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Physicians Are Revitalizing Primary Care

Primary care physicians have been struggling in recent years, as average PCP income dropped sharply in the late 1990s and since then has risen only slightly, according to the Medical Group Management Association. PCPs are also laboring in an environment fraught with increasing expenses, increased regulatory requirements, and rising medical liability costs.

What's more, the supply of PCPs is shrinking because fewer medical students are choosing to work in primary care at the same time that fewer consumers are choosing to go to PCPs, partly because some are going directly to specialists without first seeing a PCP and others are choosing self-care and alternative care, experts say.

Some PCPs are seeking to revitalize their profession. Fitzhugh Mullan, MD, a general pediatrician in Washington, D.C., contends that generalists—not specialists—should be at the center of the health system. He argues in his book, *Big Doctoring in America: Profiles in Primary Care* (Berkeley, Calif.: University of California Press, 2002), that the principle of each person having and using a PCP is of paramount importance to the success of any health system.

PCPs can help to create such a health system, says Jack Cook, MD, an internist, geriatrician, and physician leader in Leesburg, Va. He contends that PCPs must take steps to become the center of the health system, as they once were. They must make effective use of information technology that can speed the flow of information, he says. By doing so, they can save time, see more patients, and cut overhead, thereby increasing their productivity and profitability by 10% to 30%, he adds.

PCPs also need to generate more income by offering ancillary services, such as laboratory and imaging services and electronic monitoring of patients with chronic conditions, Cook says. To boost their income further, they can offer online consultations, he notes.

In an effort to generate more income, some practices are adopting open access scheduling, which enables them to see more patients in less time. About 40% of physicians attending a meeting of the American Medical Group Association last year had implemented open access scheduling. A similar trend involves group visits of 10 to 15 patients in which sessions last 90 minutes and can be used for patients undergoing physicals or those with certain common chronic conditions, such as diabetes, asthma, or congestive heart failure.

How effective these strategies will be in addressing the problems PCPs are facing is uncertain. What is certain is that PCPs must seek new ways to improve their working environment in the increasingly volatile health care industry.

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Groups Devise Management Program

To improve the practice environment for cardiologists, cardiovascular specialists, and cardiology practice managers, two groups that have traditionally focused on improving the clinical skills of physicians are now working to improve their business skills.

Together, the American College of Cardiology (ACC) in Bethesda, Md., and the Medical Group Management Association (MGMA) in Englewood, Colo., are developing education and practice management tools and services for cardiologists. "All practicing physicians must deal with business-related issues, but most need at least some assistance in negotiating today's complex and dynamic medical practice environment," explains John Schaeffer, MD, founder and president of the North Ohio Heart Center in Avon, Ohio, and a co-chair of the ACC's advocacy committee.

Changing Times

Traditionally, the focus of the ACC has been on education and research rather than on the business of cardiology practice, Schaeffer notes. "As the medical practice environment has evolved over the past 15 years, however, the ACC and other medical specialty societies have increasingly recognized that their goal is not just to help educate their membership about clinical science, but also to be advocates for their members regarding the business and practice of medicine," he says. "Many issues—including proper evaluation and management coding, business software applications, compliance with regulatory issues, and data gathering for benchmarking purposes—need to be adequately addressed for a medical practice to be successful."

Given that the MGMA has long focused on the business of medical practice, it makes sense that the ACC would partner with that organization on this venture, Schaeffer says. "The ACC's collaboration with the MGMA, which has many years of expertise in medical practice management, will provide important, practical tools and services for practicing cardiologists," he says.

ACC Chief Executive Officer Christine W. McEntee agrees: "The ACC recognizes that the business of medicine directly affects the practice of medicine, whether it is incorporating new technology or implementing new government regulations. This partnership with the MGMA will undoubtedly help the ACC in our efforts to provide members with tools and resources to efficiently and effectively address challenging practice management issues and provide the highest quality of care."

Over the past several years, the practice of medicine has become more of a challenge than it ever was, says Steve Hellebush, MGMA's vice president for business development. "Many physicians, who in today's health care environment are working harder and bringing home fewer dollars, are seeking professional associations and medical societies for help with practice management issues," he points out. "The ACC and the MGMA are natural sources for physician education and practice management tools. Their partnership will not only enable the ACC to deliver MGMA's practice management solutions to ACC members, but will also allow for the joint development of new tools specifically designed for the cardiology sector."

Converging Forces

For cardiologists, such assistance cannot come at a better time. Like physicians in many specialties, cardiologists are facing what Schaeffer calls "the perfect storm" in today's health care environment.

"On one hand, we have steadily downward pressure on reimbursement, especially related to the Medicare fee schedule," Schaeffer says. "Cardiology has been hit particularly hard, with reimbursements declining between 8% and 9% in 2002. In 2003 and 2004, instead of an expected 4.5% cut each year, we will get a 1.5% to 2% increase. But these two increases are less than half the decrease we were forced to absorb in 2002." Overall, these declines in reimbursement mean that cardiologists' income is not staying even with cost of living increases, he adds, noting that physicians in other specialties face a similar situation.

The downward pressure on reimbursement is accompanied by an upward pressure on costs. "The cost of providing care is increasing,"

(Continued on page 4)

"The ACC recognizes that the business of medicine directly affects the practice of medicine, whether it is incorporating new technology or implementing new government regulations."

—Christine W. McEntee, ACC

(Continued from page 3)

Schaeffer observes. “In particular, we are seeing accelerated growth in our largest expense categories.”

One such high-cost item is professional liability insurance. “In about 20 states, physicians are experiencing increases in malpractice insurance premiums at rates of 20% to 30% and as high as 300%,” Schaeffer points out. “Some physicians are finding that they cannot even obtain insurance, which often means that they must close their practice, retire, or relocate to a state where malpractice insurance is more accessible.”

