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INSIDE

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A strategic plan is your practice's road map to a successful operation

Long-term goals help maximize returns

Instead of complaining about changes in health care and how it affects your practice, it's time to step back and figure out how to do things differently so your practice can prosper in difficult times. This is where designing a strategic plan can help.

Strategic planning gives you a chance to:

- review past challenges and accomplishments;
- set goals for the future;
- re-examine the practice's mission, values, and expectations;
- consider pressing issues outside the office environment.

"A physician practice is a business, and any business needs planning to determine how best to spend time and expertise to maximize returns," says **Diane Peterson**, president of D. Peterson & Associates, a Houston-based health care consulting firm. Physician practice strategic planning may have been an oxymoron in the past, but that has to change if today's practices are going to succeed, she says.

In the past, physicians could count on dealing with the same patients, increasing fees slightly, and being sure of the making the same income year after year, explains **Michael Parshall**, vice president of The Health Care Group, a Plymouth Meeting, PA-based consulting company. No more. Now physician practices are faced with declining reimbursement, increased competition, consolidation of medicine, and blurring of the turf. When he talks to physicians about strategic planning, he is fond of quoting a colleague who asserts: "If you don't know where you're going, any road will take you there.

"Every successful business has a strategic plan. If it wants to do better, it has to figure out how it's going to happen," he adds.

Planning is more important than ever in a health care environment where the rules and the needs of your patients are constantly changing. Planning will allow you to step back and look at your environment and figure out how to respond, Peterson adds.

If you're a practicing physician, you have a limited amount of time and you need to decide how to best apply it to maximize a return — not just a financial return but a return in the feeling of satisfaction that results from doing what you want to do.

"A physician or physician group is a business. All the physician has to sell is his or her time and expertise. Any business needs to determine how to best spend time and expertise to maximize the return," Peterson says.

With a strategic plan, you set important goals with a timetable attached and deal with big issues, those you don't deal with on a day-to-day basis. "Physicians are often so concerned with taking care of patients that their big goals are pushed aside and never put in writing. Unless you sit down and do strategic planning, you will mosey along, never getting to those important and big questions," Peterson says. Strategic planning forces physicians and other members of their practice to look at the big issues, rather than the immediate priorities, she adds. "It's better to deal with things well in advance than to be making rash decisions."

Dick Hansen, a Palo Alto, CA-based health care consultant with the Medical Group Management Association, facilitates 20 to 25 strategic planning retreats for physicians each year. He's worked with practices that range in size from three physicians to more than 500. Medical groups should do strategic planning to have some control over their future and to clarify the practices' approaches, he says. "Unless all the members of the group are basically on the same page, the group won't be able to move forward quickly."

He gives the example of a physician practice that made all of its decisions by consensus of its members. The group made a unanimous decision in a meeting one afternoon, but by the next day, one physician had changed his mind and the process had to be repeated.

"Medicine is a business, and large practices can't conduct all decision making by consensus," Hansen says. The problem could be eliminated by including ways to streamline the decision-making process in the strategic plan. For instance, the group could specify which decisions would be made by consensus and which could be made by majority vote, he adds. Strategic planning sets out your goals in a clear, understandable manner and lets everyone in the practice knows what is expected of them.

Planning also enhances communication between people in the practice. "When you share information and involve people, productivity tends to go right up. People feel they are truly invested in the practice," Peterson says.

Hansen tells of practice that hired two new physicians who refused to go to the satellite office they had been hired to staff. "The group never made it clear that the site was where they were expected to go," he says. A strategic plan could have eliminated the problem.

You don't have to have a strategic plan, but it makes it easier to operate if you have one, Hansen says. Having a plan is essential when there is a new leader in the group, a new president or administrator. For instance, a new administrator who has 10 different physicians telling him or her 10 different things to do may never accomplish anything. But with a strategic plan, the administrator will clearly understand the goals of the practice, he adds.

Having a plan that sets out reasonable goals will give everyone in the practice a sense of accomplishment, Hansen says. "It's harder and harder to be a physician these days because of all the outside pressures. If you have a strategic plan with measurable goals, you get a feeling you are accomplishing something," he adds. ■

Planning should involve everyone in the practice

Staff buy-in is essential for success

The challenge of successfully implementing a strategic plan is to get the endorsement of everyone in the practice, whether they are physicians, nurses, or clerks.

And the way to get staff buy-in is to involve them in the planning process, the experts say.

"Everybody has good ideas about what is good about a practice and what needs to be improved. Some of the best ideas come from the people who are out there on the front line," says **Diane Peterson**, president of D. Peterson & Associates, a Houston-based health care consulting firm.

How the planning process works depends on the size of the practice. In a small practice, everyone can become involved. In a big group practice, a committee situation could work best.

