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INSIDE

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Physician extenders increase efficiency, improve patient care

Practices turning to midlevel providers to boost bottom lines

Do the physicians in your practice feel under constant stress to work harder and harder? Are your patients spending long hours in your waiting room because the appointment schedule is so far behind?

Do patients often have to wait weeks for an appointment? Are you able to spend adequate time with each patient you see? Does your practice provide the kind of patient education you would like to provide? Are you seeing more and more patients but making less money?

If the answer to any of these questions is "yes," your practice could benefit from hiring physician assistants or nurse practitioners, experts say.

Physician assistants and nurse practitioners allow physicians to improve their delivery system and make sure all patients can schedule an appointment within a reasonable amount of time.

As reimbursement declines, physicians have to see more and more patients to maintain a viable practice, says **Darrell Schryver**, DPA, principal with the Healthcare Consulting Group of the Medical Group Management Association (MGMA) in Englewood, CO.

As a result, access to physicians has become a real problem, particularly in primary care settings for internal medicine, pediatrics, and family practice. As waiting times have increased, many practices are turning to midlevel providers to fill in the gaps. **(For details on the scope of practice for midlevel providers, see related article on p. 50.)**

"Scheduling and customer service are critical to today's practices. That's why physician assistants and nurse practitioners are so important," says **William J. DeMarco**, president of DeMarco & Associates, a consulting firm in Rockford, IL. "They allow physicians to see the more challenging and critically ill patients themselves while still maintaining control over the care of all patients."

An MGMA survey conducted for the annual report Performance and Practices of Successful Medical Groups finds that better-performing

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practices make extensive use of physician assistants and nurse practitioners, Schryver asserts. These extenders help boost a practice's efficiency and still provide quality care, he says.

For instance, if a potential new patient for a pediatric practice has to wait eight weeks for a well-baby check-up, the patient is likely to go somewhere else, even if your practice is highly recommended, Schryver points out.

As an alternative to losing patients, a group could hire two pediatric physician assistants to do the initial screening and get patients established. That way, your group wouldn't lose the new patients.

"We have found that practices that use physician assistants and nurse practitioners have generally become much more efficient. I am a strong supporter of the physician assistant role if it is well-structured and well-managed, with appropriate accountability and reviews," Schryver says.

A midlevel provider is typically about half the cost of a primary care physician. **(For details on how midlevel providers are compensated, see related article on p. 53.)**

"Financially, hiring nurse practitioners was a great decision. It has allowed us to double the number of patients we can see," says **Anne Meden-Cutler**, administrator of Bristol Street Pediatrics in Elkhart, IN.

The nurse practitioners at Bristol Street Pediatrics see patients with simple illnesses, handle many well-child visits, and allow the doctors to see the really sick children.

"Doctors can stretch themselves only so far. Without nurse practitioners, we'd be in trouble during the flu season," Cutler says. **(For information on how physicians and midlevel providers collaborate, see story on p. 52.)**

Nurse practitioners are popular with patients, too. Two of the questions on the practice's yearly patient satisfaction survey ask whether patients are willing to see nurse practitioners and if they feel like nurse practitioners provide quality medical care.

"In 10 years, we've never had anyone who says they prefer not to see them. They like them and they're used to them," Cutler says.

At East Albany (GA) Medical Center, physician assistants allow the practice to guarantee that patients can be seen within 24 hours, says **Ron Malcolm**, PA-C.

"It works out very smoothly. We are an extension of the physicians. They are able to triage more and take care of the patients who really need it," Malcolm says.

A physician assistant program typically is 111 weeks, compared to 155 weeks for medical school, according to the American Academy of Physician Assistants in Alexandria, VA.

The program includes a combination of classroom and laboratory instruction, followed by clinical rotations in internal medicine, family medicine, surgery, obstetrics and gynecology, emergency medicine, and geriatric medicine.

Nurse practitioners are registered nurses, usually with extensive experience, who go through additional master's-level training.

Nurse practitioners initially were used in underserved rural and low income areas when the profession was first created in the 1960s, says **Eric Scharf**, CAE, executive director of the American College of Nurse Practitioners in Washington, DC.

"We are seeing a broader acceptance of nurse practitioners in the mainstream medical community in a variety of settings," Scharf says.

The Bureau of Nursing at the U.S. Department of Health and Human Services estimates that there are about 80,000 nurse practitioners in this country, up from about 70,000 four years ago.

According to the Bureau of Labor Statistics, there were about 34,200 certified physician assistants in clinical practice in 1999. The bureau estimates that the number of physician assistants in the U.S. will grow by 48% by 2008. ■

Gear use of extenders to your special needs

Scope of practice depends on laws, preferences

How you use midlevel providers in your practice depends on your unique patient population, your practice's preferences, and your state's laws, says **Darrell Schryver**, DPA, principal with the Healthcare Consulting Group of the Medical Group Management Association (MGMA) in Englewood, CO.

Each state has different regulations about what midlevel providers can do and the amount of supervision they require, and each practice should decide what would work best for it, Schryver adds.

"There is no set protocol for using midlevel providers. Each group has to establish its own protocols and clearly define which patients must see the physician and who can initially be screened by a physician assistant or nurse practitioner," Schryver says. For instance, at Dean Medical Center, a multispecialty group practice in Madison, WI, primary care physician assistants handle everything from well-care examinations to acute illnesses and injuries to chronic disease management, says **Lou Falligant**, PA-C, a physician assistant with more than 25 years of experience.

At Dean Medical Center, physician assistants in cardiovascular surgery and general surgery are strictly hospital-based. They assist during surgery and manage postoperative patients.

Dean's orthopedic physician assistants work predominantly in the hospital setting, assisting with surgery and postoperative care. In addition, 25% of their practice is in the clinic, where they see surgical follow-ups and outpatients and conduct simple consults.