Another significant expense is the cost of health care for the practice’s employees. “Health care costs are facing double-digit inflation, which is a hefty cost increase for all employers, including physician practices,” Schaeffer notes.

Costs related to regulation are also rising sharply. “Ensuring compliance with regulatory requirements is financially burdensome because most of these regulatory oversight requirements are not funded by the government,” Schaeffer explains. For example, over the past several years, physicians have been paying to comply with the requirements of the Health Insurance Portability and Accountability Act. “Frankly, I am protecting the privacy and confidentiality of patient records with the same concern in the post-HIPAA era that I was in the pre-HIPAA era,” Schaeffer says. “But now those activities simply cost me much more. HIPAA was an added financial burden on our 50-person cardiology and primary care practice. We spent more than $250,000 last year to purchase software upgrades and change our policies and procedures in order to comply with HIPAA.”

One cost that is particularly burdensome for cardiologists relates to technology. “Keeping up with technology so that we can provide the latest and best medical care for our patients is costly, and cardiology is the most rapidly advancing specialty in terms of technology,” Schaeffer says. “The development of new diagnostic and treatment advances in cardiology care is rapid and ongoing. Physicians in specialties that are characterized by a stable environment in terms of care processes and equipment are better off financially because they do not have to constantly consider allocating their income for reinvestment in new technologies.”

More With Less

The combination of declining reimbursement and escalating costs creates serious challenges for practice managers. “In the current health care environment, there is ongoing pressure on practice management staff to do more with less,” Schaeffer explains. “That pressure translates into a need to maximize efficiency: How can we achieve more productivity with fewer resources, lower expenditures, optimal investment, and less time?”

Often, practices are forced to make decisions that are not optimal for quality care and access. “For example, many large cardiology practices are deciding that they cannot afford to provide services in smaller communities and outlying rural areas because such outreach is not cost effective,” Schaeffer says. “As a result, reduced access to care in such areas may be a consequence of these changing economic times. Another example is that practices may defer equipment upgrades, forgo new technologies, or eliminate support for patient education activities for which they may or may not be reimbursed.”

Practices also may choose not to purchase and implement an electronic medical record, a tool that has been shown to be effective in improving patient safety. “Many cardiologists are saying, ‘I can either pay my staff or buy an EMR this year,’ ” Schaeffer observes. “For many practices, the choice is clear; so they defer making these investments. It is not that cardiologists are not supportive of the EMR. In fact, they would be willing to invest in whatever they could to take better care of people. But the reality is: Practicing cardiologists still have to pay attention to the bottom line. They can’t run a budget deficit because at the end of the year, everything must be paid up. As a result, all investment decisions must be made in the context of the pressures on income and costs that exist in today’s health care environment.”

Many cardiology practices that invest in new technologies choose those that either have the potential to enhance practice efficiency or to help the practice generate additional revenue. “Say, for example, a practice used to send its patients to the hospital for nuclear stress tests,” Schaeffer suggests. “Now, it may choose to pur-

As the medical practice environment has evolved over the past 15 years, the ACC has recognized that it needs to be an advocate for its members regarding the business and practice of medicine, as well as helping to educate them about clinical science, says John Schaeffer, MD, of the North Ohio Heart Center.

chase a nuclear camera and provide those services in-house so that the cardiologists can access a new income stream. There are benefits to making financial commitments to new technologies that add services and enhance quality and access through better internal controls within the practice but do not depend on face-to-face interactions between cardiologists and patients."

But promising as they are, such tools are not likely to provide a return on the investment for at least a few years. "When technology improves, many of us must stick with our original investment because it is not paid off," Schaeffer notes. "Until it is, we cannot afford to upgrade. As a result, some practices fall behind in their ability to provide what would be considered state-of-the-art technology and services."

Education and Services

Given the current economic climate, the appeal of practice management tools is similar across specialties, contends Hellebush. "The business of medicine in primary care, cardiology, and other specialties has become more complex over time," he asserts. "There are many regulatory issues, such as those involving HIPAA, that groups must contend with. Furthermore, dealing with insurance companies has become very complex with regard to submitting claims and receiving payments. Cardiologists are like other specialists in that they are seeking help with practice management issues because it is much more difficult to operate in the health care environment today than it has been in the past."

The first educational offering in the ACC/MGMA program was an audio conference held in December. In the program, Schaeffer and Kenneth Brin, MD, a cardiologist with the Geisinger Clinic in Danville, Pa., addressed changes in the Medicare fee schedule, recent cardiology coding issues, and new cardiology services being covered by Medicare.

"The MGMA offers several audio conferences each month for our group practice administrator members," Hellebush explains. "We can leverage our experience in providing these audio conferences by working jointly with the ACC to develop content specifically directed toward the cardiology audience. In addition, the ACC will review our general interest audio conference programs, and if its members have a particular interest in some of the issues we cover, it can promote the availability of those programs to ACC members."

Developing New Tools

Other practice management tools for cardiologists will be developed as well. "We have identified an opportunity to create coding tools that are geared specifically toward cardiology practices," says Hellebush. For years, the MGMA has been conducting comparative benchmarking surveys of its membership, typically focused on the cost components of practice. By reviewing survey data, members can compare their practice costs with those of their peers. To enhance the ability of members to benchmark their practice performance, MGMA Services Inc., a for-profit subsidiary of the MGMA, has invested in Physcape Inc., a Web-based benchmarking services company in Charlotte, N.C.