For large practices, she suggests a planning retreat, preferably on a Saturday, during which

the committee reports its findings.

Dick Hansen, a Palo Alto-based health care consultant with the Medical Group Management Association, agrees. He suggests holding a meeting in a relaxed setting away from the usual place of work, facilitated by someone outside the practice who can take a neutral view on the issues. "An outside consultant is there for the benefit of the entire group and doesn't have any baggage. He or she is able to guide the group to talk about really tough issues."

If your practice can't afford an outside consultant, consider swapping with a practice manager in another community. He could lead your strategic planning session and you could do the same for him.

"It's much easier to communicate with an outside person," Hansen says.

Whoever leads the planning process should begin by talking to everyone in the practice, asking staff to name the weaknesses and strengths of the practice and for ways they can be improved. "If you ask 10 to 15 people their top issues, you may get 30 different answers, but you can distill them down to the top issues, prioritize them, and tackle them," he says.

Questions to address include:

- How do you describe the group?
- What are the group's top three issues?
- What do you want the group to accomplish in the next one or two years?
- How can the group get there?

Also avoid the temptation to rush into a strategic plan, experts advise. Instead, take the time to do some research so you have a good idea about the issues you are facing.

Look at the health care market in your area and what's going on in your practice. "This will help you get a picture of the practice and a foundation from which to build a future," says Hansen.

If you do your homework, you should have a clear picture of what your goals and outcomes should be. Here's how to start:

- **Examine your practice and any external factors that could affect your success.** External factors may include population shifts, your competition, changes in your community, and referral sources. **(For details on how to conduct an analysis of external factors, see related article, at right.)**

Look at the internal environment of your practice itself. What kind of skills do people have in your practice? Look at management skills as well as clinical skills. How smoothly are your operations running? Look at profitability. Are there problems on the financial side? How are you marketing your practice? How satisfied are your patients? Is your practice growing or shrinking?

- **Assess your strengths, weaknesses, opportunities, and threats (also known as a SWOT analysis).** Look at what needs to be enhanced and what needs to be changed. A good plan will capitalize on your strengths and correct your weaknesses. Opportunities might include a chance to add a satellite office in a fast-growing area or to join a new provider panel. Threats might include competitors moving into your area or decline in reimbursements.
- **Establish a set of goals.** This is when your group decides how it is going to build on its strengths and opportunities and address the weaknesses and threats.

Peterson suggests coming up with no more than six strategic areas to focus on. "The outcome is what you want it to be. Your goal may be growth in your practice, changing the insurance mix of patients, or a plan to close the practice in three years. With good planning, you'll be able to see the outcome very clearly and work toward it," she says. ■

How external environment can affect your practice

Look at competition, community, market trends

If you want to create a special program for your diabetic patients, it probably wouldn't be a good idea to locate it across the street from a major diabetes center. On the other hand, if you have a pediatric practice and want to expand, a location near a master-planned community designed for families might be ideal.

Those are examples of how a review of your practice's external environment can help you in the planning process. An external environment review takes a look at demographics, payers, employers, referral relationships, competitors, hospital, community information, and market trends, says **Dick Hansen**, a Palo Alto, CA-based health care consultant with the Medical Group Management Association.

Gather information on who your patients are and where they come from, suggests **Michael Parshall**, vice president of The Health Care Group, a consulting firm based in Plymouth

10 Strategic Planning Tips

1. Involve your entire staff in the planning, execution, and monitoring of your strategic plan.
2. Agree to devote the time and money necessary to developing your plan.
3. Set aside some time each year to modify your plan to meet your goals for the coming year.
4. Project costs for the first 24 months of your plan. Consider labor, consulting, equipment, personnel, administrative, and management systems.
5. Make sure you have enough working capital to implement your plan.
6. Give yourself enough time to accomplish each step in your plan.
7. Implement your plan. It's worthless if you don't do anything about it.
8. Give your plan a three-month, six-month, and 12-month checkup or evaluation.
9. If you aren't achieving your goals, correct it. Don't think you have to stick with the plan just because you put so much time and effort into it.
10. Celebrate your successes.

Meeting, PA. He suggests creating your own database of patients and importing it into a map program to see exactly where your patients live.

If you are considering opening a branch office, locate it where most of your patients are. Keep up with population trends in your city. Contact your county planning commission to see what their population estimates are and what kind of developments are on the drawing boards.

For instance, if there's a large retirement community being planned, it might be an ideal location for a gerontology or endocrinology practice.

Knowing who your patients are and what their needs are can help you come up with strategies for the future. If you know that your diabetic populations are growing each year, consider adding a nutritionist or a weight loss program. If your practice does a good job managing diabetic patients, your goal might be to increase the number of diabetic patients you treat. Your practice might decide to publicize your success with diabetics by sponsoring an educational event, such as a talk by a diabetes educator and invite the public and the news media.