The practice's neurology physician assistants see a subset of clients, including patients with seizures, multiple sclerosis, and headache. These PAs have a strong educational role.

The physician assistants at East Albany (GA) Medical Center perform the majority of the routine health screenings, women's health checks, and other procedures, leaving physicians free to take care of the more complicated, sicker patients. The clinic has 10 physician assistants and 18 physicians.

For instance, by the time a physician has finished hospital rounds, the physician assistants already have made a dent in the day's patient load. They also assist in the hospital but typically do not make rounds.

"We are more effective working with the outpatients," Malcolm says.

At East Albany Medical Center, almost all the clinics are directed by a physician assistant, freeing the physicians to spend more time on clinical care than on managerial duties.

Falligant's duties at Dean Medical Center include a combination of administrative and clinical roles. He works in family practice, seeing patients on a fill-in basis for physician assistants who are gone for the day. Most of his time is spent in administration, performing work similar to that of a medical director.

"I do troubleshooting, such as dealing with staffing problems or personality conflicts, all the things a medical director would be involved in," Falligant says.

He recruits and conducts orientation of new physician assistants and handles practice management projects.

"I monitor patient counts and productivity and compile the data so people can see where they stand in relation to their peers," Falligant says.

Allina Medical Center in Forest Lake, MN, gives its physician assistants the ability to choose what procedures they are comfortable handling, says physician assistant **Beverly Kimball**, PA-C. For instance, one of Kimball's physician assistant colleagues prefers not to do certain procedures with male patients, so schedulers make sure men don't get put on her schedule.

Kimball works on the same schedule as the physicians and has 15-, 30-, and 45-minute slots for patients. She reserves 45 minutes for an adult physical as opposed to the 30-minute slot physicians typically use.

At Bristol Street Pediatrics in Elkhart, IN, nurse practitioners see patients with simple illnesses who are at least six months old. After six months, nurse practitioners perform every other physical examination for the child.

"It's been really well-received by our patients.

Eight Keys to Using Midlevel Providers

Here are eight keys to successful use of midlevel providers:

1. Develop protocols that clearly set out what type of patients are referred to what type of provider.

2. Set up a triage system to make sure your protocols are followed.

3. Have a professional, such as an RN, handle your telephone triage.

4. Make sure the midlevel providers you hire are graduates of a fully accredited program.

5. Check all references for potential employees, and look at the average number of patients they see each day.

6. Make sure the midlevel provider wants to fulfill the primary role you establish, such as treating patients or education.

7. Set up formal policies and procedures for follow-up and review.

8. Check with each of your payers to make sure you follow the proper procedures on claims for midlevel provider services. ■

A lot of them would rather see a nurse practitioner than a doctor," says **Anne Meden-Cutler**, administrator.

The nurse practitioner visits are scheduled with 10 minutes more time than physician visits.

When parents call the office, the calls either go to the front desk or to the telephone nurse who screens the calls. If the children are over six months old and have a simple illness, they are offered an appointment with a nurse practitioner. If they are younger than six months, the call goes to the telephone nurse, and a visit is scheduled with a physician. If patients don't feel comfortable with a nurse practitioner, they can see the doctor.

Well-children examinations are often scheduled two months in advance with physicians. The nurse practitioner can usually see a patient for a well-child exam in one or two weeks. ■

Thoughtful collaboration boosts patient care

Supervisors review dictation, prescriptions

When **Beverly Kimball**, PA-C, started work as a physician assistant at Allina Medical Center, Forest Lake, MN, her supervising physician reviewed every dictation she made, even though she had 19 years experience.

"He needed to see that he had a comfort level with the way I do things and to let me know how he preferred that I handle things," Kimball explains.

Now, the physician reviews only about 10% of her dictation.

"He reviews them, co-signs them, and puts a sticky note on them if he has any comments positive or negative," she adds.

State and federal laws require that midlevel providers be supervised by physicians, but in most places, the practice has leeway on how it will occur. Supervising physicians typically review a selection of charts and conduct regular reviews of the midlevel providers' work. In some states, the physician must co-sign the charts whenever medication is prescribed.

The staff at Allina take a team approach to practice. For example, Kimball will call in a physician if she has any question about a patient's diagnosis or if the problem is complicated. She'll often trade patients with the physician in such a situation.

The reverse is also true: Some of the male physicians who are seeing teenage girls with what could be an embarrassing problem will ask Kimball to swap with them.

At Bristol Street Pediatrics in Elkhart, IN, each doctor teams up with a pediatric nurse practitioner to provide continuity in care. For instance, each nurse practitioner does every other physical for the patients of one particular doctor.

"If the NPs get in over their heads, they always call in a doctor for an opinion. The doctors are always in the building when the nurse practitioners see patients," says **Anne Meden-Cutler**, practice administrator.

At East Albany (GA) Medical Center, both the physicians and the physician assistants conduct peer review of each other every six months. During the process, the physicians review the charts of the physician assistants and vice versa.

"It's a learning process that allows you to get to know the skills of your PA or your MD and their preferences," says **Ron Malcolm**, PA.

At Dean Medical Center in Madison, WI, "pods" of physicians and physician assistants work as a group. A typical pod may include nine physicians and three physician assistants, with the supervisory role for each PA rotating among the physicians depending on when they are in the office.

Wisconsin does not require direct on-site supervision for PAs, says **Lou Falligant**, PA-C, a physician assistant. Instead, the physician should be available either in person or by telephone.

"Typically, if I am seeing 25 to 30 patients a day, I'm going to consult with the physician on only one or two of these. When the situation is more complicated, it helps to get two heads involved," Falligant says.

When the chart notes come back from transcriptions, the physician reviews and countersigns all of them, Falligant says.

Wisconsin state law requires physicians to countersign only when the physician assistant issues a prescription, but the practice decided it provides good continuity of care for physicians to review and countersign all notes. "That way, they can give feedback if they see anything they think merits it," Falligant says.