"Physcape has created a large data repository that medical groups update with data from their individual practice management systems," Hellebush explains. "The data repository uses ICD-9 and CPT codes to benchmark practice charges. This is a compliance tool. It can help physicians feel comfortable that they are not overcharging. It is also a revenue opportunity tool, because practices may find that they are coding at a lower level than their peers. We may work with the ACC on that product line to develop certain components of the system specifically for the cardiology sector.

"We want to help medical group practices operate more effectively and efficiently," Hellebush continues. "When practices are more efficient, physicians can become more effective and efficient as well, leading to greater profitability in the long term."

All physicians, particularly cardiologists, are finding these to be challenging times, Schaeffer concludes. "Most of us have chosen this profession because we want to help people live longer and better lives," he comments. "We are committed to making the system better, improving outcomes and quality, and reducing medical errors. But the reality is, these goals must be achieved in the context of a sensible economic environment. Accessing practice management expertise and obtaining the information and education we need to make solid business decisions are crucial to our ability to provide excellent clinical care."

—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).

Cardiologists, like other specialists, are seeking help with practice management issues because it is much more difficult to operate in the health care environment today than it has been in the past.

E-Systems Help Improve Care

By Richard L. Reece, MD, editor in chief

Facing financial pressures due to falling reimbursement and rising overhead, many physicians are adopting new technologies, such as electronic medical records and Internet-based practice management systems, to improve efficiency and lower practice costs. Other physicians are reluctant to embrace the new technologies due to the expense and time required to choose among all the available options.

Making appropriate decisions when adopting new technologies takes time, but the payoff can be significant. "Naturally, physicians want to give the best care possible to their patients," says Mindi McKenna, PhD, MBA. "When physicians are squeezed financially or are pressed for time as a result of administrative obligations, they cannot adequately serve their patients. Adopting the right technologies can help physicians better meet their goals."

McKenna is president of eHealthCoach Inc., a company in Kansas City, Mo., that helps physicians incorporate information technologies into their practices. McKenna also teaches in the Health Care Leadership MBA program at Rockhurst University and is the author of *High Tech Medicine: Building Your Medical Practice With Computers and the Internet* (Rockhurst University Press, Kansas City, Mo., 2003). In her book and in her *eHealthCoach* newsletter, McKenna provides examples of practices that have successfully incorporated information technology. Examples include practices that have adopted EMRs or created Web sites.

Setting Goals

Physicians who have successfully incorporated information technologies have clearly understood their purpose in doing so and have let their goals guide their decisions. Likewise, other physicians interested in incorporating IT into their practices should decide what they want to accomplish with a system before choosing a particular technology, McKenna advises.

Defining a purpose is important even for relatively simple goals, such as developing a Web site. "Some physicians want to develop a Web site in order to grow their practices," McKenna says. "They want to enhance their visibility, attract new patients, and make themselves appealing to payers. Their Web sites are designed to highlight the range of medical services they offer."

Other physicians enjoy a fairly stable patient base, McKenna continues, and their Web sites serve a different purpose: to provide convenience for patients. "These sites make it easy for a patient to request a prescription refill, change an appointment, gather information, or transmit information," McKenna says. "Patients with chronic conditions, for example, might perform home monitoring of their blood pressure or glucose levels and then transmit the data to the physician's office. This function helps practices control their patients' conditions in a way that is cost effective and efficient."

Patient safety and health care quality are two commonly stated goals for technology adoption, McKenna notes. "Reducing medical errors is one of the triggers causing many health care organizations to invest in technology," she says. "They want to lower the likelihood of miscommunication because of illegible handwriting. They want to have the automated checkers, such as drug interaction, drug-food, or drug-allergy flags that are patient-specific. In the event of a product recall, they want to be able to notify patients automatically. With the movement toward evidence-based medicine, caregivers want access to information at the point of care."

Benefits of Technology

Once a purpose is defined, physicians will find that it is easier to choose among technology options and that the practice efficiency and patient care benefits resulting from selecting the right option can be remarkable.

Some solutions, such as patient entry of data into a medical record, save time for the practice by transferring tasks to the patient. "This type of technology does not take up more of the physician's time; in fact, it can free up the physician's time during the

> **"The physicians who have successfully incorporated information technologies have clearly understood their purpose in doing so, and have let their goals guide their decisions."**
>
> ***—Mindi McKenna, PhD, MBA, eHealthCoach Inc.***

encounter to focus on the patient's diagnosis and treatment," McKenna explains. "Several promising technologies make the patient an active participant in the encounter by automating the history, registration, and billing aspects of the visit through patient-entered information.

"We see from other industries that the consumer—the ultimate user—typically does not mind absorbing some of the labor because of a gain in control, responsiveness, flexibility, or some other advantage," McKenna continues. "In health care, we sometimes find that professionals feel reluctant to allow the consumer to assume more of the labor even though it might be advantageous both clinically and economically. As people live longer and yet are more likely to live with multiple and chronic conditions, we will find that the patient has to be the focal point, the center of all the data flow and the coordination of care. Unfortunately, nothing about our current health care system—the regulations, the financial incentives, the education—is set up to serve that purpose."

Technology can facilitate online medical consultation between physicians and patients. In some cases, physicians who are using the Internet are being reimbursed for addressing patients' straightforward medical questions. "This is an inevitable trend in our society," says McKenna. "Ultimately, employers will drive this trend, because they are incurring the cost of the encounter as well as the cost of lost productivity when the employee has an office visit. It is in the employer's best interest to reduce the number of medically unnecessary face-to-face encounters."

Information technology also is helping to alleviate the administrative burdens associated with managed care. One example involves formulary and benefit plan compliance. "Most physicians find it challenging to maintain prescribing practices that maximize clinical outcomes and meet payers' formulary requirements," McKenna explains. "Automated formulary and benefits authorization means that physicians do not need to remember which plans allow which medications."

