expert in the role service quality plays in physician practice management. “Patients are a wealth of information, not just about the practice, but about other health care organizations as well. Without feedback from patients, it is easy to be lulled into a feeling of complacency about how the practice is doing.” Baker is the author of *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients* (San Francisco: Jossey-Bass, 1998).

For rheumatologists, oncologists, allergists, pulmonologists, and other physicians, a patient satisfaction survey helps measure patients’ perceptions of their practice. Physicians can use the data to implement service improvements or enhancements that will foster patient loyalty and to demonstrate to health plans and other payers the quality of patient care they deliver. Furthermore, physicians may find that the mere fact of having a good survey (which shows an interest in patients and their opinions) could cultivate an increase in patient volume. Such surveys may be even more important today than they were in the past because patients can report on physicians

anonymously on Web sites that publish results without ever contacting the physicians involved.

Creating an Opportunity

Such surveys provide an opportunity to learn patients’ perspectives regularly, Baker continues. “Understanding what patients want and feel is critical to creating an organization that patients want to return to and refer others to,” she says.

Furthermore, these surveys can be especially useful because some patients will not tell physicians how to improve their practices unless they are encouraged to do so. “An example is a specialist practice that did not hear directly from a patient about the patient’s discontent,” Baker reports. “Instead, the patient sent a scathing letter to his primary care physician and reported that he was not returning to the specialist. The primary care physician then informed the specialist that he would no longer be receiving her referrals. Had there been a satisfaction survey in place, the dissatisfied patient might have used that vehicle, rather than writing to his primary care physician. The specialist practice would have at least had a chance to make it right with the patient, but instead, lost some business.”

A meaningful patient satisfaction survey process can boost patient volume, Baker believes. “The process begins with letting patients know that the survey exists, and that the results matter,” she says. “By distrib-

uting and publicizing a survey, physicians convey that they care about their patients, they care what their patients think and feel, and they want to know.”

Furthermore, word of mouth recommendations remain important to prospective patients. “A patient who sees that his opinions matter may be more likely to talk about the practice,” Baker says. Practices may want to post a report about survey findings so that all patients can see the results. Such a report might thank patients participating in the survey and report on what the practice learned and what it did as a result of the findings. “This sends a very powerful message that patients count,” Baker explains.

Learning From Patients

Prospective patients often use search engines to learn about practices before making a choice about a physician. Practice Web sites that publicize survey findings showing patient satisfaction with the quality and service the physicians offer may benefit by publishing such data. “On the other hand, if patients do not have an opportunity to provide negative feedback directly via a practice satisfaction survey, they may find the opportunity online, and many prospective patients viewing those comments will consider them credible,” Baker cautions. At the very least, patients are likely to complain to friends, family, or co-workers. “If a patient has a concern, complaint, or constructive feedback, physicians are much better off

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Patient satisfaction surveys provide an opportunity to learn patients’ perspectives regularly. “Understanding what patients want and feel is critical to creating an organization that patients want to return to and refer others to,” says consultant Susan Keane Baker.

(Continued from page 9)

hearing that information directly from the patient,” Baker says.

If a patient identifies herself on the survey and makes a suggestion that the physician acts upon, the physician then has an exceptional opportunity to cement that relationship. “The physician can thank the patient for the suggestion and explain the action taken,” Baker says.

Survey comments attributable to a particular patient are far more credible and may help boost patient volume. “The survey can include a statement that says, ‘Please initial here if we can use your comments on our Web site. Your name, city and state will be cited,’” Baker suggests.

Individualized Data

In fact, a survey can provide a surprising amount of information, if the physicians are willing to accept the findings. “I hear a lot of physicians say, ‘My patients are sicker, my patients aren’t savvy,’” Baker notes. In these cases, physicians should consider a survey managed by an outside organization that compares results with benchmarked data. “Physicians are scientists, and they will be more likely to accept the feedback if they know that the survey process is objective and fair,” she adds.

Gathering results about individual practitioners gets attention fast, Baker observes. “In most organizations, when satisfaction survey results are shared, the practitioners are not identified by name,” she says. “Physicians know their own codes only. At first, they will be preoccupied with breaking the code! Then they will be forced to take a hard look at how their communication and patient care skills measure up against those of colleagues.”