Once a year, the physicians conduct a thorough performance appraisal of all the physician assistants in their pod. Each physician does his own appraisal, and a supervisor puts together a compilation of appraisals for each PA. ■

Most payers cover midlevel providers

Most practices bill the same as for physician visits

In addition to allowing the practice to see more patients more efficiently, physician assistants and nurse practitioners can have a positive effect on your practice's bottom line.

Midlevel providers earn far less than physicians, but in most cases, your practice can be reimbursed for services at close to the same level you would charge for physicians.

If you submit claims under the physician assistant or nurse practitioner's provider number, Medicare will reimburse you for 85% of physician fees. Medicare regulations allow for services of physician extenders to be billed as "incident to" physician services under certain circumstances, meaning reimbursement will be 100% of the physician fee schedule.

In this case, the claim must be submitted under the physician's provider number and must meet strict Health Care Financing Administration regulations. The physician extender must be an employee of the physician, the physician must perform the initial examination, and the physician must provide direct supervision of the extender.

In its 2001 Work Plan, the Office of Inspector General stated its intention to examine the scope of practice of nurse practitioners, clinical nurse specialists, and physician assistants to ensure that they meet Medicare requirements when their services are billed as "incident to" physician services. **(For details, see *Physician's Managed Care Report*, December 2000, pp. 177-179.)**

Most insurance companies credential physician assistants and accept claims under the PA's provider number, says **Beverly Kimball**, PA-C, a physical therapist with Allina Medical Center in Forest Lake, MN.

If the company does not credential the PAs, the practice submits the claim under the supervising physician's number.

Bristol Street Pediatrics in Elkhart, IN, charges the same amount for nurse practitioner visits as for physician visits.

"Every time we get a complaint, we ask them if they feel like they got qualified medical service, and if so, why should they get it for less," says **Anne Meden-Cutler**, practice administrator. ■

Pay plans vary depending on individual choice

Practice setting, experience are factors

The salaries of your midlevel providers will vary by specialty, practice setting, local pay scales, and the provider's experience. Expect to pay roughly half of a typical physician's salary for an experienced physician assistant or nurse practitioner. Whether you pay your midlevel providers a straight salary, an hourly wage, or based on production is up to you.

Bristol Street Pediatrics in Elkhart, IN, pays its nurse practitioners by the hour and gives them an end-of-year production bonus, says **Anne Meden-Cutler**, administrator. The practice started its production bonus system for nurse practitioners to reward them for their years of service.

"They've all been here a long time. We felt we needed to offer them something extra," Cutler says. The practice uses a complicated formula based on relative value units (RVUs).

At the beginning of the year, the practice sets a revenue limit over which the nurse practitioners are able to get a bonus. At the end of the year, Cutler adds up the total number of RVUs for all of the nurse practitioners and figures the percentage of the total RVUs each nurse practitioner has produced.

Encouraging NPs to see more patients

The bonus is based on net collection. The RVUs include office visits and procedures, not ancillary services. "It encourages them to see more patients," Cutler says.

Dean Medical Center in Madison, WI, takes a different approach with its physician assistants. The Dean physician assistants are paid a salary but no production bonuses. Full-time physician assistants are required to have 35 hours of patient contact time open and accessible each week.

"Our own feeling is that we are not interested in putting physician assistants in competition with physicians for patients," Falligant explains. At Dean, physician compensation is based on productivity. ■

Thinking outside the box reaps benefits for clinic

Patient access, collections have increased

East Albany (GA) Medical Center does things a little different from the typical medical practice: The support staff escorts patients and takes vital signs; a nurse reminds the patients of unpaid balances; and the entire 56-member staff, from the front desk to the providers, can be in constant communication with each other via walkie-talkies.

And it works.

The clinic, in rural south Georgia, sees more than 39,000 patients a year. Patients can get an appointment within 24 hours after calling, and all patients, including walk-ins, are in and out in 45 minutes or less.

After an extensive re-engineering project geared toward increasing efficiency and improving patient access, patient satisfaction is at an all-time high and collections are up. And the project costs very little because it uses common, off-the-shelf technology such as cordless telephones and electronic databooks.

The redesign project took place over a six-month period as four members of the clinic staff attended a six-month course in re-engineering and applied the techniques they learned to improve patient flow.

"The seminars taught us about redesign and thinking outside the box. We took those concepts and started applying them in our clinic," says **Ron Malcolm**, PA-C, a physician assistant and leader of Team Delta Force, the redesign team. Other members of the team were Bernard Scoggins, MD, medical director; Diane Carter, business manager; and Belinda Morrison, RN, nurse manager.

After a 90-day implementation period and trial, the redesign team is currently in the process of expanding the redesign to include the other six clinics operated by Albany Area Primary Health Care.

The program has received an Innovations in Health Care Award from the American Academy of Physician Assistants / Physician Assistant Foundation / Pfizer recognition program.

"Our clinic was chosen for the redesign project because it's the busiest and often the most frustrating for staff," Malcolm says.

The 18 physicians and 10 physician assistants treat 39,000 patients a year in a rural part of Georgia that ranks high in morbidity and mortality statistics, including AIDS and infant mortality.

The goal of the project was to increase efficiency at the clinic and cut down on lengthy waiting times for patients.

The team started out by doing detailed measurements of patient flow. Each team member followed patients one at a time from the time they walked in the clinic door until they left. This helped identify the problems and bottlenecks and came up with way to correct them.

Their solution was to change the way the clinic operated and enhance communications by using inexpensive, off-the shelf technology including walkie-talkies for all staff, electronic data books and cordless telephones for the nurses, and computer terminals in all the treatment rooms. **(For more information on how the clinic uses walkie-talkies, see story on p. 60.)**

"We used everyday equipment that doesn't cost much. If you really take the time, you can see that there is a better way to do things at very little cost," Malcolm says.