Malpractice Protection

EMRs and electronic documentation may serve as a safeguard against frivolous malpractice suits. "Some electronic patient record vendors claim that their systems will reduce liability because they put safeguards in place that would otherwise not be feasible," McKenna says. "For example, they will allow a physician to verify that the record has been updated and by whom, or that the record has been accessed or tampered with. That verification wouldn't be possible if it were a piece of paper in a file cabinet. Also, some professional liability insurers are giving discounts on malpractice insurance to the early adopters of technology because the use of technology reduces the likelihood of errors. However, the technology can reflect only the actual services offered. Doctors who aren't completely confident about the accuracy and comprehensiveness of their decisionmaking are nervous about documentation that can reveal mistakes and thus increase their risk."

No doubt, complying with the Health Insurance Portability and Accountability Act is a key concern of many physicians. "The typical physician who is ambivalent about technology but very passionate about patient care needs to be compliant with the spirit of HIPAA, the goal of which is to improve service to the patient," McKenna says. "The aspect of HIPAA that seems to be getting the most attention involves privacy, meaning the patient's right to privacy and the physical implementation of policies and procedures that ensure privacy, many of which are quite complex and costly to implement. Most physicians and medical professionals do not disagree with the spirit and intent of HIPAA; they simply wish that our society would provide some relief and support in helping them get there. The economic burden, the labor investment, the learning curve in terms of understanding the regulation, the need to ensure compliance are all burdens placed on clinicians who are already strapped."

Physicians who see only the costs and time involved in adopting new technology without considering the long-term benefits are reluctant to adopt a new technology. "For example, electronic prescribing has not been widely adopted," McKenna says. "Many physicians say that they can write a prescription on a pad of paper faster than they can by using any electronic method. However, what they may not appreciate is the fact that writing is quick for the initial prescription, but for refills, particularly for patients with chronic conditions, the time spent to retrieve the patient's file, review it, get the signature, call back the pharmacy, autho-

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"As people live longer and yet are more likely to live with multiple and chronic conditions, we will find that the patient has to be the focal point, the center of all the data flow and the coordination of care," says McKenna.

(Continued from page 7)

rize the refill, and refile the chart is enormously expensive. Those costs could be eliminated by using an electronic prescribing system."

Overcoming Barriers

Despite the many advantages of new health care systems, numerous barriers slow the spread of technology. "Some of the biggest barriers involve the cost of these technologies and who should absorb the initial investment," says McKenna. "Another obstacle is the lack of standards, meaning what we call something, how we sort it, how we can access it. Doctors wonder why they should invest in a system that they may not be compatible with those of other health care organizations. Another barrier is time: the time required to select the system, to get it installed, to train the staff, and to change behaviors."

Even though these barriers are significant, physicians are increasingly adopting new technology, for various reasons. "First, patients are demanding that physicians use these technologies," McKenna observes. "Research has shown that the ability to e-mail a doctor's office to schedule an appointment, to get test results, or to request a prescription refill is a significant criterion by which consumers are choosing a physician.

"Second, caregivers who are new graduates are looking for a work environment that uses technology," McKenna continues. "They grew up with it, they expect it, and they demand it. Given the shortage of nurses and certain specialists, existing practices are seeing the urgency of technology adoption in order to recruit caregivers successfully. Some physicians might say they don't care about using computers, but they do care about being able to attract good nurses or having a good patient mix."

Financial assistance for physicians seeking to adopt technology may be possible in the future. "Governments are beginning to consider sharing in the cost of health care technology adoption because of the public good," McKenna explains. "We are starting to see more grant money, more reimbursement, and in some states, legislation that is mandating the use of computerized data entry or bar coding. In addition, many specialty societies are making investments on behalf of their members. They are negotiating either discounted rates or group rates, or they are helping them select some preferred solutions that are widely adopted within the specialty."

Smaller physician practices might consider using the application service provider (ASP) model if affordability is a problem, McKenna adds. "Instead of investing in the software themselves, running it at their own location, and employing a technical person to handle the issues that arise, they are tapping into software provided by an organization they trust, and accessing it over the Internet or through a private computer network," McKenna explains. "Then, they are not responsible for technical support, so they do not need to employ a technical employee. Also, they can pay a monthly fee instead of obtaining a software license, which can be a big capital investment."

When adopting new technology, physicians concerned about a practice's loss of productivity may be able to alleviate some of this loss through planning, but physicians also should accept that inevitably there will be some loss of productivity, at least in the short term, McKenna points out.

Making Choices

Choosing EMR software can be overwhelming, given the number of vendors and concerns about their survival over time. "When contracting with an EMR vendor, physicians need to ensure that they have control over their own data so that if a vendor fails or if a practice is bought and must switch over to another system, they will still have access to all their patient information," McKenna counsels. "Physicians should also ask a vendor to outline clearly the initial cost of the investment and future costs that may be incurred when the vendor upgrades the product. Physicians should ensure that they are made aware of all fees they will be paying so that they can budget accurately."

Often, physicians forget to budget for the training cost of using a new EMR. "Other items to include are the consulting fee, the cost of outsourcing technical support, and other maintenance and operational kinds of expenditures," she adds. Finally, she cautions physicians to be aware of the need to be able to use the EMR system with other existing technologies, such as a billing and scheduling system or managed care software applications. "Integrating all of those technologies can be more challenging than physicians often anticipate," she says.

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

Since technology can be used to reduce the likelihood of errors, some professional liability insurers are giving discounts on malpractice insurance to the early adopters of some systems, McKenna says.

TECHNOLOGY

EMRs Offer Lessons for Groups

The cost of implementing an electronic medical records system for a small physician group is about $15,000 to $50,000 per physician, and the median cost is $30,000, according to a recent report.