Get a sense of what is going on in your marketplace. If your hospital consolidated with a bigger hospital, look at how is it going to affect you.

Check out the competition, too, suggests **Diane Peterson**, president of D. Peterson & Associations, a Houston consulting firm. Find out if other practices in your specialty are consolidating, or if they're moving into your neighborhood. If your group was once the only doctors' office in your area of specialty but now four other practices have moved in, you'll want to come up with a strategy to keep your patients.

Find out what other practitioners are doing for their patients and referral sources. Keep up with federal, state, and local legislation and how it will affect your practice.

Also monitor the requirements from your managed care payers. The federal regulations and managed care mandates for electronic medical billing may mean that it's time for you to revamp your information technology.

Here are some potential sources of data for your environmental assessment:

❒ U.S. Census population projections;

❒ local planning department or economic development office;

❒ local hospitals and health systems;

❒ local chamber of commerce;

❒ local, state, and national professional organizations. ■

How to get started on your strategic plan

Many practices face similar issues

No matter what the specialty or the size of the group, most physician practices face similar issues, **Dick Hansen** asserts.

He should know. Hansen, a Palo Alto-based health care consultant for the Medical Group Management Association, facilitates strategic planning initiatives for 20 to 25 physician groups each year.

Physician's Managed Care Report asked Hansen and other consultants what components to include in a strategic plan. Here are some of the key areas mentioned:

• **Operations.**

On the clinical side, this could include purchasing new equipment, offering new services, or coming up with new product lines. When you examine business operations, you may want to

improve insurance billing and collections, or it may be as simple as dealing with an incompetent clerk.

• **Financial aspects.**

If expenses are rising and reimbursements are declining, decide how to handle it. You could decide to trim costs or boost revenue. Look at the financial arrangements you have with physicians. If you're considering purchasing new equipment, look at whether the practice can handle a capital investment at the time.

• **Marketing program.**

Look at what your practice is doing to market itself, not just to insurance companies but to patients and other physicians. Come up with a plan to monitor your referral sources and put the information to work for you. Keep tabs on who is referring patients to your practice. Be specific. For instance, instead of listing "doctor" as the referral source, list the practice or the physician by name. Monitor it from month to month, and take action if their referrals drop off.

Survey your referring physicians personally to find out what they like or dislike about your practice. The doctor-to-doctor relationship is important here, Parshall says.

Meet with your managed care plans' medical directors, find out about their future plans and take the opportunity to educate them about your specialty.

• **Customer service.**

Referrals by current patients are the lifeblood of any physician practice even if you are part of an insurance company provider panel. Decide whether you need to do a patient satisfaction survey and come up with a program to improve service. Look how your patient load is changing and how you should respond to it. For instance, if many of your patients are demanding baby boomers, decide how you will meet their demands.

• **Retirement of senior physicians.**

If your practice has a number of older physicians, this could be a key issue for the future, Hansen says. Strategic planning gives you the opportunity to set out your expectations for physicians who want to retire or cut their hours. Don't put yourself in the position of one practice, which was short a physician for six months when a senior physician gave the group only 90 days notice of retirement.

Many groups specify that physicians should give at least 12 months, and preferable 24 months notice for retirement. Physicians who fail to give the proper notice may get less buy-out money, he says.

• **Growth.**

If the issue is growth, adding new physicians, or adding new sites, plan how you will go about it. A project for recruiting new physicians often takes a lot of discussion and planning for a group practice, Hansen says. "Everybody wants to interview the candidates, but it's just not practical for each candidate to be interviewed by 10 to 15 people," he adds. One technique that has worked well is to appoint a committee to interview each candidate but invite anyone else from the practice to join them at lunch or dinner. ■

Does your coding pose a compliance problem?

Electronic records make it easier to get caught

As the government and payers institute stricter reimbursement policies and electronic medical records make it easier to check for compliance, it's more important than ever for your practice to improve its coding performance.

If you're not coding correctly, you could face a government review and stiff fines — even if it's an honest mistake.

Proper coding is important because it's how you communicate what you've done, points out **Todd Welter**, MSM, CPC, coding consultant for the Medical Group Management Association in Englewood, CO. It's getting easier to get caught if your coding isn't correct. The federal Office of the Inspector General (OIG) and local Medicare carriers are conducting pre-payment and post-payment reviews comparing you to others in your specialty, he says.

"In the government's eyes, if you bill for a 99213 and all you documented was for a 99212, it's the same thing as saying you did four bypass graphs when you did only two. The government looks down on that," he says. "If you do more of a particular code than your peers, they may randomly ask you to send in documentation of some patients. Such a letter is the beginning of an audit."