Surveys also can reveal considerable information about the practice staff, and encourage positive attitudes. “Physicians and practice administrators cannot be everywhere at once,” Baker says. “The patient

Maximizing Response Rate

Regardless of the method used for the patient satisfaction survey, the physicians will want to get the most responses possible. Satisfaction surveys can be mailed, conducted by e-mail or telephone, or be done by simply asking patients to complete a comment card before leaving the office, says consultant Susan Keane Baker.

For physicians who use comment cards, Baker suggests that the cards:

- Be printed on white or pale paper
- Be anonymous
- Include a minimum number of questions
- Ask patients if there is a specific employee who should be recognized
- Include a postage-paid option for returning the card
- Be available where patients wait or be included in billing statements
- Ask permission to share their patients’ comments
- Let patients know that the practice appreciates their opinions.

Baker also suggests having a physician ask a patient directly to participate in the survey. “A personal request from the practitioner to the patient, asking the patient to take a few minutes to complete the survey, is often enough to prompt a response,” she says. —DJN

satisfaction survey provides an opportunity for patients to recognize staff.” One practice Baker knows copies the surveys in which staff members are recognized by name. “Once a month, the administrator and physicians write personal notes of thanks on the copied surveys and the copies are mailed to the individual staff members’ homes. If you’ve had a really hard day at work and when you arrive home, your mailbox contains positive comments from a patient and a thank you from your boss, you will feel great about going to work the next morning.”

Recognizing Indifference

Of course, the feedback will not always be positive. “Staff members do not intend to be indifferent; they are simply extremely busy all day long, trying to respond to the needs of patients, physicians, and colleagues,” Baker acknowledges. “But being busy can lead to feeling stressed, and that in turn, can lead, for some people, to negative attitudes and behaviors.

“Obtaining feedback from patients via a survey accomplishes two things:

first, when staff members know that they will be rated, they are encouraged to shore up their performance a bit,” Baker continues. “Second, the feedback can identify opportunities for improvement that a staff member may not be aware of. For example, one front desk receptionist began to eat lunch at her desk because there wasn’t time to take a lunch break. Lunch took several hours because she was constantly interrupted by the phone or people asking her for help. When survey participants commented on the unprofessional appearance of the front desk due to fast food wrappers, open soda cans, and half-eaten snacks and sandwiches, the practice manager decided it was time to provide additional support so that the receptionist could take a lunch break away from her desk.”

Improving Performance

When developing a survey, the questions to include will depend upon the purpose of the survey. “If one of the survey objectives is to help the practice enhance its operations, questions need to be designed to prompt all

feedback, not just positive comments," Baker says. If the practice is looking for an opportunity to recognize staff, survey questions should ask patients to identify staff who made a difference.

"If the practice promotes itself as doing something for patients (for example, 'We take time to listen and answer your questions'), then that practice should consider including questions that determine if this goal is being achieved," Baker counsels.

Important questions to include are those that ask if the patient plans to return when services are needed again, and whether the patient would refer others to the practice, she adds.

An open-ended question is always important to gather information that the survey design doesn't address. "What can we do to make visiting us a nicer experience for you?" is an example of an open-ended question. Baker notes that the survey should leave room for a real response. "The amount of space you leave sends a message about how much information you want," she says.

Getting Results

Once the survey is prepared, the practice should make it easy for patients to obtain and return it. "Patients shouldn't have to request the survey," Baker says. "It should be readily available, or given to the patient at some point during the visit, or mailed with a postage-paid reply envelope. If a telephone survey method is being used, make sure that the patient expects the call, ask if the time is convenient, and provide a realistic estimate of how long the call will take. This builds trust and encourages participation."