The report also found that physicians who implemented an EMR system lost revenue for a few days during its installation because they had fewer patient visits, and they experienced lower revenue for a period of weeks or months after the EMR had been implemented because they scheduled fewer than normal visits to allow physicians and staff to become accustomed to using the new system.

Yet, despite the relatively high costs and lost revenue, the new systems helped the physician groups improve patient care quality by making data more legible and accessible and by improving prescription ordering, as well as by providing physicians with decision support information about illness prevention and disease management, according to the report. Prepared for the California HealthCare Foundation in Oakland and written by professors from the University of California at San Francisco (USCF), *Electronic Medical Records: Lessons From Small Physician Practices*, is available online (at www.chcf.org).

An IT Rx

A physician who was interviewed for the report was quoted as saying that the EMR clearly helps to improve patient care: "There is a tremendous amount of poor or lost information that impacts patient care. Doctors don't remember all the illnesses or all the medicines and can't read anybody else's notes in the chart." The physician had looked through many charts at an academic health center and found most were illegible. "And that goes for every institution around the country," the physician notes. "So you can't read the information and you can't find it. You can fix all that with an EMR." What's more, if a medication is recalled, the practice can quickly find all of its patients who might be affected, he points out.

For the report, the UCSF researchers interviewed physicians in 20 solo or small group practices who support the use of EMRs. Half of these physician champions used seven different EMR systems and the other half used the same EMR system. Almost all of its practices had 10 or fewer primary care physicians and 13 were in California.

Cost Savings

The financial benefits of using an EMR—ranging from no benefit to gains of more than $20,000 per year for two physicians in one practice—were more difficult to quantify, the report says, and many factors affected the cost of an EMR system. According to the report, having better preexisting hardware or leasing the software or hardware decreased the initial outlay, and costs were comparatively higher for groups that had more nurse practitioners and physician assistants per physician and for those that used more notebook computers.

One notable benefit of using EMRs was decreased staff costs, the report says. The groups that had the most success in using EMRs were able to cut the number of full-time equivalent staff who work on transcriptions, medical records, data entry, billing, and in reception, although some of the physicians interviewed for the report had the same number of staff before and after using an EMR, the report notes.

Another benefit of using EMRs was increased revenue as a result of coding to a higher level of care, although the groups could not quantify the amount of increased revenue they received, the report says. "Many interviewees felt more comfortable coding to higher Medicare Evaluation and Management (E&M) levels (for visits and consultations provided by physicians or residents under a physician's supervision) than they had prior to using an EMR, because the electronic forms had prompted them to do what was needed to justify the higher levels and to document that fact," the report says. "When asked whether the EMR helped a practice to increase revenue by raising the level of coding, one physician said the EMR forced the user to think carefully about using the proper code. Many physicians

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"There is a tremendous amount of poor or lost information that impacts patient care," one physician says. "Doctors don't remember all the illnesses or all the medicines and can't read anybody else's notes in the chart. You can fix all that with an EMR."

Differences Explain Some Benefits

One lesson the researchers learned from producing the report, *Electronic Medical Records: Lessons From Small Physician Practices*, was that EMRs differ in their capability, usability, and flexibility, thereby affecting the ability of physicians to use them successfully. The report was prepared for the California HealthCare Foundation in Oakland by researchers from the University of California at San Francisco.

"Clearly, differences among EMR software products had some effect on the benefits the physicians achieved with them," the report says. "Some EMRs were more capable, usable, and flexible than others." What's more, one practice found that its EMR software was unacceptable and needed to be replaced. The report did not name the manufacturer of the software that was deemed to be unacceptable.

"Unfortunately, it was impossible to determine which EMRs provided the most benefits and the best value, given the small sample," the report adds. "Moreover, most interviewees were quite satisfied with both EMR products and services. One explanation for these findings is that in selecting software, clinicians looked for different EMR styles that would work for them. Another explanation is that many in this extraordinary sample of early adopters had characteristics that enabled them to make changes that led to at least some success, despite differences in the underlying usefulness of the technology."

In other words, the research shows that the way the EMR is used may be the most important factor in its utility to a practice, the report says.

—JB

(Continued from page 9)

tend to use the same code for many different types of treatment and in doing so tend to undercode because it is easier to do so than worrying about overcoding and the possibility of Medicare fraud and abuse charges that can result."

Other physicians reported they had increased revenue as a result of being able to more efficiently capture information about the services they provided, especially when EMR and billing software systems were integrated, the report says. As a result of using an EMR, a few physicians provided more services per visit, which increased revenue. Revenue tended to accrue most to physicians who saw fee-for-service patients and to those physicians who had systems that integrated EMR and billing. Again, the physicians could not quantify the amount of increased revenue they had received.

Types of Users

The report identifies five types of physicians who use EMRs and suggests that those who are most involved with the EMRs get the most from their systems. The five types of users are viewers, basic users, strivers, arrivers, and system changers. The viewers and basic users were the least advanced users, had left their clinical and business processes mostly unchanged, and still relied heavily on paper or scanned images. Strivers—in the middle of the spectrum—spent the most extra time at work on the EMR and continued to make changes that could generate benefits and would eventually reduce the time they spent on EMRs, the report says. Arrivers and system changers had reengineered work processes enough to almost eliminate paper-based clinical processes. Thus, the more advanced users took advantage of more EMR capabilities, usually reaped more financial and quality benefits, and had invested more time in their EMR systems.

Investing time was essential for physicians to get the most from their systems, the report says. Time was needed to make changes that would allow the physicians to use the system most effectively, such as entering patient data from paper charts, customizing electronic forms that came with the software, creating documentation shortcuts, arranging for extra technical support, reorganizing the workflow in the exam room, and rearranging processes in the office.