If you do get a letter requesting more documentation, take it seriously, he adds. "A lot of those letters requesting documentation look

benign but they can get doctors in a lot of trouble," he adds.

Welter cites three reasons for coding correctly:

✔ **Compliance.**

Your practice can prove that it provided the services it billed for.

✔ **Reimbursement.**

Each code has a dollar figure applied to it. If you code correctly, you'll get the correct amount of reimbursement.

✔ **Statistical analysis.**

Coding shows the acuity of your patients. This is important in a lot of managed care situations. You'll need the information if you are going to enter into any kind of capitation arrangement.

Most health plans, including government programs, use the CPT code as a method to determine the payment you'll receive. If you're going to get paid correctly, you have to submit the correct code.

"Although there are a number of software products and tools that can help, there's really no substitute for a good background in coding principles," says **Rita A. Scichilone**, of Woodbine, IA, practice manager of coding products and services for the American Health Information Management Association.

Sometimes coding software gets physicians practices in trouble, particularly if it suggests certain code combinations or tends to maximize billing, Scichilone says. However, other software may have useful segments, such as showing if the CPT code is correct for Medicare coverage or if you have to add additional codes, she adds.

If in your practice, the physicians check off codes on the encounter form, they should be aware of the rules and guidelines that affect code choices, she points out. "The best situation is to have the physician select the code, and the billing and coding specialist validate the code choices to make sure the codes are complete, accurately represent what was performed and what was documented, and [ensure] there are not any conflicts with health plan reporting requirements."

She suggests having anyone in your practice who deals with coding attend an educational seminar to make sure his or her skills are up to snuff. Or your practice can hire a consulting firm to review your records and provide one-on-one instruction on coding principals, coding guidelines, and improvement of documentation.

Your practice may decide to conduct its own coding audit. A good coding review includes checking to see if the documentation meets the criteria laid out for the particular code.

Welter suggests compiling a year's worth of utilization data by doctor, broken down by code. Then ask for 10 randomly selected evaluation and management (E&M) notes and accompanying billing forms for each physician. Go through the E&M notes, tear them down into subpieces, and compare them to the coding criteria. Look at coding per practice and per physician. If a physician's coding varies from the norm, look at whether he or she has sicker patients or isn't coding right.

When Platte Medical Clinic in Platte City, MO, conducted a coding audit, the staff took the physicians' office notes and compared them to what was billed to see if the level of services the physician billed matched the documentation.

In addition to beefing up the practice's coding compliance, the audit discovered that the practice was losing revenue because some physicians were undercoding, explains **Lori Norris**, FACMPE. She was formerly practice manager at Platt Medical, and now is physician recruiting and marketing director for North Kansas City (MO) Hospital, the owner of the practice. **(For more information on undercoding, see related story, below.)**

"I encourage every practice to have it even if it has to outsource. Not only do you need a coding audit for compliance, but you can find a lot of missed revenue," she says. ■

Don't cheat your practice: Improve coding techniques

Improper codes can mean less revenue

When the Platte Medical Clinic in Platte City, MO, conducted an audit of its coding practices, the staff were surprised to learn that the practice was missing out on revenue because physicians were undercoding.

"Most of the time, we found the physician did not give himself full credit for the work done. He could have selected a higher code," says **Lori Norris**, FACMPE, former practice manager who is now employed by North Kansas City (MO) Hospital, the owner of the practice.

However, she adds, physicians are not always comfortable with coding and fear being audited

(Continued on page 59)

Physician's Capitation Trends™

• Capitation Data and Trend Analysis •

When capitation gets raw, start with CHF 'best practices'

Pharmacists offer optimism, tested strategies

One of the more promising ways to supercede the challenges of capitated pharmacy contracting lies in first going after the "biggie" — congestive heart failure (CHF) — and managing the nation's most prevalent disease with an eye toward avoiding all too common negative drug interactions among elderly patients.[1]

That's the recommendation of **William J. Waugh**, PharmD, director of disease state management and outcomes research at Wellpoint Pharmacy Management, a part of Wellpoint HMO, both based in Calabasas Hills, CA.

Using a three-part approach

Waugh has tested with success a three-part approach to making a start toward taming the beast of pharmacy capitation. His research team's common-sense, pharmacy-driven approach offers hope for a healthier quality of life for CHF patients at significantly lower costs. In brief, the three main steps he and his team recommend are:

• Identify Medicare risk enrollees who have a CHF diagnosis.

• Screen (at minimum) for the top 20 most commonly contraindicated drugs in the elderly. **(See chart, p. 56.)**

• Follow the Agency for Healthcare Research and Quality's (AHRQ) clinical guidelines for CHF — particularly the drug recommendations.

Waugh's overall message is to insurers: "Managed care organizations should be willing to pay for medications if they are going to take on Medicare risk, because that is the most cost effective." He stops short of recommending physician groups accept pharmacy capitation.

