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INSIDE

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American Health Consultants® is A Medical Economics Company

Aging, health-conscious males becoming a more attractive market

Good health becomes more of a guy thing

For years, conventional wisdom and many studies showed that women make most medical purchasing decisions. They are more likely to go to a doctor, take their children to a doctor, or insist their husbands go. But as the baby boom generation ages, men are taking a greater interest in their own health care, says **Neil Baum**, MD, a urologist in New Orleans. "Men are more knowledgeable, more interested in health care, have more access to information, and will make more and more health care decisions," he says. The focus for practices will become men born between 1935 and 1950, he adds.

Jerome Morgan, MD, whose urology practice is based in Santa Rosa, CA, agrees that male patients now are more aggressive in seeking information and treatment than they used to be. That is partly due to an increased emphasis on male problems such as erectile dysfunction and prostate cancer. And while Baum and Morgan have urology practices that are traditionally male-oriented, both believe that any practice can — and should — start paying more attention to the needs of their male patients. "Otherwise, they will miss out on this market," Baum says.

Here are some simple ways any practice can become more "man-friendly":

❑ **Let them know you speak their language.** "You have to let them know you speak 'man,'" Baum says. "You should make that clear from what plays on your hold message, to the magazines you have in your reception area." If all you have are *Good Housekeeping* and *Elle*, men won't feel comfortable, he says. Offer sports, hunting, mechanics, and financial publications. Keep the daily paper and perhaps the *Wall Street Journal* on hand. And if your practice caters to both women and men, consider keeping the male-oriented magazines on a separate rack.

❑ **Learn to speak with men.** Men don't communicate in the same way or as readily as women, says Morgan. For instance, a man is usually very reticent to say anything is wrong with his sex life. "Men don't volunteer information," he says. "You have to ask much more specific questions: 'Are you having sex? How often? Why not more often?' You have to tease information out of them."

❑ **Don't make them wait.** The tolerance for waiting among males is about half that among women, Baum says. "I think it's because women are more used to waiting for their gynecologists," he says. "Men have a very short fuse about this, and you have to see them in a timely fashion." The risks of not doing so became apparent to Baum when he heard about a colleague in New Orleans who was running about an hour behind. A man with a 2 p.m. appointment hadn't even been told why he was waiting or how long it would be. He took out his cell phone, borrowed a *Yellow Pages* and started calling local doctors to find one who could see him immediately. When he found one, he went to the front desk, demanded his chart immediately, signed the release, and walked out of the practice. Three other individuals immediately followed his lead. "If each patient was worth $20,000 per year, then $80,000 in revenue walked out the door for not letting that man know why he was waiting."

❑ **Make your education appropriate.** Men learn differently than women, says Baum. That means that your educational material may have to be different for men than for women. "Men need more pictures and visual aids," he says. "When I talk to a man about his prostate, I blow up a balloon and put a clothes pin on it and tell him this is why he can't urinate. He can understand that picture. With vasectomies, I use a rubber band as a visual aid. Just think through what you need to tell the man and find some visual way to illustrate it."

❑ **Pay attention to male problems.** It's relatively easy to find information on breast cancer and self-exams, but how much information is available to men on testicular cancer? Baum has created a laminated shower card that has information on breast self-exams and warning signs of breast cancer on one side, and information on testicular cancer and guidelines for testicular self-exams on the other. His practice's name is on both sides of the cards, which cost about 40 cents each to have printed. Not only is it a value-added service, but he catches at least one testicular tumor per year because of the cards.

SOURCES

- **Neil Baum**, MD, Private Practice of Urology, New Orleans. Telephone: (504) 891-8454.
- **Jerome Morgan**, MD, Private Practice of Urology, Santa Rosa, CA. Telephone: (707) 528-3800.

❑ **Go to where the men are.** If men in your market favor a particular golf course or health club, approach that organization and ask to write articles on men's health for its newsletter. Morgan also suggests giving seminars or health talks at such venues.

❑ **Pay attention.** Just as female patients do, men "like to feel special," he says. To accomplish that, he makes sure his office calls patients the night before any procedure and the evening after it happens. "They like that extra touch."

❑ **Be efficient.** Because men have a low tolerance for waiting, Baum calls in prescriptions for patients to the pharmacy of their choice. He makes sure to tell patients to let him know if there is any delay when they get there. "If there is, I tell them we'll find another pharmacy to work with." Invariably, the pharmacy has the prescription waiting for the patient.

❑ **Cultivate a community interest in male health.** Morgan says developing a relationship with area press also may help your practice become known as being male-friendly. Not only can you get reporters to do more stories on male health issues, but when they do a story, you can be the one who is quoted.

Making your practice — whether primary care or specialty — more appealing to male patients will pay off, says Baum. "This works. From the moment they walk in the door, they know that this is a man-friendly practice, from what is on the wall to the people they communicate with and the magazines and books they can read here."