A Key Lesson

One key lesson coming from the research is that when a small group is considering an EMR, at least one or more of the physicians in the group needs to serve as a champion for the new system, the report says. "EMR champions must be willing to lead in purchasing and implementing the EMR," the report explains. "Potential EMR champions need to assess whether they have the personal characteristics, including determination, needed to succeed with an EMR."

Even though physicians may be savvy about information technology, are skilled in changing workflow, and have positive attitudes toward change, they may find it difficult to make the changes necessary in their practices so that they get the most out of the new EMR, the report says. Solo physicians or those in small groups who are not savvy about information systems and who are not enthusiastic about making changes to accommodate an EMR may find it even more difficult to achieve suc-

Physicians need to commit to working with the EMR. If they do not, they may become discouraged, not generate EMR-related financial or quality benefits, and reduce the benefits generated by others, according to the report.

cess, the report says.

"While some physicians are willing to spend some time getting used to EMRs and making needed changes, most physicians do not necessarily want to figure out by themselves how to most efficiently enter past data, fix hardware and software IT problems, customize software, reengineer their workflow and their office's workflow, and orchestrate data exchange interfaces between themselves and outside data providers," the report points out.

Committing to the EMR

One key recommendation in the report involves a commitment to the system: Physician leaders should get members of the group to commit to using the EMR. "If a practice has one or more EMR champions, other physicians in the practice must make specific time commitments in order to achieve success," the report says. "Physicians must understand that they will have to change their workflow in order to generate benefits." In particular, physicians should not write or dictate progress notes but instead should type in text or click on check boxes to do so, the report explains.

"Moreover, they need to commit extra time to learn to use the EMR effectively, including customizing electronic forms and their own documentation shortcuts," the report says. "Without that commitment, some physicians will quickly become discouraged, reduce their potential EMR use, not generate EMR-related financial or quality benefits, and reduce the benefits generated by others."

Physicians using EMRs also should maximize the use of electronic data exchange, the report comments: "Maximizing electronic data exchange is critical for reducing paper and data entry and thus for reducing costs. First, the practice has to obtain adequate electronic data from outside sources. In particular, this means obtaining specific commitments from the labs to set up efficient electronic data exchange to enable physicians to view lab results within the EMR. Second, the practice needs to arrange adequate data exchange between the EMR and the billing and scheduling software within the practice. For some, this means purchasing an EMR with integrated scheduling and billing modules, and converting data from the old system to the new system. For others, this means obtaining contractual commitments from the EMR and practice management software vendors to set up efficient electronic data exchange between the two systems."

To be successful with a new EMR, it is also important for the group to arrange comprehensive support services, the report says. "Clearly, comprehensive and multifaceted support services would help many physicians learn to use EMRs more effectively and more quickly," the report states. "Comprehensive services should address all technical issues, including hardware, software, operating systems, telecommunications and process issues, including data entry, template customization, work flow redesign, and learning efficient use of the EMR.

"Although some vendors provide good support, it tends to be less comprehensive than needed for the many changes that go well beyond direct use of the EMR software," the report continues. "In reality, it may be very difficult to arrange truly comprehensive support, since the market does not offer it in most areas. At a minimum, the practice must have solid technical service support as a backup to whatever the hardware, telecommunications, and software vendors can provide. Most EMR vendors supply the names of potential technical support service firms, although some vendors may not know how effective such firms are. Practices considering adopting an EMR also could get support from other practices in the same area that have already successfully adopted the same EMR and are willing to provide advice on how to use the EMR efficiently, change work flow, and overcome obstacles."

And, finally, the report adds that groups must motivate physicians to use the EMR. "Practices should consider rewarding those physicians that electronically document and thus generate benefits from reduced medical records, transcriptionist, and data entry staff time," it says. "Incentives had a major effect on behavior in the few practices that tried them."

—Reported and written by editor Joseph Burns. More information on physician practice strategies is on our Web site *(see page 16)*.

Some physicians increase revenue by using the EMR to more efficiently capture information about the services they provided.

IOM Wants Changes in Nursing Levels

In a climate of high turnover among nursing staffs and a nursing shortage that may get worse in the coming years, the Institute of Medicine is making recommendations to improve the work environment of nurses. Implementation of the recommended changes could help health care organizations recruit and retain nurses, says the recent report from the IOM.

Nurses represent the largest segment of the nation's health care workforce, and they often have a significant effect on the quality of patient care, the IOM says. Given the current nursing levels in most health care organizations and the hours nurses are required to work, improvements are needed to better protect patients from health care errors, according to the report. One study found that nurses in two hospitals intercepted 86% of medication errors before they reached patients.

Issued last year, the report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, calls for changes in how nurse staffing levels are established and mandatory limits on nurses' work hours. It also promotes a comprehensive plan to reduce problems that threaten patient safety by strengthening the work environment for nurses in four areas: management, workforce deployment, work design, and organizational culture. The report is available on the Web (at www.nap.edu).

Steps Required

"Creating work environments that reduce errors and increase patient safety will require fundamental changes in how nurses work, how they are deployed, and how the very culture of the organization understands and acts on safety," says Donald M. Steinwachs, PhD. "Because the supply of nurses is unfortunately stretched thin right now, they must be supported by work processes, work spaces, hours, staffing practices, and a culture that better defends against errors and readily detects and mitigates errors when they occur. Nurses will be more likely to stay in health care organizations that implement the management and work-design practices recommended in this report." Steinwachs is chair of the committee that wrote the report.

Nurses make up 54% of the health care provider workforce in the United States, the report says. Their actions are directly related to better patient care, and studies show that increased infections, bleeding, and cardiac and respiratory failure are associated with inadequate numbers of nurses.