His key worry is that patient medications will get short-changed. When that happens, overall costs will shoot up, he says. To guard against that threat, a physician group is advised to determine whether a capitated drug plan under consideration is set up to pay adequately for drugs.

The assertion that lowering drug therapies results in higher long-term costs is confirmed in a 1999 study by Robert Popovian, PharmD, senior medical liaison for Pfizer Inc., and his team at the University of Southern California in Los Angeles. In Popvian's study, primary care patients in the capitated drug plan incurred 14% higher overall costs than patients in noncapitated drug plans. **(See related story, p. 58.)**

But his theme rings true for physician practices engaged in Medicare risk contracting, too. One of the best places to start when looking to managed cost issues in a Medicare risk contract is coronary heart disease (CHD), Waugh suggests.

Targeting the country's biggest killer

CHD is the nation's biggest killer. This year an estimated 1.1 million Ameri-cans will have a new or recurrent coronary attack, according to the Centers for Disease Control and Prevention in Atlanta. About 650,000 of these will be first attacks, and 450,000 will be recurrent attacks.

The patient survival rate is about 60%, and after age 50, the prevalence of CHF doubles with each decade of life. **(For more highlights of epidemiological and economic data relative to CHF, see related article, p. 57.)**

Given such high rates of heart disease, expenditures for CHF treatment also are high, but they are not uncontrollable, Waugh asserts. Of

Contraindicated Drugs in the Elderly

Drug Name	Reason	Suggested Alternative(s)
diazepam	daytime sedation, risk of falls	temazepam, estazolam
chlordiazepoxide	daytime sedation, risk of falls	temazepam, estazolam
flurazepam	daytime sedation, risk of falls	temazepam, estazolam
meprobamate	daytime sedation, risk of falls	temazepam, estazolam
pentobarbital	daytime sedation, risk of falls	temazepam, estazolam
secobarbital	daytime sedation, risk of falls	temazepam, estazolam
amitriptyline	anticholinergic effects, risk of orthostatic hypotension	nortriptyline, desipramine
indomethacin	risk of CNS toxicity	other NSAIDs
chlorpropamide	risk of SIADH syndrome	other hypoglycemics
propoxyphene	risk of CNS & cardiac toxicity	acetaminophen
pentazocine	risk of CNS & cardiac toxicity	acetaminophen
isoxsuprine	no demonstrated efficacy	
cyclandelate	no demonstrated efficacy	
dipyridamole	headaches and dizziness	aspirin
cyclobenzaprine	risk of CNS toxicity	acetaminophen
methocarbamol	risk of CNS toxicity	acetaminophen
carisoprodol	risk of CNS toxicity	
orphenadrine	risk of CNS toxicity	
trimethobenzamide	no demonstrated efficacy, risk of drowsiness, diarrhea	other antiemetics
propranolol	risk of CNS toxicity	atenolol, nadolol
methyldopa	risk of CNS toxicity	atenolol, nadolol
reserpine	risk of CNS toxicity	atenolol, nadolol
guanethidine	risk of hypotensive episodes	atenolol, nadolol
guanadrel	risk of hypotensive episodes	atenolol, nadolol

Source: Waugh WJ. Managing congestive heart failure in the Medicare risk population. *Journal of Managed Care Pharmacy* 1999; 5:16.

the $10 billion spent nationally each year on CHF treatment, hospitalization consumes $7 billion, and rehospitalization is a big part of that high price tag. Drugs account for $230 million overall, or about 2.3% of total expenditures.

But improved drug treatment — even if drug costs go up — can significantly reduce hospital admission and readmission costs, Waugh argues. Otherwise, without prevention and optimal drug therapy, CHF cases will only increase as the whopping numbers of baby boomers turn gray. Waugh recommends this three-step approach, which he and team tested among a sample of the HMO's Medicare risk beneficiaries:

1. Identify Medicare risk enrollees who have a CHF diagnosis.

This is done by flagging patients based on prescription records and the ICD-9-COM codes for CHF if hospitalization has occurred. This is where the urgency for insurance coverage starts. Many elderly cannot afford to comply with all the drug therapies they need if they are not adequately covered in their plan, Waugh notes. Therefore, their risk for heart failure may not show up in medications records.

2. Screen for the top 20 (at minimum) most commonly contraindicated drugs in the elderly.

Even though the threat of drug side effects is well known, often patients are not screened for drugs they are taking to ensure they will not interact with other new prescriptions, Waugh says.