The biggest cost was $12,100 for buying and installing the computers in each treatment room.

The staff of 56 is divided into teams, which include a front desk clerk and a records clerk as well as the provider and the nurse. Some of the clerks work with more than one team.

"A critical part of the redesign was training everyone on the staff to be a part of the team," Malcolm says. For instance, the front desk people and records people are trained to escort the patient to the treatment room and take basic vital signs like weight and height.

"They need to understand about privacy and how to treat patients courteously. Instead of a skilled nurse taking time to escort the person, the other staff can do it," Malcolm says.

Initially, the nurse director provided the training. The clinic has worked with a local technical school on a cross-training curriculum. When the clerks have finished their training and meet the proficiency standards set by the practice, they will get a step raise in hourly wages.

"They are really excited and love being part of the team. It makes them feel involved with the patients," Malcolm says.

The clinic couldn't afford to put telephones in each treatment room but was able to purchase six

(Continued on page 59)

Physician's Capitation Trends™
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Survey gathers 'lessons learned' from MD experiences

Searching for what works, what doesn't work

Ford Motor Co. used to tout in its ads that "Quality is Job One." With health care in recent years, many physicians and patients have said that's not the case with capitation and managed care.

But if you look more closely, you find that there are things doctors hate and things they appreciate about the huge shift in health care delivery. What do they hate?

• highly competitive markets with frenzied managed care corporate activity;

• losing patients they were building a relationship with because of market and contractual changes;

• high-growth physician practices that are less selective about the capitation and other managed care contracts they'll accept.

What do they appreciate about the changes?

• **Scoring systems that financially reward physician productivity.** Physicians whose compensation is affected by meeting quality measures tend to perceive that type of payment system as appropriate.

• **Practices that take patient satisfaction surveys seriously.** For instance, capitated physicians are the strongest advocates of patient self-care, says **Judith H. Hibbard**, PhD, a Robert Wood Johnson researcher and professor of planning, public policy and management at the University of Oregon in Eugene. **(See related story on p. 57.)**

• **Group practices that have the management skills to buffer physicians from the downside and maximize ways to improve patient care.** For example, two positive outgrowths of managed care pressures are that some practices have developed skills at making specialist referrals a manageable process, and they are integrating what patients are asking for in surveys.

If changes are in the offing, it's advisable to look more closely at what works and what doesn't, says **James Reschovsky**, PhD, lead researcher for the Washington, DC-based Center for Studying Health System Change.

"The 'managed care backlash' is predicated on concerns about quality of care and has led to numerous legislative proposals to regulate managed care plans," points out Reschovsky and colleagues, who recently published findings based on the Community Tracking Study Physician Survey of 12,365 physicians.[1]

Capitation often tops the list of complaints from many doctors. "The concerns appear to be fueled more by anecdotes than by systematic empirical evidence," Reschovsky says.

That's largely because of measurement constraints. Methodologies for comparing clinical results under various modes of care systems are adding to our knowledge base, but they still show inconsistent findings. Most scientists agree the results lack comparability.

Scholars measure physician perceptions

Until that discipline is perfected, the next best strategy is to measure and compare physician perceptions of quality in managed care and non-managed care settings, Reschovsky and team assert. That's the approach they took in an effort they bill as the "largest and most comprehensive study with a large, nationally representative sample of patient care physicians."

The team investigated how aspects of physicians' exposure to managed care are associated with perceptions of their ability to provide high quality of care.

In reviewing survey responses, researchers drew six key "lessons learned" from physicians' experience with capitation and related managed care issues:

1. More than two-thirds of physicians express minimal concerns about quality, while the remainder have quality of care anxieties. Between 21% and 31% of physicians disagreed with the quality statements. This suggests that between one-fifth and one-third of doctors overall believe that the quality of care they deliver is being compromised to some degree.

2. Specialists express more disdain for managed care than primary care physicians (PCPs) do. Specialists were 50% more likely than primary care physicians to express concerns about their ability to provide high-quality care under managed care constraints. This may largely stem from pocketbook issues, the study says. "Specialists are more likely than PCPs to have lost income and some control over the management of patient care as a result of managed care," Reschovsky and team note. "Consistent with this, previous studies have found specialists to be more dissatisfied."

A negative perception of quality of care was not associated with the percentage of practice revenue from managed care; rather, there was an association between a negative quality perception and the number of managed care contracts the physician's practice had.

3. Juggling multiple contracts complicates practice management. A negative perception of quality of care was not associated with the percentage of practice revenue from managed care; rather, there was an association between a negative quality perception and the number of managed care contracts the physician's practice had. Plan structures are already changing to respond to consumer complaints, but at the same time, health care spending is back on the rise, according to **Katharine Levit**, director of the National Health Statistics Group of the Health Care Financing Administration in Baltimore. **(See related story on national health cost trends, p. 57.)**

4. Market environment has a huge impact. The level of market penetration of managed care in a physician's geographic area is directly related to the doctor's level of confidence in his or her ability to deliver high quality of care. The more crowded and competitive the insurance market is in a particular area, the more anxiety doctors feel in their practices.

For instance, those in high managed care markets (50% or more revenue from managed care) were 10% less likely to agree that they have adequate time with patients and were 16% less likely to agree with the continuity of care measure. That's compared with physicians practicing in markets with 30% or less physician revenue from managed care.

5. There is strength in numbers. Well-run group practices make it all a lot easier, respondents said. Physicians in groups expressed fewer concerns about managed care pressures and fixed payment issues than physicians in solo and two-physician practices. That trend is even more pronounced when the group is well-established rather than in a fast-paced growth mode.

6. Specific financial incentives and care management tools, which have flourished under capitation and other managed care systems, garner mixed reviews from doctors. For example, physicians whose income is affected by quality and productivity scores show more confidence that managed care techniques deliver appropriate quality of patient care. But two of the icons of managed care "care management" technologies — written guidelines and practice profiling — are perceived as less likely to improve patient care. Patient satisfaction surveys that are taken seriously by a practice, however, are perceived positively.