After getting the results, physicians should publicize the results quickly. "That means that someone has to analyze and report on the results in a timely manner, and that action has to be decided upon," Baker explains. "When surveys or survey results are

Patient Satisfaction Checklist Promotes Service Quality

Susan Keane Baker, a practice management consultant in New Canaan, Conn., has developed the following checklist that rheumatologists, oncologists, allergists, pulmonologists, and other physicians and staff can use to determine if they are fostering an environment that is satisfying for patients. Physicians and staff should answer the following questions:

- Do you speak first when you see a patient, visitor, or family member?
- Are you quick to smile at patients, visitors, and family members?
- Do you introduce yourself, giving your first and last name clearly?
- Do you explain your role in an understandable way?
- Do you orient the patient about what will happen next?
- Do you make eye contact with the patient?
- Do you wear a visible and legible identification badge at chest or collar level?
- Is your clothing neat and professional in appearance?
- Do patients see you following standard precautions?
- Are you conscientious about protecting patient confidentiality?
- When speaking with the patient, do you put yourself on the same physical level as the patient?
- Do you use the patient's name at least once?
- Do you listen to the patient's initial statement without interrupting?
- Is your work area free of inappropriate messages?
- Do you stop any personal conversations when a patient approaches you?
- Do you respond to requests with kindness?
- Do you give your undivided attention for the first 60 seconds?
- Do you find out what the patient needs before addressing your needs?
- Do you use courtesy terms, such as "please," "thank you," and "you're welcome"?
- Do you ask the patient how he or she prefers to be addressed?
- Do you speak your name slowly and clearly when you answer the telephone?
- Do you listen for the caller's name at the outset of the call?
- Do you use the caller's name at least once during the call?
- Do you refrain from making negative remarks about co-workers?
- Do you appear happy in your position?

For each "yes" answer, score four points. Most physicians find it is extremely difficult to score above a 91. Those scoring 76 and higher provide exceptional service. Those scoring 60 to 75 may want to improve their service quality, and those scoring below 60 should make patient satisfaction a major focus of the practice.

—DJN

placed in a box under a desk or in a closet, to be reviewed when there's time, the practice has made a poor investment."

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

Physicians Develop Survival Strategies

As income declines, physicians are finding new and innovative ways to continue to provide patient care and make the practice of medicine moderately profitable as well.

Some physicians are eliminating the health plan middle man by delivering care to patients who pay cash each month for easy access to their doctors. Others are using technology to improve efficiency.

Concierge Care

Concierge or boutique care are terms used to describe practices that charge patients a set amount of money for easy access to appointments, longer visit times, and wellness care. Physicians in MDVIP, in Boca Raton, Fla., have made this model work well for them. The organization, currently in 13 states, is a network of almost 120 physicians who practice preventive and personalized care.

“The philosophy behind MDVIP is to decrease our physicians’ patient loads from an average of 2,500 patients to about 600, so network doctors can spend more time with every patient,” says Ed Goldman, MD, MDVIP’s president and CEO. To make up for revenue losses from such small patient loads, patients pay a premium that amounts to \$125 to \$500 per month to cover wellness visits. The cost of care for illnesses is submitted for reimbursement to the patient’s insurance company. Physicians in the organization earn an average of \$600,000 per year, Goldman says.

“But don’t think this is a retirement

plan for doctors,” he adds. “Our physicians work very hard. The organization keeps \$500 of the yearly premiums and in turn pays for billing, malpractice insurance, and collections costs.” The remainder of the premium payments go to the physicians.

The organization supports its physician members with computer hardware and software for electronic health record systems at no cost to the doctors. Using the system, patients can access Web-based wellness information and health assessments, and a program that features 150 video tutorials. The organization also offers staff training in wellness care.

“Our data show that our doctors reduce Medicare hospitalizations by 60% and commercially insured patient hospitalizations by 80%,” says Goldman. Insurers and employers are interested in such numbers, he adds. “We’ve opened a niche for good doctors as well as for patients who want to take a wellness approach to their health care,” he adds.

A similar strategy involves not getting any reimbursement from insurers. In other words, all patients pay cash. The average physician employs four employees who are dedicated solely to filing and tracking insurance claims. Physicians could readily decrease the hassle factor and greatly reduce costs by not treating patients in health plans. Some experts estimate that a physician could cut overhead by 50% by eliminating insurance claims paperwork. The disadvantage, however, is that physicians would need to depend on having all

patients pay at the time of care. (See Interview, page 14.)

Benefits of Technology

One way to increase efficiency is to invest in technology. Allen Wenner, MD, a primary care physician and a former assistant professor of family medicine in West Columbia, S.C., for example, developed software that lets patients electronically record their own health and family histories. The process takes a patient about 10 minutes and can be done in the waiting room on a laptop computer. The program includes questions based on 17,000 possible complaints and provides physicians with a narrative of symptoms and patient history electronically. The system can save doctors as much as six minutes for every patient and provide more information than the doctor would typically elicit. The system is marketed by Primetime Medical Software in Columbia, S.C.