At one plan he and his team researched, 15% of the Medicare risk patients were taking a contraindicated drug. After intervention, drug therapy changes were prescribed for some 70% of the patients in that plan. While end results are not yet available, Waugh expects hospitalizations to be

Heart disease ravages health and resources

Why you should focus on CHD

Coronary heart disease (CHD) is America's biggest and costliest health predator. Its devastation to life and health could be drastically reduced, however, by changes at two levels:

1. Patient behavior changes — quitting tobacco use, increasing exercise, and improving diet.

2. Clinical behavior changes — identifying high-risk patients; following "best practices," or clinical guidelines; and adhering to established drug prescriptions that avoid contraindications, according to **William J. Waugh**, PharmD, director of disease state management and outcomes research at Wellpoint Pharmacy Management, a part of Wellpoint HMO based in Calabasas Hills, CA.

If your practice is considering a Medicare risk contract, key epidemiological and economic trends are important to apply when looking at the patient base and how your practice already manages CHF patients. The Atlanta-based Centers for Disease Control and Prevention (CDC) reports these current trends in coronary heart disease (CHD):

• CHD is the single largest killer of American males and females.

• About every 29 seconds an American will suffer a coronary event, and about every minute someone will die from one.

• This year, an estimated 1.1 million Americans will have a new or recurrent coronary attack — defined as myocardial infarction (MI) or fatal CHD. About 650,000 of these will be first attacks, and 450,000 will be recurrent attacks.

• More than 40% of those who experience a heart attack in a given year will die from it.

• About 225,000 people a year die of CHD without being hospitalized. Many of these are sudden deaths caused by cardiac arrest, usually resulting from ventricular fibrillation.

• 12.2 million people alive today have a history of heart attack, angina pectoris (chest pain), or both. This breaks down to 5.9 million men and 6.2 million women.

• It's estimated that 7.2 million Americans, 20 and older, have a history of MI (4.4 million men and 2.8 million women).

• From 1987 to 1997, the death rate from CHD declined 24.9%, but the actual number of deaths declined only 9%.

(CDC information is based on data from the "Atherosclerosis Risk in Communities" study of the National Heart, Lung, and Blood Institute, 1987-1994." These data represent Americans hospitalized with definite or probable MI or fatal CHD, not including silent MIs.) ■

lowered in that plan while quality of life for beneficiaries will improve.

3. Follow the AHRQ's clinical guidelines for CHF — particularly the drug recommendations.

These guidelines emphasize appropriate drug use. They recommend use of angiotensin converting enzyme (ACE) inhibitors in all CHF patients and the use of low-intensity warfarin in most atrial fibrillation patients to reduce the incidence of stroke, Waugh explains.

While "firm research" supports the use of ACE inhibitors and warfarin in CHF patients, use has not greatly increased, he says. In Waugh's study, both drugs were used by less than 40% of the patients in plans managed by Wellpoint's pharmacy benefits management company. And, 20% of patients were not appropriately monitored for warfarin effectiveness.

According to other research cited by Waugh, of patients who need ACE inhibitors, only 40% under primary care physician supervision are prescribed them and only 70% under the care of specialists are receiving the prescription.

This overall three-step approach for CHF was applied recently to one of Waugh's assigned plans. While his research is not yet complete, he estimates that hospitalizations will decrease up to 40% within the first year. He also expects that overall patient outcomes will improve and be reflected in the Health Plan Employer Data and Information Set as well as other key performance measures.

Reference

1. Waugh WJ. Managing congestive heart failure in the Medicare risk population. *Journal of Managed Care Pharmacy* 1999; 5:14-17. ■

Cutting drug selection may backfire on you

Short-term savings lost in long run

In what may be the first empirical study of the impact of pharmaceutical capitation on primary medical groups, researchers are confirming what many practitioners are saying anecdotally: A "Catch-22" occurs when capitation meets pharmacy. At first drug costs go down, but within a year, medical costs overall and drug costs in particular both increase.

That's the overall finding of a recently released study of 22,848 Medicare HMO members over a 12-month period. In the study, patient groups enrolled in pharmacy capitation contracts were compared to one Medicare risk group in which pharmacy was not folded into capitation coverage.

Capitation — 14% higher

Even when taking into account typical cost differences among ages and disease cohorts, costs were vastly different. "When controlling for age, gender, and severity of illness, pharmaceutical capitation patients had 14% higher total health costs than noncapitated patients, an additional $376 per patient per year, and 29% higher pharmaceutical costs, $110 per patient per year," according to a study conducted by Robert Popovian, PharmD, senior medical liaison of Pfizer Inc. and Kathleen A. Johnson, PharmD, PhD, professor of clinical pharmacy and pharmaceutical economics and policy at the University of Southern California in Los Angeles, and colleagues.[1]

The reason? Capitation's incentive to keep a tight budget on drug costs initially achieves that goal, but it later results in poorer patient care. That leads to higher hospital admission and readmission rates, which then incur associated higher drug costs, the researchers asserted.