These findings are based on measuring physician agreement levels with seven statements related to quality of care. Their data came from the Community Tracking Study Physician Survey, a cross-sectional, nationally representative telephone survey. The response rate was 65%. Physicians who took part provide direct patient care for more than 20 hours a week, excluding federal employees and those in selected specialties.

Reference

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Will rising inflation bring new 'medical arms race'?

Health care at critical juncture

While the stock market keeps heading southward, health care costs are moving in the opposite direction, spurring sirens of concern about unnerving levels of inflation for the remainder of this year.

That's the finding from two research organizations in March — both the Health Care Financing Administration (HCFA) and a private-sector group, the Center for Studying Health System Change (HSC) in Washington, DC. The government is forecasting steady but not out-of-control medical inflation, while HSC has gone further and declared a resurgence of the "medical arms race" that characterized the pre-managed care 1980s.

Both groups say health care is at an important juncture.

"Initial findings from recent site visits indicate that the U.S. health system is at a critical turning point," says **Paul B. Ginsberg**, HSC president, in a recent report summarizing site visits conducted with 12 health system leaders across the country.[1] Ginsberg is the former chairman of the Physician Payment Review Commission, now the Medicare Payment Advisory Commission in Washington, DC.

'Back to the future'

"Managed care as we knew it in the early and mid-1990s appears to be in retreat in both the commercial market and public programs. With growing provider clout and increasing resistance to risk-based contracting, there seems to be a move 'back to the future' in the financing and delivery of health care." Cost controls based on strict physician panels as well as requirements for prior approval of specialist referrals are disappearing.

Further reductions in providers' income won't be happening much longer either, Ginsberg predicts. "There may be less potential for further savings through reduced payment rates to providers, given the degree to which they have been squeezed in recent years."

According to HCFA, U.S. health care spending increased 5.6% in 1999 from the previous year. Spending totaled $1.2 trillion in that year, the most recent year for which figures are available. Yet the increase still represents the seventh year in a row that the rate of growth fell below 6%, Levit and colleagues report.

Levit and team do not expect double-digit inflation in health care. They project spending to be at 8.3% in 2000 and 8.6% in 2001 before it moderates again at 6.5% by the year 2010.

At the top of the cost list are prescription drugs, for which spending rose 16.9% in 1999 to $100 billion. HCFA projects this category to grow an average of 12.6% a year, accounting for 16% of total personal health spending by 2010.

After 2002, HCFA officials project a move back toward more restrictive health plans as economic growth slows, stimulating private health insurance premiums to rise and employers to push for more cost controls. Overall, HCFA economists project spending to grow at rates faster than the 1990s but slower than the previous three decades.

Reference

1. Back to the future? New cost and access challenges emerge. Issue brief #35. Washington, DC: Center for Health System Change; February 2001. ■

Capitated physicians lead pack in self-care support

Self-care may ease utilization, patient worries

"Do it yourself "may remind you of what your mom used to say about the dishes and the laundry. But "self-care" has a more serious tone these days in medical circles, particularly among clinicians who champion preventive care.

A group of preventive medicine experts now says patient self-care is more commonly supported by capitated physicians than any other group of doctors. The trend suggests that a positive outgrowth of capitation may be leadership in an area of clinical practice that is crucial for both empowering patients and lowering unnecessary utilization.

Some clinicians believe self-care is growing into a significant medical discipline unto itself — so much so that the likes of the Robert Wood

Johnson (RWJ) Foundation, the National Institutes of Health, and the Washington Business Group on Health are devoting significant resources to the topic.

Exactly why capitation is such a strong influencing factor isn't clear, according to **Judith H. Hibbard**, DrPH, lead researcher for an RWJ-sponsored study on self-help initiatives. The research team made this discovery based on 448 surveys and 30-minute interviews with physicians in three Northwest communities (Boise, ID; Eugene, OR; and Billings, MT). Eugene has rather high managed care penetration (37%). Boise and Billings have lower managed care penetration (10%-15%).

Motivation is the key

"The findings suggests that physicians who are paid on a capitation basis have more motivation to have patients be less reliant on the formal care structure," writes Hibbard, who is also professor of planning, public policy, and management at the University of Oregon in Eugene.[1]

"It is unclear whether the payment mode generates this support, or if physicians supportive of patient self care self-select themselves into capitated systems of care."

Why capitated physicians? Hibbard and colleagues offer several possible reasons:

- Pre-set payment arrangements may make prepaid doctors more cost-conscious.
- Managed care's emphasis on preventive care could be encouraging self-care techniques.
- Managed care's focus on patient demand management overall is aimed at reducing unnecessary utilization of physician time and resources.

All three reasons may apply, say Hibbard and team, although based on their qualitative research, the only statistically significant predictor of self-care support was the presence of the capitation payment mode.

Less reliance on formal medical sources may stem from capitation, or it may be part of other health care trends such as the climbing prevalence of chronic disease. In a recently released Harris poll, 45% of Americans reported living with a chronic medical condition, and 72% say it is difficult for the chronically ill to obtain necessary care from clinicians, according to **Gerard F. Anderson**, PhD. Anderson is national program director of Partnership for Solutions, a RWJ-Johns Hopkins University joint initiative that funded the poll.

Anderson describes the poll as a wake-up call from Americans who see a need for more support in techniques such as wound dressing, bathing, transportation, and financial resources — all parts of self-care literature. Currently, 125 million Americans are living with at least one chronic disease. Paralysis, Alzheimer's, mental health problems, high blood pressure, and HIV / AIDS are topping the list, Anderson notes.