Of course, many physicians, particularly those in large groups, are transforming their practices by introducing electronic health record (EHR) systems. Citizens Memorial Healthcare, in Bolivar, Mo., is a rural integrated health care system that introduced an EHR in 2001. CMH won the Nicholas E. Davies Organizational award, given by the Healthcare Information and Management Systems Society for excellence in the implementation and use of health information technology.

“We opened the hospital in 1982, just in time for the new DRG payment system, which helped to close

“Our data show that our doctors reduce Medicare hospitalizations by 60% and commercially insured patient hospitalizations by 80%,” says Ed Goldman, MD, president and CEO of MDVIP.

about 300 hospitals,” explains Denni McColm, CMH’s chief information officer. Since that time, CMH grew into a system that includes a 74-bed hospital, five long-term care facilities with a total of 476 beds, a residential care facility, 16 physician offices, and 1,500 employees.

McColm credits exemplary leadership, CMH’s relationship with its physicians, and the EHR system as important elements of their success. “We had so many services that continuum of care and seamlessness became a critical issue,” she says. “Because we had so many different systems running, we decided to implement an electronic health record that would unite them all. Installation was completed in 2001.

The clinical computer system contains patient records that physicians can access from anywhere in the system. The system contains all of the data on every outpatient visit or inpatient admission, laboratory reports, and patients’ use of home care and the pharmacy. Physicians enter their orders for laboratory tests, X-rays, medications, and nursing care directly into the computer. The system, made by Meditech in Westwood, Mass., alerts physicians regarding allergies and potential drug-drug interactions.

“Some of us believed there would be no return from the EHR, but we see real savings,” McColm says. The system cost \$6 million and reduces employee workloads, uses far less paper, saves on storage space, and reduces prescribing and other errors from handwriting. In addition, medications are bar-coded and can be ordered through the system anywhere, including at the patient’s bedside. Fifteen pharmacies in the system have agreed to use bar code labels.

Patients also benefit from the system because of an electronic portal that provides information on lab results and billing and allows direct electronic communication between

patients and providers. “Previously, when a patient called for information, we would take a phone message, pull the chart, and place it on the doctor’s desk,” McColm says. “Then, the doctor would talk with the patient, write an order and route it to the laboratory or pharmacy, and the chart would be returned and refiled.”

Now, a patient using a personal computer and a secure connection can type in a message that goes directly to his or her physician, McColm explains. “The doctor reads the message, pulls up the record, and orders a prescription refill or patient visit that is routed to the right per-

son,” she says. “All of this is done on the system in one smooth operation. Everything is much more efficient.”

While this example comes from a large health care system, it has helped to make the physicians more efficient and has improved patient-physician communication. For these reasons, electronic health record systems are helping physicians in all practice sizes and in a variety of specialties to increase their productivity and to cut costs.

—Reported and written by Deborah Epstein, in West Milford, N.J. More information on physician practice strategies is available on our Web site (see page 16).

Using Clinical Staff to Improve Care

One of the best ways to improve physician office efficiency is to add clinical staff such as physician assistants or nurse practitioners. The 64,000 clinically practicing physician assistants (PAs) and 115,000 nurse practitioners (NPs) in the United States are helping physicians provide high-quality, efficient patient care.

“NPs allow practices to handle larger patient loads and to grow,” says Mary Jo Goolsby, director of research and education for the American Academy of Nurse Practitioners, in Austin, Texas. “We fit well into the need for more quality and efficiency, and help increase productivity.” Although reimbursement varies, nurse practitioners can bill Medicare for 85% of physicians’ rates. Most NPs are salaried and practice in a wide range of settings. About 33% of NPs practice in private physician practices, where they see patients, prescribe medications, perform minor surgery, and provide patient education, in addition to delivering other services.

Studies have shown that NPs provide high-quality care and are cost-effective providers in a range of settings.

Physician assistants also can provide a substantial portion of medical care services, including conducting physical examinations, diagnosing and treating illness, ordering laboratory tests, suturing, acting as first-assists in surgery, counseling patients, and providing specialized care. Virtually all states allow PAs to write and sign prescriptions.