"Men come in more now than they used to, and they come in with more questions and more and more informed questions," Morgan says. "We have to be able to meet their needs." ■

COMING IN FUTURE MONTHS

- ■ New compliance rules: What do they mean to your practice?
- ■ The making of a successful radio campaign
- ■ Bringing patient-focused care to your practice
- ■ Does your marketing plan need overhauling?
- ■ Protecting your rights during a fraud/abuse probe

Using the 'idiot box' can be a smart move

Television can help spread the word

In Seattle, two local plastic surgery practices have taken to advertising their services on television. A battle for the faces and bodies of the new technology millionaires is now being waged on the airwaves of daytime TV.

According to **Andrea Eliscu**, RN, president of Medical Marketing in Winter Park, FL, plastic surgeons and ophthalmologists have long known the benefits of television advertising. "Their services are usually purchased out of pocket," she explains. "It is a competitive market with no insurance." But now, others are learning that television advertising can work for them, too. Cancer centers, medical imaging practices, and orthopedics groups are coming to realize that television offers a great way to give your practice brand name cachet in a large, competitive market.

"Don't get me wrong. Television can be costly," says Eliscu. "In large markets, you can get some breaks from the television stations that will help you produce the spots for a reduced fee. Otherwise, you have to hire a producer, and that costs money." And for the ad to be effective, you have to run it more than once. "Otherwise, you get little if any return on your investment. But on the plus side, you get access to a large market, which, with effective placement, you can target nicely."

Know the local market

One of his clients, the Jewett Orthopaedic Clinic in Orlando, FL, recently ran a television campaign. He says its success was predicated in part on the relationship she had built with the advertising representatives in the local television market.

"You have to learn how to work with the station to get the most out of your time. Jewett doesn't have the buying power to go to an advertising agency. We could either go in and say, 'We have a budget of $12,000. What can we get for that?' or go in an ask them what they think we should do and compare it to our budget." The latter is a much smarter option, but it means developing a good rapport, she says.

If the station is going to be able to help you, adds Eliscu, you have to go in there with a known goal, whether it is to brand your practice or to create some business you can track. "If it's the latter, you have to have a phone number devoted to calls related to the ad," she warns. "You can have a system where they get a recording, leave a name and address, and then you send them information."

When you have a good relationship with a local station, you can do more than just advertise, too. For instance, Jewett did a half-hour program on first aid for Little League-age children. "We included information on what kind of injuries they might sustain, what kind of first aid to do on the field." The clinic then went to big area businesses, such as the Olive Garden restaurant chain, and asked them to advertise during the show. "That reduced our cost and presented them with a good targeted marketing campaign."

Besides airing the program, the station created a version without ads that was put on video and distributed to area Little Leagues, libraries, and coaches and parents who were interested.

Getting more for your money

The clinic also worked with a local health reporter on a program on total hip replacement. "They did the marketing, and it was newsy and popular," says Eliscu. "That is the purpose of building a relationship with the station: You get more for your money than if you go in and plunk down $12,000 and ask what you can have for it."

If you opt to do a news-type program, Eliscu says, it's best to find a talent that is known in the community, and even better if you find one that has a relationship with your practice. Jewett found a retired television anchor who had been a patient and used him for a commercial. "It was a trusted talent and an informative ad," she says. Rather than touting Jewett, it relied on the anchor, images of couples playing golf and dancing, and at the end mentioned that those interested in total joint replacement should ask their doctor or call Jewett. "It was tasteful and responsible, but still raised awareness. We had a great response."

But Eliscu says that you shouldn't advertise on television just because you can. "There has to be a reason, some goal you have in mind. In these days of no-fat practices, you have to know what you want and do something constructive with the money you have."

SOURCE

- **Andrea Eliscu**, RN, President, Medical Marketing, Winter Park, FL. Telephone: (407) 629-0062.

If you are looking for television exposure but don't have the budget to run ads, Eliscu says you can sponsor or underwrite a public television program. In Orlando, the public television station will do a 30-second spot for sponsors. "You get coverage in the beginning, at the end, and sometimes in the middle. If you do it on an appropriate show, then you can really raise awareness."

The main thing is to use the expertise of television station staff. "Don't insist on a certain time if the station demographics show you won't reach your target audience," says Eliscu. "Tell them what you want and then ask them to help you get there. Then listen to what they answer." ■

FDA releases list of possible Y2K problems

Do you have any of this equipment?

Recent surveys of hospitals and medical groups indicate that most think they will be ready for any potential problems related to the year 2000 computer bug. One recent poll by the American Medical Group Association of Alexandria, VA, found that more than 95% of its respondents have discussed Y2K, more than 90% had a strategy for dealing with potential problems associated with Y2K, and 86% had a contingency plan in development.