Dissemination of information on self-care practices has increased in the past decade under managed care in particular and health insurance overall, Hibbard and team say. "It is becoming common practice for health plans and health insurance companies to distribute and make available various self-care services and products to members," she explains. They include products and services such as self-care manuals, nurse advice lines, computerized decision support systems, and other features of "demand management."

The wide range of self-care products is aimed at decreasing demand for formal health care and increasing patient empowerment, researchers point out. Also, they can act as an intermediate step to help patients determine if their problems can be managed at home or if they need to see a physician.

While these products and recommendations are available to both fee-for-service and managed care physicians, prepaid doctors are taking the lead. Physician ambivalence, however, may actually stem from the lack of clear evidence on whether self-care is effective, Hibbard and colleagues note. For example, in their review of more than 1,000 articles of self-care efficacy studies, about half of those studies cite cost and utilization savings from self-care manual dissemination, while the other studies report little if any difference.

At the same time, other influences may affect efficacy. Much evidence points to the powerful influence of physicians' personal recommendations about most kinds of treatment (smoking cessation, for instance). "One hypothesis is that physician support for self-care makes an important difference in whether self-care manuals are effective with patients," Hibbard says.

Reference

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(Continued from page 54)

900 MHz cordless phones for each team's nurse to use. The nurses also have electronic databooks that include the pharmacy names and telephone numbers.

This way, if a patient is in the treatment room and isn't sure whether her medicine needs refilling, the nurse can call the pharmacy. The process has greatly reduced the number of phone calls for prescription refills, Malcolm says.

"We had been inundated with elderly patients calling us after their visit to say their prescription needed refilling. It added a whole level of additional work, pulling the chart, getting the approval of the provider, calling the pharmacy. This way, the proper number of refills can be made because the nurse knows when the follow-up appointment is."

The practice installed computers in each treatment room to help minimize patient movement and increase efficiency.

Unique concepts that work well

Here are some unique concepts developed by East Albany (GA) Medical Center:

- A physician assistant is designated to handle walk-in patients.
- A Nurse Express window takes care of patients who are returning for nursing services such as shots or blood pressure checks.
- A Lab Express window handles patients coming in only for laboratory services.
- The "team" includes a records clerk and a front desk clerk as well as the provider and nurse.
- All members of the team are on the same walkie-talkie frequency and can be in constant communication.
- All patient tasks, from taking vital signs to appointment setting, takes place in the treatment room.
- The front desk and records people are trained to escort patients to the treatment rooms and take vital signs like weight and height.
- When the nurse checks out the patient, she reminds the patient if he or she has a co-pay or a balance due. ■

For instance, when a provider finishes with a patient, the provider calls the nurse over the headset, says the patient needs an appointment in three months, and gives the medication that needs to be refilled.

The nurse can come into the treatment room, schedule the appointment, and call in the refill. If the nurse is busy, someone from the front desk comes in and checks out the patient. ■

PA solves problem of unscheduled walk-ins

Most are seen within an hour

If a patient walks into East Albany (GA) Medical Center without an appointment, reception staff no longer have to plead with providers to squeeze in just one more patient.

Instead, the walk-in is likely to get in and out of the clinic is less than an hour, thanks to a redesign project that assigns one physician assistant each day to handle walk-in patients. That PA is not scheduled for any other appointments that day except for quick follow-ups.

The physician assistants have stayed busy with the walk-in patients, says **Ron Malcolm**, PA-C, the physician assistant who led East Albany Medical Center's re-engineering team.

As a patient arrives, the front desk makes a decision about how he or she should treated. For instance, a patient having chest pains is referred directly to a hospital. If the patient is very sick, he or she gets immediate treatment ahead of walk-ins with less acute problems.

The reception staff has been educated to recognize patients with chest pains, shortness of breath, neurological changes, and other acute conditions and immediately call the triage nurse to see the patient.

The staff uses walkie-talkies, and the physician assistant who sees walk-in patients is on a different channel from his or her usual team. A triage nurse, who also handles the Nurse Express window, is included on that walk-in team.

Because the physician assistant is listening via the walkie-talkie to the conversation between the front desk and the triage nurse, he or she can answer questions and give orders without leaving the patient he or she is treating and then see the walk-in quickly if necessary. ■

Private payment talks prove a winner

Process has increased collections dramatically

When **Ron Malcolm**, PA-C, first considered the idea of having the medical staff ask patients for money in the treatment room, he initially rejected it as "a sacrilege."

But as Malcolm, a physician assistant at East Albany (GA) Medical Center, and Bernard Scoggins, MD, the clinic medical director, discussed ways to improve efficiency at the clinic by "thinking outside the box," they decided to bite the bullet and test the idea.

To their surprise, the process proved to be very successful. Not only did patients not object; it had a positive impact on the clinic's bottom line.

"It blew us away. Our cash receivables went up and up and have continued to go up," Malcolm says.

During its project to improve efficiency at the clinic, the redesign team decided to install computers in each examination room and have the nurse check out the patients and refill any prescriptions before the patient left the room.

Malcolm proposed that the nurses check the patient accounts. If the patient has a balance due, the nurse asks them to pay, if they'd like to pay on it that day, and how much. She enters the amount into the computer. If they have a co-pay, she does the same.

Asking for cash at the point of service

"The accounts are discussed with the patient in privacy at the point of service, when patients feel they got something for their buck," Malcolm says.

When they initiated the program, the clinic staff did satisfaction surveys for all patients. Only one person said they didn't like to be asked for cash in the examination room.

The practice has many indigent patients who often do not have enough to pay their bill or their co-pay and are embarrassed when the cashier asks them about their account in front of a full waiting room.

"We asked about the accounts in private so that patients were not embarrassed when they didn't have enough to pay," Malcolm says.

Even if the patients can't pay their entire bill when they get to the cashier, they won't be embarrassed. For instance, if they owe $20 but tell the nurse they have only $12, the nurse sends the cashier a note about how much the patient can pay, and the cashier only asks for $12.