A PA practices medicine with the supervision of a physician (though a physician’s presence is not required). “In 2006, approximately 57% of all practicing PAs were employed by a solo or group practice and 22% by a hospital,” says Nancy Hughes, vice president for communications for the American Academy of Physician Assistants, in Alexandria, Virginia.

PAs are reimbursed under Medicare at 85% of the physician fee. The medical and surgical services they provide are also reimbursable under Medicaid and Tricare, and through third-party payers often at 100% of the physician rate.

—DE

FP Succeeds as a “Personal Doctor”

Michael Stein, MD, once ran a typical primary care medical practice in Salem, N.H. He had 10 employees, 4,000 patients and earned about \$300,000 a year. But he also was working 12 hours a day and seeing patients every five minutes, sometimes 35 to 40 a day. Dissatisfied with his working conditions, he changed his practice into one that no longer accepts insurance payments. He has about 250 patients who pay him \$1,000 a year (or \$1,500 annually for certain extra services) and one employee, his wife Gena Stein. He sees about six patients a day and patients get unlimited access. He spoke about his practice with Editor-in-Chief Richard L. Reece, MD.

Q: Some physicians would say you have a concierge practice. How do you characterize your practice?

A: My style of practice is independent personal medical care. There's a big difference between what I do and concierge practices. Concierge doctors charge additional fees for additional privileges. They continue to deal with the insurance companies and Medicare in the usual way. The fee covers privileges such as not having to wait in the waiting room, having the doctor's cell phone number, and having the doctor travel with you to specialist appointments. It is a model that is meant to attract rich people for extra services only.

I have a problem with that because I don't think you should get better medical care than any other person just because you can afford it. In primary care, the physician is many things but chiefly you are an advocate for your patients. You're there to

make sure that they are treated correctly, to take care of their routine problems, perform necessary procedures, and take care of whatever issues you can. But primarily you're their advocate. Anything that gets in between you and the patient is a conflict of interest. Working with an insurance company whose only goal is financial creates a conflict of interest. There shouldn't be anything between me and my patient.

The reason I used the retainer fee model is because once I'm paid, money is no longer an issue. Now my decision making has nothing to do with money. What I do or don't do with that patient has no financial relationship whatsoever. The onus is on me to care for each patient. That's it. There's a distinct difference between what I do and what a concierge doctor does. I practice medicine the way doctors did 40 years ago.

Nowadays, of course, the culture is distinctively different and part of that is due to insurance regulations and the growth of managed care. HMOs are an entity with purely financial interests stuck between the primary care doctors and their patients. For me to come home with \$50 in my old practice, someone, somewhere had to spend \$200. The insurance companies basically buried us in bureaucracy and ruined our ability to take care of patients. I've had to see 20 patients a day just to pay for the overhead. So medical care now becomes about paperwork and you no longer have the time

required to be a patient advocate, to take appropriate care, to listen to them, and to diagnose their problems correctly.

Q: When did you make the transition to this new practice?

A: By March 2003, I realized that I had two options. I had to quit medicine and try something else or develop an alternative medical practice. People were becoming dissatisfied with the treatment they were getting in primary care. I thought that if I get the insurance companies out of the way, my overhead would drop from \$300,000 a year to \$50,000 a year. That's a huge drop. So that would mean I would not have to see as many patients to make a living and I could spend more time with the patients I have and take better care of them. The shortest appointment that I schedule is 30 minutes. Many of them are an hour or 90 minutes long.

And by operating this way, I don't have to divorce my practice at the end of the day. My patients have my cell phone number. If they get into trouble, they call me directly. There is no pager service, and no answering service. In normal practices, at the end of the day, one doctor covers for the group. If a patient has a problem after hours, that doctor gets a phone call and he doesn't know you from Adam. And if he's the least bit nervous about your problem, he sends you to the emergency room.

Q: What do you do for call coverage after hours?

“Working with an insurance company whose only goal is financial creates a conflict of interest. There shouldn't be anything between me and my patient,” says Michael Stein, MD, a family physician in Hampstead, N.H.