But according to the U.S. Food and Drug Administration (FDA) in Rockville, MD, some biomedical equipment you may have may not work — or may not work correctly — when Jan. 1 rolls around.

To help the medical community deal with the problem, the FDA has developed a list of types of computer-controlled, potentially high-risk medical devices that have the potential for the most serious consequences for the patient should they fail because of date-related problems. **(A copy of the list appears at right and on p. 101.)**

The list is comprehensive, and the FDA notes that inclusion on the list doesn't mean that the device has a problem, or if it is not Y2K noncompliant, that it might pose a risk to patients. The FDA administration plans to use the list to audit manufacturer claims of compliance and later issue a list of noncompliant devices.

The equipment on this list includes items used in the direct treatment of a patient where device failure could compromise the treatment or could injure the patient; those used in the monitoring of vital patient parameters and whose data are immediately necessary for effective treatment; or those necessary to support or sustain life during treatment or patient care.

(Continued on page 102)

FDA Device Warning List

Post-medical device amendments, class III devices, and devices not yet classified

- ✔ Ventilator, high frequency
- ✔ Cardioverter, implantable
- ✔ Defibrillator, automatic implantable cardioverter
- ✔ Defibrillator, implantable, dual-chamber
- ✔ Pulse-generator, dual chamber, implantable
- ✔ Pulse-generator, program module
- ✔ Pulse-generator, single chamber, sensor driven, implantable
- ✔ Pulse-generator, single chamber
- ✔ System, pacing, temporary, acute, internal atrial defibrillation
- ✔ Automated blood cell and plasma separator for therapeutic purposes
- ✔ Lipoprotein, low density, removal
- ✔ Separator for therapeutic purposes, membrane automated blood cell/plasma
- ✔ Pump, drug administration, closed loop
- ✔ Pump, infusion, implanted, programmable
- ✔ Kit, test, alpha-fetoprotein for neural tube defects
- ✔ Stimulator, cortical, implanted for pain
- ✔ Stimulator, electrical, implanted for Parkinsonian tremor
- ✔ Stimulator, sacral nerve, implanted
- ✔ Stimulator, spinal-cord, totally implanted for pain
- ✔ Stimulator, subcortical, implanted for epilepsy
- ✔ Device, thermal ablation, endometrial

(List continues in box, p. 101)

FDA Device Warning List

Here's a list of devices the U.S. Food and Drug Administration has listed as potential problems related to the Y2K changeover next Jan. 1.

Classified devices (classification regulation number followed by classification name):

862.1345 Glucose test system
862.2140 Centrifugal chemistry analyzer for clinical use
862.2150 Continuous flow sequential multiple chemistry analyzer for clinical use
862.2160 Discrete photometric chemistry analyzer for clinical use
862.2170 Micro chemistry analyzer for clinical use
868.1150 Indwelling blood carbon dioxide partial pressure (pCO_2) analyzer
868.1200 Indwelling blood oxygen partial pressure (pO_2) analyzer
868.1730 Oxygen-uptake computer
868.2375 Breathing frequency monitor
868.2450 Lung water monitor
868.5160 Gas machine for anesthesia or analgesia
868.5330 Breathing gas mixer
868.5400 Electroanesthesia apparatus
868.5440 Portable oxygen generator
868.5470 Hyperbaric chamber
868.5610 Membrane lung (for long-term pulmonary support)
868.5830 Autotransfusion apparatus
868.5880 Anesthetic vaporizer
868.5895 Continuous ventilator
868.5925 Powered emergency ventilator
868.5935 External negative pressure ventilator
868.5955 Intermittent mandatory ventilation attachment
870.1025 Arrythmia detector and alarm
870.1750 External programmable pacemaker pulse generator
870.3535 Intra-aortic balloon and control system
870.3545 Ventricular bypass (assist) device
870.3600 External pacemaker pulse generator
870.3610 implantable pacemaker pulse generator
870.3700 Pacemaker programmers
870.4220 Cardiopulmonary bypass heart-lung machine console
870.4320 Cardiopulmonary bypass pulsatile flow generator
870.4330 Cardiopulmonary bypass on-line blood gas monitor
870.4360 Nonroller-type cardiopulmonary bypass blood pump
870.4370 Roller type cardiopulmonary bypass blood pump
870.4380 Cardiopulmonary bypass pump speed control
870.5225 External counter-pulsating device
870.5300 DC-Defibrillator low energy (including paddles)
876.5270 Implanted electrical urinary continence device
876.5630 Peritoneal dialysis system and accessories
876.5820 Hemodialysis systems and accessories
876.5860 High permeability hemodialysis system
876.5870 Sorbent hemoperfusion system
876.5880 Isolated kidney perfusion and transport system and accessories
880.5130 Infant radiant warmer
880.5400 Neonatal incubator
880.5410 Neonatal transport incubator
880.5725 Infusion pump
882.5820 Implanted cerebellar stimulator
882.5830 Implanted diaphragmatic/phrenic nerve stimulator
882.5840 Implanted intracerebral/subcortical stimulator for pain relief
882.5850 Implanted spinal cord stimulator for bladder evacuation
882.5860 Implanted neuromuscular stimulator
882.5870 Implanted peripheral nerve stimulator for pain relief
882.5880 Implanted spinal cord stimulator for pain relief
884.1700 Hysteroscopic insufflator
884.1730 Laparoscopic insufflator
884.2660 Fetal ultrasonic monitor and accessories