"It looks very professional," Malcolm says.

The clinic's financial counselor visits with patients who are in arrears while they are in the treatment rooms. She gets a list of the scheduled appointments each day, notifies the nurses of whom she needs to talk to, and is alerted when the patient is in the room and the providers are gone.

"In the past, the cashier would have flagged the account and asked the patients to wait to see the financial counselor. Now, it's built into the waiting time," Malcolm says. ■

Walkie-talkies solve communications problem

Team members can be in touch instantaneously

Like most medical offices, East Albany (GA) Medical Center had problems with communication between the providers and nurses before the practice instituted a re-engineering project. In fact, improving communication was the first task the re-engineering team tackled.

The team decided to try solving the problem by using walkie-talkie head sets to provide two-way communication between nurses and providers.

Ron Malcolm, PA-C, team leader for the redesign project, gives this example of time savings: The provider goes out of the exam room looking for the nurse, who is around the corner making a telephone call. There is an inevitable wait for the provider and the patient.

With the walkie-talkies, the provider merely asks the nurse for whatever he or she needs without leaving the patient's side. "Multiply that day in and day out, and the time savings are enormous. The frustration level just melted away," Malcolm says.

The process worked so well that the clinic added the front desk person and the records person to the same walkie-talkie frequency.

Now if a patient is coming in late or has any other issues, the front desk can communicate instantaneously with the provider or the nurse.

The records person also hears the conversation and can be looking for the chart by the time the conversation is over.

Adjusting to the walkie-talkies was frustrating initially, Malcolm says. "At first, the chatter was truly awful. We learned to minimize the chatter so we were communicating only about the patients," Malcolm says.

Some providers are still frustrated because they have to take off the walkie-talkie head sets to use the stethoscope.

The walkie-talkies are not secured lines, so staff are cautioned not to mention specific names or diagnoses.

When Malcolm doesn't want to be interrupted, such as when he is performing a test, he pushes a button that sends a code that the headset is off, then pushes a button later when he is ready to be contacted again. ■

Express windows move patients quickly

Process frees up front desk staff

When patients at the East Albany (GA) Medical Center are scheduled for a quick blood pressure check, tetanus shot, or blood test, they no longer have to sit in the waiting room to see a provider.

Instead, they go to the Nurse Express or Lab Express window and ring a bell, and a nurse or lab technician takes care of them in a hurry.

The lab and the Nurse Express nurse receive preprinted forms each morning alerting them to who is coming for what procedure each day. "Before, the front desk was inundated with everything, and patients had to wait for routine procedures. Now patients are in and out in a brief time," Malcolm says.

The clinic uses the old triage room for the nurse express. The nurse who staffs it works with a physician assistant who handles only walk-in patients and can call in the PA if needed. For instance, the PA would be called in if the patient's blood pressure was elevated.

"We often treat people right there and we use it for quick treatments. If someone comes in with a sore throat, we see them then and there and get them out," Malcolm says. ■

Don't tighten your belt to the point of strangulation

Improving the bottom line takes careful planning

If your practice is like most, you are facing lower reimbursement from managed care plans, yet you have to spend more for malpractice insurance and add more staff to take care of all the paperwork required by the managed care plans.

That's why looking for ways to improve the bottom line is one the most important things a medical practice can do, says **Sherry L. Migliore**, MPA, FACHE, eastern regional director of consulting for PMSCO, a subsidiary of the Pennsylvania Medical Society in Harrisburg.

PMSCO provides a variety of services to physicians and managed care organizations, including practice management, medical management, and medical data analysis.

There's no cut-and-dried answer to increasing profitability, Migliore says.

"It's a combination of getting a better handle on costs and making sure you are billing properly and collecting properly," she says.

But don't be hasty in your efforts to cut costs, Migliore warns.

For instance, because personnel costs are a practice's biggest expense, many physicians falsely believe that cutting staff is the best way to save money.

"Cutting personnel is not the best way to save money. Look at people in your practice as being your right arm, so to speak. The people on your staff can be your best asset," she says.

If you cut back too much and patients can't get through on the phone or staff are snappish with patients because they are pressed for time, you may lose patients, she says.

The first step is to get a handle on exactly what your costs are, Migliore suggests.

"Doctors need to pay attention to their overhead and what types of things are costing the most money. We recommend that they look closely at how much it costs to provide every procedure they perform," Migliore says.

"A lot of times doctors don't realize what goes into providing these services, such as staffing and overhead," she points out.

The doctors and the business manager should look at the practice's financial statements every month, Migliore suggests.

Your cost analysis should include the work component (the physician cost), the malpractice component, and overhead or the cost of running your practice.

Use your cost data to work with payers to change your reimbursement. If you show the payers your cost for a certain procedure vs. what they are paying, they may be willing to work with you.

"Some practices have successfully gone to payers and negotiated a better fee. If the practice provides a unique service, the insurer may be willing to pay extra money if they need someone in the area to perform that service," Migliore says.

If a service is costing you money, consider discontinuing it. Some practices in Pennsylvania have discontinued certain high-risk services because of the cost of malpractice insurance, Migliore notes.

For instance, a number of practices have discontinued providing obstetric services because of the expense of malpractice insurance.

The next step in increasing profitability is to make sure you are capturing all the revenues to which you are entitled.

Based on her consultations with Pennsylvania physician practices, Migliore offers the following tips for avoiding revenue shortfalls:

• **When a doctor provides services in a hospital, make sure the practice receives the information necessary to bill for the costs.**

Physicians may participate in a procedure or perform an evaluation or consultation on a patient in the hospital and fail to provide the notes to the office staff.

"If the office staff doesn't have the information, they can't bill for the service," Migliore says.

• **When you do a procedure or treat a patient, make sure you fully document what you did so the practice can bill at the highest possible level.**

"Doctors are undercoding because they are concerned about billing at a higher level. We see far more undercoding than overcoding in our coding audits," Migliore says.