Despite mounting evidence that better nursing staff levels result in safer patient care, nurses in some health care facilities may be overburdened, the report says. For instance, some hospital nurses may be assigned as many as 12 patients per shift. Hospitals and nursing homes uniformly do not use available methods for achieving safer staffing levels, such as authorizing nursing staff to halt admissions to their units when staffing is inadequate for safe patient care, the report says.

Requiring nurses to work many hours threatens patient safety because fatigue slows reaction time, decreases energy, diminishes attention to detail, and contributes to errors, the report says. Most nurses work eight- to 12-hour shifts, but some work longer shifts. What's more, patients admitted to hospitals typically are more acutely ill and require technologically more complicated care than patients required in the past.

Staffing Levels

Hospital intensive care units should increase internal oversight when staffing falls below one nurse for every two ICU patients, the report says. Federal and state report cards on nursing homes should include information on nursing staff levels, and measures of staffing levels should be developed for hospital report cards, it adds. Also, whenever possible, health care facilities should avoid using nurses from temporary agencies to fill staffing shortages, the report says.

The report also addresses nursing levels in nursing homes, saying old regulations that specify minimum standards for staffing should be updated. The U.S. Department of Health and Human Services should require nursing homes to have at least one RN in the facility at all times and should specify staffing levels that increase as the number of patients rises and that are based on the department's minimum staff-to-patient ratios for nursing homes. Also, the report says, state regulatory bodies should prohibit nurses from working more than 12 hours a day or 60 hours a week.

—Reported and written by editor Joseph Burns. More information on physician practice strategies is on our Web site *(see page 16)*.

Nurses must be supported by work processes, work spaces, hours, staffing practices, and a culture that better defends against errors.

How to Benefit From Medicare Reviews

By Betsy Nicoletti

Too many practices ignore the useful information contained in Medicare's requests for notes. Fulfilling these requests can provide a practice's physicians and staff with critical insights that can save time, money, and aggravation.

A practice's billing staff should watch for two types of requests: prepayment audits and progressive correction action (PCA) letters. Typically, intermediaries send out both.

Prepayment Audits

A prepayment request for notes arrives with the message that Medicare cannot process a certain claim without the documentation for that service. The single-page letter states: "Dear Doctor or Supplier, we are processing a claim for John Doe received on x/x/xx, and we cannot complete this processing with the information requested below."

In this letter, Medicare requests a copy of the original documentation of the history, exam, and medical decisionmaking for the service provided on a certain date. If the service was a consult, Medicare asks for documentation of the request and the report. Some physicians are receiving requests for 99244 notes for the level 4 outpatient/office consult. It is wise to review the documentation requirements for this level of service and learn from colleagues' experiences.

The federal Office of Inspector General consistently shows interest in consultations. Reviewing the OIG work plan (at http://oig.hhs.gov) is a good way to discover which services this watchdog agency is monitoring most closely. Physicians can take advantage of this early warning system, and practices that ignore the work plan do so at their own risk. Practices should ensure that all physicians, nonphysician practitioners, and billing and coding staff understand the rules for each relevant area within the OIG work plan, as well as the importance of following the rules completely and consistently.

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The Work Plan

The OIG consistently highlights consultations and incident-to billings in its work plans. This year, the work plan specifically notes that the OIG will identify "physicians with aberrant coding patterns, specifically coding disproportionately high volumes of high-level evaluation and management codes."

The OIG is also looking at the following coding patterns:

- Use of -25 modifier
- Use of modifiers with NCCI edits, meaning bundling and unbundling (NCCI is Medicare's National Correct Coding Initiative)
- End-stage renal disease capitation payments
- Errors involving place of service
- Care plan oversight
- Diagnostic tests
- Radiation therapy services

Answering a Request

Physicians should have a procedure in place for billing staff to follow when responding to a Medicare request. At a minimum, the staff should take the following six steps:

1. Upon receipt of the request, notify the billing supervisor or manager and the physician involved.
2. Log the request on a spreadsheet, noting the date of service, the type of service, the procedure code, the physician involved, the date of request, and the date records are sent to Medicare. Two additional columns to be included in the log are the date Medicare responded and the code paid.
3. Prepare all necessary information.
4. Have the billing supervisor or manager review the information before it is sent to the carrier. Copies should be clear and inclusive. In the haste to respond, no important supportive documentation should be forgotten.
5. Send all relevant materials to the insurance carrier, making sure to include the note for the service, any history sheets referenced in the note, and the lab or other diagnostic test ordered or reviewed at that visit. If the request was for a consult, any documentation should be sent that supports that the service provided was a consult and the request or evidence that a copy of the report was sent to the requesting physician.
6. Keep a copy of what was sent to Medicare in the billing office.

The carrier will not write a special letter stating that the coding has been accepted. Instead, the claim will be paid and appear on the physician's explanation of benefits with his or her other claims. Using the log established in step one, the staff should track whether or not the claim was paid.

When the claim is paid, the intermediary's determination should be

(Continued on page 14)

Responding to a Medicare Carrier's Request

When answering a request for more information from a Medicare carrier, physicians should be thorough and act quickly. Also, they should make copies of all paperwork sent and create a log to track progress over time. Here's what to send:

- The notes for the day in question
- All history sheets referenced in the note
- Any lab work or x-rays ordered or reviewed during the visit
- If the visit was a consult, any back-up documentation verifying that the service was a consult (such as a request or proof that the report was returned).