The following device classifications include radiation treatment planning systems that are accessories to these device types

892.5050* Medical charged-particle radiation therapy system
892.5300* Medical neutron radiation therapy system
892.5700* Remote controlled radionuclide-applicator system
892.5750* Radionuclide radiation therapy system
892.5900* X-ray radiation therapy system

** The device classifications flagged with an asterisk include radiation treatment planning systems that are accessories to these device types.*

The list does not include diagnostic devices whose failure would not result in immediate harm to the patient, even though the diagnostic information they provide might be unavailable or incorrect.

However, a few diagnostic devices have been included, if the results of calculations or other information processing by the device would not be readily apparent to the user and a Y2K failure of the device reasonably could be expected to lead to serious adverse health consequences before detection by the user. The list contains the potentially high-risk device types.

Where the generic device type has been classified by the FDA, the list includes the section number in Title 21 of the Code of Federal Regulations where the device type is described. That information can be found on the FDA's Web site, http://www.fda.gov/cdrh/yr2000/classification.html. For those devices cleared for market through the FDA's premarket approval application process or those that have not yet been classified, no classification regulation number is given.

The Web site also includes links to the Federal Y2K Biomedical Equipment Clearinghouse Search — http://www.fda.gov/scripts/cdrh/year2000/y2k_search.cfm — to determine the compliance status of medical devices, as reported by the manufacturers. An additional link is provided to the Manufacturer Registration Database — http://www.fda.gov/scripts/cdrh/cfdocs/cfrl/registra/search.cfm — which contains names and addresses of manufacturers who have registered with the FDA. ■

Be aware of your rights if fraud/abuse cops visit

What to do when investigators arrive

(Editor's note: This is the first of two articles in a step-by-step guide to responding to the on-site search warrants, record requests, and subpoenas from federal and state regulators.)

You are working at your desk when the front office receptionist buzzes on the intercom and says a special agent from the U.S. Postal Service, along with a dozen rather stern-looking men and women, have just come in the front door and started searching your medical files and interrogating employees.

Within minutes, the investigators have cut off access to your outside telephone lines and are herding employees into the conference room for questioning. Other agents are loading records, including patient charts, into boxes and taking them away. A third team is trying to obtain access to your computers.

As far as you know, none of the physicians or other staff members in your office has done anything wrong — certainly nothing to warrant being the subject of a federal health care fraud investigation. What do you do?

"Health care facilities are playing out this nightmarish scene across the nation," comments **Philip L. Pomerance**, a health care lawyer with the Chicago firm of Hinshaw & Culbertson.

All kinds of providers, most of whom never before thought themselves subject to criminal scrutiny, are facing teams of federal and state investigators bearing search warrants, subpoenas, or medical records requests.

"Prosecutors believe that high-profile criminal and civil investigations are cost-effective and have a strong deterrent effect," he notes. The execution of search warrants — and, to a lesser extent, the delivery of administrative subpoenas with a demand for immediate compliance — allows the government the opportunity to seize critical evidence.

"But equally important, these tactics engender an atmosphere of fear and concern in a targeted provider that prosecutors believe enhances their ability to successfully bring charges," Pomerance explains. "These shock tactics are a critical step in many potential criminal or civil enforcement actions."

The playing field is rarely level when a team of investigators comes to execute a search warrant. The agents have the benefit of weeks of planning. In contrast, the target of the search is usually caught off-guard.

Again, what do you do? Below is a series of tips and tactics Pomerance suggests you consider if you ever find yourself in the position of having federal agents show up at your front door demanding to search your practice's premises.

1. Identify what is happening and who is doing it. "Your first reaction should be to call

How to deal with staff if the feds come probing

Search warrant does not compel interviews

If federal or state agents show up at your office with a search warrant or request for records as part of a fraud and abuse investigation, remember that the warrant does not allow them to interrogate office employees.

"This does not mean that the agents will refrain from trying to interrogate the people on the premises," says **Philip L. Pomerance**, a health care lawyer with the Chicago firm of Hinshaw & Culbertson. "The agents executing the warrant will use the fear, shock, and confusion engendered by the search to talk with as many people at the site as possible."