A: I'm available 24 hours a day, seven days a week. When I'm in town, I cover my patients. My patients can always get a hold of me. The only time they can't get hold of me is I when I go on vacation. Three weeks a year I go away on vacation and I have a physician who covers for me. For 400 to 500 patients you can do it. On weekends I frequently don't get any calls. I have to yell at my patients for not calling me when they should have. They're concerned about disrupting me. It's a totally different ballgame. My patients are concerned about my survival. They buy me gift certificates for restaurants. It's just a totally different thing.

Q: *What advice would you give to other doctors who want to adapt your kind of practice?*

A: For many doctors, this kind of practice is difficult because it can be a gamble especially if they are concerned about their income or worried about change. I did this at the age of 49 after many years of experience and when I still had a number of years left to build up my practice. This kind of practice is not for everyone and specialists might find it particularly difficult. But in primary care in a small town like this, it's possible to make it work.

The problem is that a lot of the doctors are secondary care doctors. For instance, an endocrinologist I know is like many specialists in that she is providing what I call secondary medicine. The care is episodic and so her ability to provide value for a retainer fee is limited.

Q: *Are you making a distinction here between primary care and secondary or episodic care such as rheumatology, oncology, or allergy care?*

A: You have to make that distinction because they're very different. I take care of patients over a long period of time. The relationship that I have with those patients very much determines my effectiveness with them. Secondary medicine

“My patients have my cell phone number. If they get into trouble, they call me directly. There is no pager service, and no answering service,” Stein says.

is expensive and episodic. You break your leg, you go to an orthopedist, he sets the leg, the leg gets better and you never see him again. And the charge will be \$10,000 to \$15,000. Whether that orthopedist is a nice guy or not, is secondary. You want the best technician. My relationship with my patients is personal.

The other specialists you mentioned provide care as needed, but they are still going to defer to a primary care doctor for everything else. If somebody is developing a cardiac issue and they happen to have arthritis, the secondary care doctor is going to defer back to the primary care doctor. The primary care doctor should be available on all levels but the secondary care doctor is not. When I refer a patient it's usually for a procedure that I'm not trained to do. If a patient of mine has appendicitis, I refer them to a surgeon. It's the same thing with a patient who needs cardiac bypass surgery. They need to see the appropriate cardiac surgeon. After the cardiac surgeon takes care of the problem, the patient comes back to me.

Q: *Is it true that you don't worry about malpractice?*

A: With my patients? Heck, no. In a practice where you're seeing 4,000 patients and you can't remember half of their names until you look at the chart, you might have to worry about malpractice. You might have patients who are there for ulterior motives other than medical care. For example, you might have patients who see you just to get a note from a doctor to get out of work for a few weeks so they get go on vacation. Or, you might have patients who are

drug abusers who are trying to get you to prescribe drugs for them. Those are potentially dangerous people. If you make a mistake with them, there's a liability risk. But my patients are my friends. I would have to do something significant for any one of them to consider suing me.

Forty years ago, your doctor was a trusted adviser, like your lawyer, your priest, or a family member. My point is that the relationship you have with your patients is extraordinarily important. Your physician has to have only your interest at heart and nothing else, and certainly not money or liability.

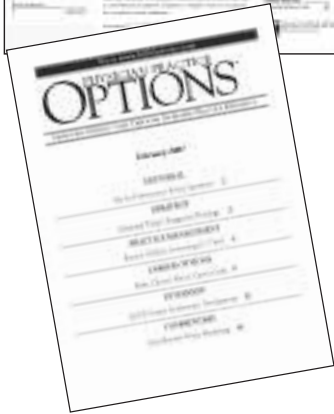
Q: *What do you do about referrals and relationships with hospitals?*

A: I have privileges at two hospitals and I have a group of specialists whom I refer to and we have a great relationship. When I send them patients, they get a referral letter, giving them some background information on the patient, the patient's personality, and the patient's family situation. I'm fully computerized. I hit one button and I can punch out an entire patient chart.

My office is about as high tech as you possibly can get. Our records are totally electronic, but they're not connected to the Internet. Nobody can get to them, meaning I am exempt from the federal electronic transaction requirements because I do not transmit any information electronically anywhere. I don't bill insurance companies. If the patient can bill an insurance company for my services, then I will give them a bill with all the correct billing and coding.

—More information on practice strategies is available on our Web site (see page 16).

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