In the log established to track the request, the following categories should be included

- The date of service
- Provider's name
- Type of service
- Procedure code
- Date of request
- Date notes sent to Medicare
- Code level paid by Medicare
- Date paid by Medicare

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reviewed. Was the claim paid at the level of service billed, denied, or downcoded? This direct feedback should be used to educate the practice's physicians, nurse practitioners, and physician assistants about the documentation requirements for the code audited by Medicare.

The PCA

The PCA is a more ominous communication from the carrier. The practice's management, the compliance officer, and the physician involved should be notified immediately when such a letter is received. This letter will tell a physician that he or she has been selected for review because his or her coding pattern differs from that of peers of the same specialty in the area. (It should be remembered that the OIG work plan specifically instructs carriers to identify physicians with aberrant coding patterns.)

The notes should be sent in a timely fashion and include the note for the service, any history sheets referenced in the note, and any lab or other diagnostic test ordered or reviewed during the visit. If the request was for a consult, all documentation that supports that the service provided was a consult should be sent (meaning the request or evidence that a copy of the report was sent to the requesting physician). A copy of what was sent to Medicare should be kept in the practice's billing office. Also, the practice's auditor should be asked to audit the notes that have been sent.

When the results from the carrier are received, the specific feedback that comes from the carrier should be noted and the recommendations should be communicated to all physicians and other providers, so that everyone in the practice can improve the documentation of services. If the results are not favorable, claims for that code should not be submitted until after the physician or physicians affected have been informed.

A PCA is accompanied by a thick packet of information and includes copies of the documentation guidelines and instructions on how to bill Medicare correctly. It also contains a letter outlining the results of the review. This letter summarizes how many of the notes were judged to have met the criteria for the selected code and delivers specific feedback and findings about the notes that were reviewed. In addition, some boilerplate information about documentation guidelines is often included.

Special attention should be given to the parts of the PCA letter that are titled "Findings/Feedback." These suggestions should be incorporated into the documentation. If the carrier audited any of the notes at a level lower than they were billed and documented, it will ask to be paid for the difference between the two levels of service.

Using the Information

Receiving a PCA provides a practice with an opportunity to compare

The PCA will tell you that you have been selected for review because your coding pattern differs from that of your peers in the same specialty and area.

Avoiding Problems With the OIG

Practices should ensure that all physicians, nonphysician practitioners, and the billing and coding staff in the practice understand the rules for each relevant area within the work plan of the federal Office of Inspector General. This year, the work plan specifically notes that the OIG will identify physicians with aberrant coding patterns and those who are coding disproportionately high volumes of high-level evaluation and management (E/M) codes.

To avoid problems with the OIG, all physician practices can do the following:

- Ask if the billing department has received prepayment requests
- Compare the E/M distribution of the practice's physicians with national norms
- Review encounter forms (are all levels listed for each service?)
- Review the OIG work plan (at http://oig.hhs.gov)
- Educate physicians and other providers about E/M documentation guidelines.

When dealing with the OIG, the mistakes to avoid include the following:

- Ignoring requests
- Having a defensive attitude
- Not communicating the results to all physicians and other providers and staff
- Not educating physicians and providers.

—BN

notes that the intermediary says do and do not meet the criteria for the level of service. For example, the correspondence may state: "The intermediary audits this documentation as a 99213 and this documentation as a 99214. These are the issues that made a difference in the auditing."

In most instances, prepayment reviews and PCAs offer a useful opportunity to learn and improve both the physician's and the practice's performance. But they may not be viewed this way within a practice. Some physicians and practice managers may respond in a way that is not useful, with comments such as "They're wrong," or "They don't understand my practice or my patients," or "My patients are sicker than other physicians' patients." Such responses are counterproductive.

Nor will it help the practice to file away these reports without careful review or to review the findings only with the physician whose notes are requested. Every physician and nonphysician practitioner can learn from the results. Therefore, practices should schedule an educational session or staff meeting to review the results and the documentation guidelines. Then, all physicians can incorporate the specific findings and feedback into their documentation.

E/M Distribution

Another area that is important for physicians to evaluate is the use of evaluation and management codes. Physicians must compare their E/M distribution and coding patterns with those of national norms for their specialty. If coding varies significantly in a practice from these norms, the practice should ensure that physicians and other providers are appropriately documenting the level of service being billed. (Medicare collects these national numbers by specialty and publishes them in raw form on the Web. Many companies repackage and sell these data in user-friendly workbooks.) Physicians also should compare the rates of E/M use for each provider with those of other members of the group in the same specialty.

All physicians should avoid billing only one level of service in each type of visit. They should not, for example, bill all consults as level 3, or all admissions as level 2. Doing so is a serious mistake.

Medicare expects the work performed for each patient to be driven by medical necessity and by the complexity of each patient's problem. In fact, in the *Medicare Carrier's Manual*, physicians are told specifically not to select the level of service based solely on the volume of the documentation, but rather on the medical necessity for providing and documenting that level of service.

Some physician specialists say that all their consults are a level 4, and they believe this to be true because all of their patients are ill or because they have attended a coding class in which an educator detailed the documentation needed for a level 4. Or physicians may use an electronic medical record or coder that reminds them to document review of systems and family history, so all notes are coded at this level. Physicians must, however, always consider the medical necessity of each service level.

What's more, practices should review all encounter forms to ensure that all service levels are listed within each category. If a form lists only level 3 and level 4 new patient visits, requiring physicians to write in the lower level visits manually, it appears as though physicians are being encouraged to bill at higher level visits.

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

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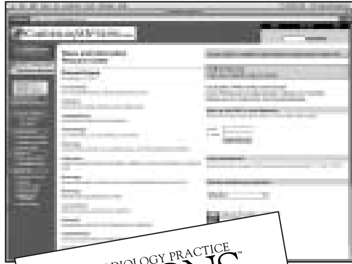

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