He recommends asking the agent in charge to instruct his or her people not to talk to your employees. If the agents continue in attempts to interrogate the staff, continue stating your objection.

If you have not already done so, advise employees that they may, if they choose, refuse to answer all questions directed to them. Do not direct the employees not to answer; the investigators may construe that as obstructing justice or even witness tampering.

Explain to the employees that they have a choice whether they will answer any questions, both during the search and subsequently. Object strenuously if an agent intimidates anyone. If employees agree to be interviewed, you should insist that your lawyer be present during the interview. Record the interview, if possible. Quietly — and as quickly as possible — send all nonessential employees home. Advise the agent in charge that you are sending the employees home for the day.

"In rare instances, you may want to stay open the rest of the day, but it is generally better to close during a search," says Pomerance.

Keeping some employees on the site may be valuable to help agents obtain computer information and other documents that are the subject of the search without risking damage to your property.

"Make it clear to the agent in charge that you are not consenting to the search, but that the employees are here to ease the disruption and damage to your business caused by the search," he says. "Then send all remaining employees home."

The agent in charge has no authority to detain the employees. The agent in charge may ask for a list of the employees' names, addresses and phone numbers. You are not required to produce this information, but the investigators undoubtedly will discover it during the search, so providing this information does little damage and may reduce employee contact with the agents.

Remember that because most employees will be confused or even afraid, you should reassure them that business will continue as usual. Also, talk with your lawyer about how to best educate employees about the allegations being brought.

"Clients often are very resistant to educating their staff about the nature of the investigation. However, I believe that it is far better for an employee to learn about the search from a supervisor or co-worker than to receive information by watching the 10 p.m. news," says Pomerance.

You also may get questions from employees about their need to hire a lawyer. "You must talk with your attorney about the right of employees to individual counsel — and whether the practice should pay for it— as soon as practical," he says.

"Remember that the investigators may contact key employees right after the search while the shock is still fresh. In turn, you may want to advise employees of their ability to retain counsel before an agent knocks on their door. Finally, make certain that no employee attempts to remove company property from the search scene or to destroy or hide any property or materials." ■

your lawyer," he says. "Next, identify who is conducting the search and on what authority."

Determine which agencies are participating in the search. Because a search team usually consists of agents from various agencies, there could be investigators from the FBI, the Office of the Inspector General, the Railroad Retirement Board, and the U.S. Postal Service, along with agents from the state police and Medicaid office.

"Finding out which agencies are conducting the search is relatively easy. Agents carry business cards and will give you one if you ask," says Pomerance.

2. **Identify the agent in charge of the search.** The agent in charge likely will have the original search warrant and should be the focal point of any discussions you have or complaints you make during a search.

If you object to anything during the search, make your case to the agent in charge and not to the agent whose actions you find objectionable. Remember, individual agents take instructions only from the agent in charge.

The agent in charge also is responsible for securing the premises, beginning the search,

clearing the search, and delivering an inventory of all items taken during the search.

3. **Ask for a delay.** Next, ask the agent in charge to seal the premises and delay the search until your lawyer arrives. If the agent says no, "carefully monitor the search, but do not attempt in any way to impede or obstruct it," says Pomerance. "You do not want to draw a charge of obstruction of justice."

Ask the agent in charge not to speak to your employees until the lawyer arrives. While it's good to make this request, the agent in charge probably will not agree to it.

If the agent in charge starts to proceed with employee interviews, you have the right to tell workers that it is their choice whether they speak to the agents and that they are under no obligation to answer any questions. **(For more on how to help your employees through this situation, see story, p. 103.)**

4. **Identify the type of search document presented.** The strongest authority an investigator can present is a search warrant, issued by a magistrate or judge. The warrant allows investigators access to specific physical premises (which must be identified in the warrant) to seek evidence of specified suspected violations of the law.

An agency subpoena or a records request, on the other hand, only requires that you produce information, but it does not allow the officers presenting the document to search your office or home for that information.

"If no search warrant is presented, carefully question the investigators about what they want and when they want it. If your legal counsel is not at the search site, ask for a delay while you consult with your lawyer on the telephone," recommends Pomerance.

"I know of several searches which, in fact, were really just the delivery of a state agency subpoena for medical records. Nonetheless, the agents still demanded immediate compliance and began to search the client's office and interrogate their employees," he says.

"In one such instance, if the provider's lawyer had not thought to question the agents' authority, they would have closed the client's clinic for at least four hours during a busy day while they searched its records." Instead, the agents agreed to let the clinic deliver copies of the records they were looking for within three days of the delivery of the subpoena.