"Elevated pharmaceutical expenditures in the capitated group may have resulted from physician focus on prescribing based on pharmacy cost rather than optimal pharmacotherapy," they explained. "This approach would perhaps result in more drug switching [to generics or lower-cost substitutes] initially, but overall achieve poorer outcomes, resulting in more visits and higher total health care costs."

The sample studied was divided into three groups — two which had pharmacy capitation (the experimental groups) and one in which the patient paid for drugs out-of-pocket (control group).

The capitated cohorts were allocated a capitation payment, which was managed by a pharmacy management company (PMC). The noncapitated group also was managed by the PMC, but not via a capitation arrangement; those beneficiaries were free to choose their drugs via a network of preselected pharmacies.

The role of chronic disease

Also as part of the study, each enrollee was assigned a chronic disease score identifying six chronic diseases: pulmonary disorder, cardiovascular disorder, diabetes mellitus, glaucoma, hyperlipidemic disorder, and gastrointestinal disorder. The score was assigned via the American Hospital Formulary System, a drug-directed method of identifying diagnoses.

"The strongest factor in whether an enrollee had any health care expenditures during the study interval was chronic disease score," the researchers pointed out.

"The pharmaceutical capitation variable also was associated with an increased chance of incurring total health care and pharmaceutical expenditures. Enrollees receiving care at pharmaceutical capitation PMGs had a 70% greater chance of incurring health expenditures or a 69% greater chance of incurring pharmaceutical expenditures than the patients receiving care [in the control group]," they added.

Other studies have shown that curtailing access to medications through rigid cost-control methods ultimately end up raising overall costs, the researchers said. Theirs is the first to specifically test capitation systems. They offer two recommendations:

1. To policy-makers, recognize that reductions in one sector of health care may induce cost increases in other domains.

2. To physician groups, contracts that capitate medical groups for pharmaceuticals may face higher costs overall.

Reference

1. Popovian R, Johnson KA, Nichol MB, Liu G. The impact of pharmaceutical capitation to primary medical groups on the health expenditures of Medicare HMO enrollees. *Journal of Managed Care Pharmacy* 1999; 5:414. ■

(Continued from page 54)

and accused of fraud. "They may be so afraid, that they cheat themselves out of money by not billing for what was performed."

To avoid the appearance of trying to collect more than they are due, some physicians tend to undercode. But in the long run, this isn't any better idea than coding for a higher level of care than you provided, the experts say.

"Physicians can cheat themselves if they don't code properly," points out **Rita Scichilone**, of Woodbine, IA, practice manager for coding products and services for the American Health Information Management Association.

And the problems created by undercoding go further than just receiving less for the services you perform. For instance, a managed care plan may look at your practice and decide that you don't treat patients with a high level of intensity. As a result in a capitated plan, the insurer may cut the per-member-per-month payment your practice receives, she adds.

Undercoding gives the appearance of something not being right if too many services receive a low-level code, Scichilone adds. "In a normal practice, you see a wide variety of levels because the physicians see a wide variety of patients with different needs." Some physicians get stuck on level 2 or level 3 codes and don't use any others, she adds. "Unless physicians are familiar with how the systems work, they may check off the same code every time."

If your practice exhibits an unusual pattern, the insurer or the Health Care Financing Administration (HCFA) may decide to conduct an audit to see what's going on. This is a time- and labor-intensive process.

Here's an example of how undercoding can hurt your practice: If you are a cardiothoracic surgeon and give every patient a low-level office visit code, yet you do open-heart surgery, HCFA could conclude that you are doing open-heart surgery on patients who are not sick, points out **Todd Welter**, MSM, CPC, a coding consultant for the Medical Group Management Association in Englewood, CO.

After Welter conducted a coding audit for one physician group practice, the practice manager wrote out fake "checks" to each physicians for the money the practice would have received had he or she coded properly. "Some of them got checks for $12,000 or more. It made quite an impression," he says. ■

Performance improvement can help the bottom line

Involve the entire staff in the process

Platte Medical Clinic was operating at a loss of about $20,000 a month when the hospital that owned the practice hired a management firm to find ways to turn the situation around. The consulting company mandated that each practice develop a plan to improve its financial performance. The goal was to reach break-even status.

"They asked each manager to come up with ways to cut expenses and maximize revenue at the same time," says **Lori Norris**, FACMPE, physician recruiting and marketing director for North Kansas City (MO) Hospital, formerly practice manager for Platte Medical Clinic in Platte City, MO.

Platte Medical Clinic is a member of Meritas Health Corp., a group of seven clinics owned by North Kansas City Hospital.

Norris says she started by listing projects she believed would help the practice meet its objectives of cutting expenses and maximizing revenue. Then she sat down with the physicians in the practice to discuss why it was important to improve the practice's financial performance and to ask for their suggestions. She repeated the process with the office staff.