Physicians should be aware of the Health Care Financing Administration's (HCFA) stringent coding rules to make sure they get paid for the services they perform but don't cross the line and run afoul of government regulations.

• **Conduct a fee schedule review every year.**

"A lot of doctors think fee schedules aren't relevant any more, but HCFA makes adjustments to Medicare payments every year," Migliore says.

If you aren't paying attention to what Medicare will pay for each procedure you perform, you could be losing money.

For instance, if HCFA has raised its reimbursement for a certain procedure to $60 and you are billing the previous year's $50, you will lose $10 each time you perform the procedure.

"In the case of all payers, they will not pay more than what you are billing, even if they normally pay more," Migliore says. ■

Patients help physicians ride the 'age wave'

'Information therapy' empowers patients

By **Molly Mettler**, MSW
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The graying of the baby boom generation has been likened to an "age wave" that will engulf and forever change the landscape of American health care. Your article heralding the onslaught of baby boomers, "Physicians need new skills for boomer demand" **[*Physician's Managed Care Report*, January 2001, pp. 1-4]**, paints a challenging picture for physicians. Confronted by a new type of patient with heightened expectations of customer service (". . . they're demanding, they're outspoken, they want hard, cold facts . . ."), you urge physicians to call upon nurse practitioners and physician assistants to help lighten the load. You also suggest

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that physicians look to disease management as a cost-efficient means to improve outcomes.

Making better use of allied health professionals and employing disease management models (which, as your article points out, physicians don't have the time or the wherewithal to implement) are two good suggestions, but they hardly mark the starting point from which physicians need to begin. The two together make for a tiny, vulnerable life raft in a mighty rough sea.

Look instead to ride the age wave by embracing what baby boomers and older adults can do for themselves and for one another. Make them your partners in care. Embrace these new feisty, educated, and discriminating consumers. Put them at the center of your health care team, and they become your allies.

Step 1. Teach self-care. Empower and educate your graying patients (in truth, all of your patients) to become active and informed providers of their own care. Fully 80% of all health problems are treated at home in people's bathrooms, kitchens, and bedrooms without the intervention of a health care professional. Give people the tools to practice good self-care, and they do just that: They provide good care in the home, and they reserve their office and emergency room visits for those health problems that demand professional medical intervention. The self-care guide *Healthwise for Life: Medical Self-Care for People Age 50 and Better* is one such tool. In one Healthwise for Life impact report, 38% of the participants reported fewer doctor office visits; 14% indicated that they avoided hospitalization; and 46% said they were better able to maintain their health and quality of life.

Step 2: Teach chronic disease self-management. Yes, as we age, we are more subject to the vicissitudes of chronic illness and the complexity of comorbidity. But that doesn't mean people have to become any less capable of participating in their own health care.

Remember the adage: Give the people a fish and they have one meal. Teach them to fish and they are fed for a lifetime. It's time to teach patients systematically and supportively how to care for themselves. With their Arthritis Self-Management Program, Drs. Lorig, Holman, and Mazonson and their colleagues from Stanford University demonstrated that costs go down, outcomes improve, and health satisfaction goes up when people with arthritis participate in their own care. Pain declined a mean of 20% and visits to physicians declined 40%, while physical disability had increased 9%. Comparison groups did not show similar changes. Estimated four-year savings were $648 per rheumatoid arthritis patient and $189 per osteoarthritis patient.

Step 3: Provide "information therapy." Information therapy is the prescription of specific medical information to a specific patient to help manage a specific problem. The rise of evidence-based medicine and multiple technologies for delivering personalized messages means we can meet baby boomer demands for individualized attention, 24/7 service, choice and control over treatment options, and access to the best information. Information therapy can be prescribed, just like a pill. The clinician selects from a huge array of options the right information in the right dose and in the right formulation to best help the patient. Rather than being a hit-or-miss optional

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Editorial Questions

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service, information therapy will become a standard part of every clinical visit and service.

Step 4. Make a move to group appointments. A few years ago, Edward B. Noffsinger, a health psychologist at Kaiser Permanente's San Jose (CA) Medical Center, had an epiphany about how physician practices were going to unfold over his career. Doctors could either continue to see chronically ill older patients one at a time and repeat the same words and actions over and over again, or they could bring similar patients with similar concerns together and, with a team of other providers, address their concerns as a group. (The clinicians provide individual attention as needed.)

Wonder of wonders, the patients greatly enjoyed the new model. Not only were they satisfied with the care they received; they particularly liked the social connectedness fostered by group appointments. The patients helped one another solve problems and lent one another emotional support. If physicians are too busy and too overwhelmed to meet the psychosocial needs of their patients, they can rely on the wisdom of patients who have been there and know what it means to cope with illness. As Thomas Jefferson astutely noted, "Who then can so softly bind up the wound of another as he who has felt the same wound himself?"

To build a sturdy ship in which to ride the age wave, physicians need creative and compassionate approaches to working with their aging patients. Your recommendations do not provide the durability that medical practices need to succeed. It's not enough to add staff as a "first line of defense" (which focuses on supply management rather than demand management), to implement piecemeal disease management programs that physicians don't have the time to implement, and to lament that baby boomers are disagreeable and overly demanding. The challenges before us require that we all recognize older patients as powerful providers of care in their own right, with a wellspring of wisdom and experience that can come only from the sheer exercise of living and surviving. To add value to your own practice, recognize where the value lies. Invite your senior patients to be your partners in care.

[Editor's note: Molly Mettler, MSW, is senior vice president of Healthwise, Inc., and chair-elect of the National Council on the Aging. She is co-author of Healthwise for Life and is currently working on a book about information therapy. Healthwise is located at 2601 N. Bogus Basin Road, Boise, ID 83702. Telephone: (800) 706-9646.] ■

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