Rarely are state regulatory agencies empowered to issue subpoenas that demand immediate production of records. Therefore, it is important to determine if the document presented by the investigators entitles them to simply search for specific material or to take immediate possession of that material. Remember also that the statute authorizing an agency's subpoena power often gives the target of the subpoena a "reasonable amount of time" to produce requested records.

Search warrants are a different matter. Whether issued federally or locally, "a search warrant allows the designated officer to search a specifically identified location and seize property that may constitute evidence of the commission of the alleged crimes described in the warrant," says Pomerance. "Except in the rarest cases, the search will continue under a warrant."

Ask the agent in charge for a copy of the search warrant and fax it to your attorney.

"You should then tell the agent in charge that you have asked your attorney to be present during the search, and that he or she is on the way," says Pomerance.

5. **Identify the supervising prosecutor and magistrate.** The agents, including the agent in charge, are not directing the legal aspects of the search. That is the job of the prosecutor who obtained the warrant, and that person ultimately will determine how the agents respond to claims of privilege, impropriety, or harassment during the search.

It is also important to remember that the prosecutor got the warrant from "a judge or magistrate who has the judicial authority [subject to appeal] on these same issues," Pomerance says.

While it is unlikely that either the prosecutor or the magistrate will be at the search scene, the magistrate is usually reachable if your lawyer has a dispute with the prosecutor and feels the issue needs to be argued immediately.

In federal cases, the name and phone number of the supervising prosecutor (most often an assistant U.S. attorney) is on the warrant. "If you or your counsel does not have that information, ask the agent in charge for the name and phone number of the prosecutor, and when possible during the search, your lawyer and the agent in charge should place a call to the prosecutor," Pomerance explains.

It is imperative that you obtain the prosecutor's home telephone in order to raise issues of

privilege, any claims of illegal or improper search, or any other issue affecting the search.

"I have defended searches that went reasonably well for seven hours, and then had a major issue of attorney-client privilege surface at 1 a.m.," he says. "The agent in charge will not deviate from the search because of your legal objections or claims. Just as the other agents defer to the agent in charge, the agent in charge will defer to the prosecutor. Therefore, an open channel to the prosecutor — and, if necessary, to the magistrate — is critical."

(Editor's note: Part two of this series will appear in the September issue of Practice Marketing & Management. *It will cover records and computers, what is subject to seizure, Fifth Amendment protections against self-incrimination, the physician-patient privilege, attorney-client privilege, and the self-evaluation privilege.)* ■

Constant communication helps office run smoothly

Flowcharts track how the business works

For a physician's office to run smoothly, it's not enough for people to just concentrate on doing their jobs, says **Jeannette Perich**, CPA. Instead, staff must work together and understand how what they do affects the rest of the staff, says Perich, administrator of the Fort Collins (CO) Youth Clinic.

Along with customer service for patients, she stresses internal customer service among staff to ensure the service delivery system works smoothly. The clinic has implemented strategies to promote better communication among staff. Those include regular meetings at which staff members share knowledge and flowcharts as communication tools to allow individuals to see the impact of their actions on the rest of the operation.

"So many times, people get caught in their own little area and don't realize the impact they have on other people," Perich says.

That's why Perich uses flowcharts to give staff an idea of how the business systems work and how their part fits into the entire process.

"We were looking at processes and trying to see where bottlenecks happen in the practice. It's helpful for the staff to see where they fit in," he says.

For instance, one flowchart, "Life Cycle of a Fee Sheet," tracks the path of the fee sheet from the time a patient is scheduled for an appointment through the time the account is paid. **(See flowchart, p. 106.)**

"This helped the people at the front desk understand that if we don't have good demographic information and good insurance information, we can't bill out. Our staff has a better understanding of the whole picture and how the entire process works," Perich adds.

For instance, by studying the flowchart, employees can see how benefits are sometimes denied because the patients are no longer covered by a certain plan, Perich says. "Then we have to start all over again and resubmit the claim, and this is bad for the cash flow," she adds.

Another flowchart traces telephone calls, how they are routed, and what decisions need to be made to route the calls. Another tracks the patient visit and details who comes into contact with the patients and how their actions affect the patients.

For the fee sheet project, Perich started the process by asking a staff person to write out the entire process of how a fee sheet moves through the practice. After the process was written out, Perich went back to each member of the staff who handles the fee sheet to make sure it was correct. Then she used an off-the-shelf flowchart software program to create a document that was easily understandable to the staff.

"Putting it in flowchart form makes it much easier to read. People get turned off by long narratives, and they tend not to read them," Perich says.

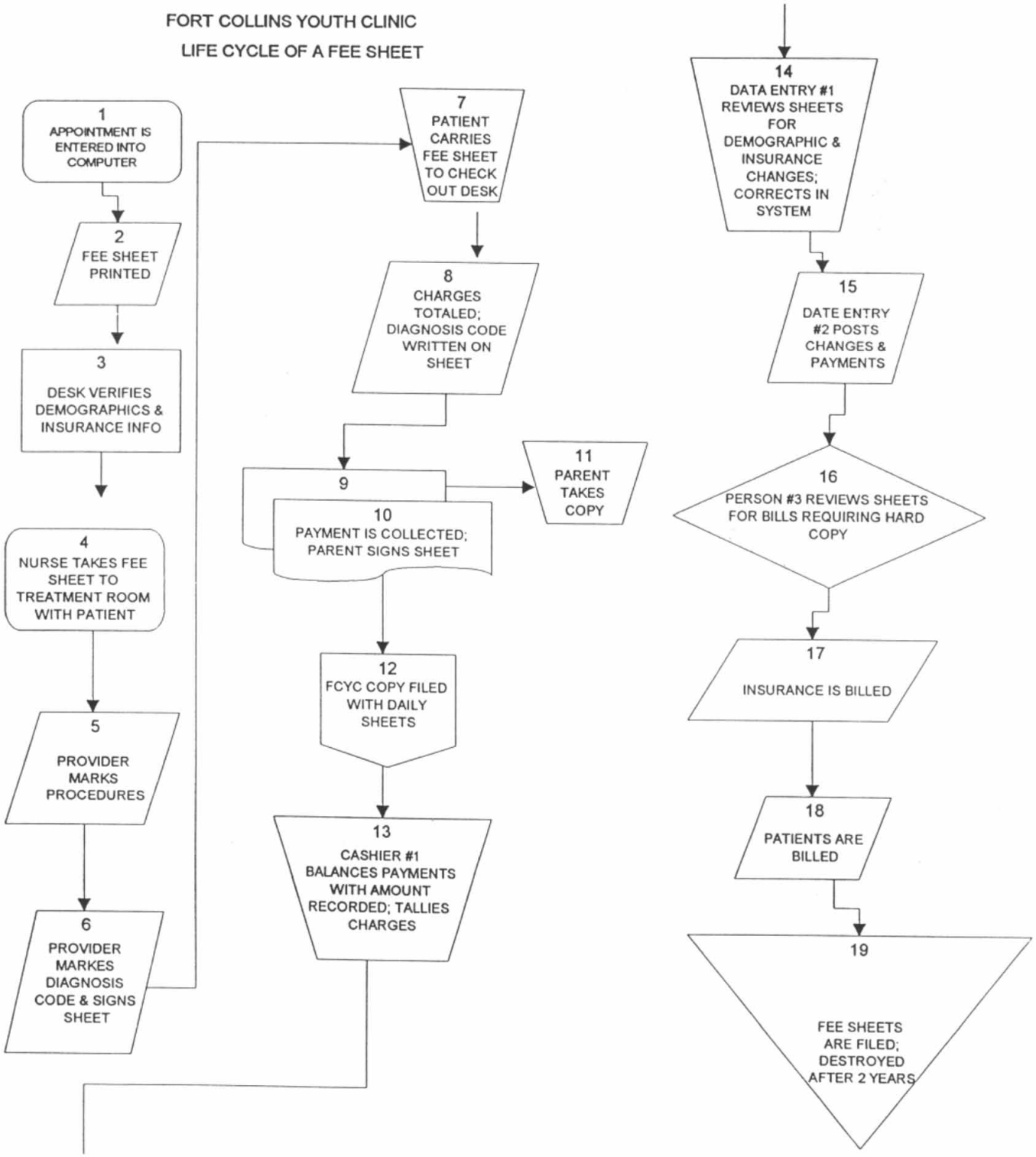
Perich meets once a week with all the managers in the office. That includes managers in the business office, nursing, lab, and transcription areas. The entire staff of 63 meets for lunch once a month. The staff includes eight physicians, four midlevel providers, and laboratory personnel.

"We talk about what we need from other staff people and what they need from us in order to do their jobs well. This all ties into communications and customer service," Perich says.

Giving the staff an opportunity to communicate regularly has been "a tremendous help" in ensuring that the office runs smoothly, Perich adds. For instance, one staff member recently proposed making a change in his department and didn't think it would make any difference to the rest of the staff.

"As soon as it was mentioned, about four people here spoke up about how it would impact their departments," she adds. ■

Life Cycle of a Fee Sheet



Source: Fort Collins (CO) Youth Clinic.

More physicians using e-mail to communicate

It saves time, produces a record

When it comes to improving communications with patients, "the telephone is no longer adequate," says **Daniel Hoch**, MD, assistant in neurology and director of neurology operations improvement at Massachusetts General Hospital in Boston, who is running a pilot e-mail program with about 10 patients.

"There are too many calls, and people are not satisfied with a quick answer. The Web-based approach is more convenient, and more information can be given," he says.

The neurology department has had a service for about a year that allows patients to post a message to Hoch on a bulletin board. He answers directly to the bulletin board, and the postings are saved to provide a record of the interaction that is easy to review. The site is password-protected and more secure than standard e-mail, he says.

Cutting phone time

Hoch uses the e-mail method to answer patient questions, leave instructions for medication changes, and direct patients to Internet sites that might supply more information.

He says using e-mail has cut the time he spends on the phone with patients by 25% to 50%.

"We've generally found it more efficient than phone calls. There is the ability to take care of business from remote sites, to do so at odd hours without worrying about waking someone up. And it is often faster than phone tag," he says.

Another benefit: Since e-mail messages can be printed out, there is a written record for both the patient and the physician.

Hoch is on the cutting edge of using a technological tool that could transform the day-to-day practice of medicine. Only about 5% to 10% of physicians currently correspond with their patients by e-mail, up from 1% to 2% one year ago. However, experts predict this number will rise quickly as patients used to e-mailing business associates, friends, and family demand the doctors respond to their e-mail inquiries.

"The small group of clinicians who routinely use provider-patient e-mail say that it has revolutionized their practice in very positive ways," says **Tom Ferguson**, MD, an Austin, TX-based consultant. "In many cases, they can avoid the need for a clinic visit by an on-line exchange. And there is always a full record of the on-line conversation, so it can automatically become a part of the patient's medical record."

Ferguson says 25% to 30% of doctor-patient e-mail deals with follow-up questions after an office visit, a perfect example of the benefits of e-mail. "It's wonderful as a doctor to say, 'Send me an e-mail in 10 days, and let me know how you're doing.' You usually don't know what happens to the patient. Think how good that could be for your clinical expertise."

Cost benefits

Paul M. Ford, MD, an assistant professor of medicine at Stanford University in Palo Alto, CA, who practices internal medicine, has been using e-mail with his patients for about five years. "E-mail unloads a lot of the administrative stuff you have to do in medicine, " he says.

"I really believe if we had more patients using e-mail, it would decrease our overall practice costs," he continues. "We wouldn't need so many people to answer the telephone, so many people in the file room moving charts around. Also, patients would feel more connected to the practice, which could help financially in the long run."

Ford's practice of 10 physicians has a central e-mail address and a software filtering program that helps automatically route messages to the appropriate people. An automatic reply is sent to notify patients their message was received and who will take care of their request.

Sometimes, the practice adds standardized reminders to the automatic message such as information about flu shots. Many of the messages involve prescription refills, appointments, and specialist referrals that can be handled by someone other than a doctor. Physicians only give out their private e-mail addresses when they feel it's appropriate.

(For additional information, the American Medical Informatics Association Internet Working Group has developed "Guidelines for the Clinical Use of E-mail with Patients." The guidelines are available on the World Wide Web at www.amia.org/pubs/pospaper/positio2.htm.) ■

NEWS BRIEFS

Stark to HCFA: Give us final rule by 2000

At a May hearing by the U.S. House of Representatives Ways & Means Health Subcommittee, Rep. Pete Stark asked the Health Care Financing Administration (HCFA) to present a final rule on physician self-referral by next year.

The Stark law is working, he said of his namesake legislation, and "referral rip-off schemes" that were common in the 1980s are more rare. "Efforts to repeal or narrow the physician self-referral law must be turned back," Stark told the hearing. "The whole point of the . . . law is to put a halt to unethical investment schemes that fuel overutilization and cost taxpayers billions in unnecessary care."

However, Stark said the rules can be more effective once the regulations take full effect. He asked HCFA to promulgate final regulations next year. But he does acknowledge that some reporting requirements are onerous for physicians. As a result of concerns, HCFA will require physicians to keep in their offices only those records indicating the nature of their financial relationships in accordance with standard business rules, he reported. ▼

Aging male population boosting urology pay?

Urologists saw the largest increase in compensation between 1995 and 1998 of any specialty, according to a new survey the American Medical Group Association of Alexandria, VA.

Urologists' salaries increased by 14.77% during that time period, the largest among 89 specialties evaluated by the survey. The biggest decrease was 1.1% among emergency physicians. While salaries rarely increased by more than 10%, productivity gains hit the double digits in most specialties. It went up by a 44.2% among cardiologists. Six other specialties increased median gross production by over 30%.

Practice Marketing & Management will have more on the survey next month. It's available for purchase from the AMGA at (703) 838-0033. ■

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Editor: **Lisa Hubbell,** (thehubbells@earthlink.net).
Vice President/Group Publisher: **Donald R. Johnston,** (404) 262-5439, (don.johnston@medec.com).
Executive Editor: **Glen Harris**, (404) 262-5461, (glen.harris@medec.com).
Production Editor: **Terri McIntosh**.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.