"Everyone in the practice had to understand that this wasn't going to be easy and it wasn't going to go away. We needed them to be committed and to buy into the performance improvement process," Norris says. She solicited ideas from everyone in the practice on how they could increase revenue and efficiency and minimize expenses.

The staff originally came up with about 20 expense-reduction projects and about 20 revenue-enhancing ideas. These were honed down to eight to 10 projects in each category. The ideas ran the gamut from new methods for appointment scheduling and patient check-in to ways supplies could be given out and how claims could be paid.

"We looked at the entire operational process. That's why it's important to involve everybody in the practice. A lot of people have different perspectives," Norris says.

Some ideas were rejected from the outset. For instance, if the physicians were reluctant to take

on a project, it was eliminated from the list. "There was some trial and error. If the buy-in wasn't there, we knew we weren't going to realize the results no matter how much effort and cost we put into a project," she adds.

The planning process took a couple of months. Some changes were implemented right away, and others took time. "It was pretty easy to implement. We went through the initial training with the managers then repeated it with the physicians and staff," Norris says.

To track progress, she created a spreadsheet showing the projects and goals, allowing progress to be checked at any time. "As we worked through the plan, we realized that some goals weren't achievable. If they weren't realistic, we had to back off," Norris says. For instance, the plan called for increasing net patient revenue by $5 per patient. A more realistic figure would have been $1 to $2 to start with, she adds. "We originally set our goals too high. I encourage anyone else who starts such a plan to take baby steps."

Staff hold quarterly meetings when everyone is accountable for what has been happening with the plans. "If they aren't looking at them everyday, they aren't going to be successful," Norris says. ■

I-G-N-I-T-E Your Improvement Plan

When **Lori Norris**, FACMPE, talks about performance improvement plans, she uses the acronym "IGNITE" to describe the best way to make it work. Norris is the physician recruiting and marketing director for North Kansas City Hospital, formerly practice manager for Platte Medical Clinic in Platte City, MO. "When you start something, you can have two possible outcomes. It can fizzle out or it can go all the way and really catch on," she says.

Here are her tips for making a plan ignite:

- I **Inform and involve**
- G **Gain an understanding**
- N **Notice the positive**
- I **Inform and involve again**
- T **Talk about plan, keep it in the forefront**
- E **Entertain, spread enthusiasm, and make the plan fun for everybody**

Focusing on efficiency pays off for clinic

Patient load increased, overtime was eliminated

By getting the staff to concentrate on efficiency, Platte Medical Clinic in Platte City, MO, was able to increase the number of patients treated without increasing staff, eliminate overtime, and save paperwork for the administrative staff, who in turn could concentrate on collecting payments.

To cut expenses, the staff formed a group to look at internal processes such as overtime pay, staffing issues, and workflow processing. "We didn't cut staff because that would have been viewed negatively and hurt the buy-in. Instead, we concentrated on eliminating redundancies and doing things more efficiently, says **Lori Norris**, FACMPE, physician recruiting and marketing director for North Kansas City (MO) Hospital, formerly practice manager for Platte Medical Clinic.

Here are some of the performance improvement projects the clinic implemented:

• **Tracking lost revenue.** The practice implemented a system to make sure that everything got recorded on the charge ticket. For instance, sometimes if a nurse gave an immunization it might not get recorded. The same was true with EKGs and X-rays.

The practice used a cross-check system. The nurses were instructed to mark down a procedure before it was done. The physicians were told to make sure everything ordered was included before they signed the fee slip. The staff did spot checks by random chart reviews.

Each EKG and X-ray was assigned a number. To get the number, the nurse had to log them in. The fee slips were compared to the log.

• **Increasing patient loads.** Each physician and each nurse practitioner were given a goal as to how many patients they needed to see each day and asked for their input. The staff tracked the patient load each day to see how it was working.

If the physicians weren't meeting their goal for the number of patients they saw each day, Norris looked for the reason. If there were no-shows, the staff looked at double-booking and using a patient-reminder system. The front desk had information on how many patients each physician agreed to see each day.

"If the physicians complained about the front

desk working patients in, the staff reminded them that they agreed to see a certain number of patients a day, which gave them room to add additional patients to the caseload," Norris says.

Instead of holding Saturday open for emergency appointments, the staff decided to book 10 appointments. Staff members were assigned to give reports on how the practice was working.

• **Coding.** The staff conducted a coding review and coding education for physicians, showing where they were documenting but not giving themselves enough credit. **(For more about coding reviews, see articles, p. 53 and p. 54.)** ■

Wall chart keeps track of managed care data

A simple chart and color-coded stickers help the staff at Platte Medical Clinic in Platte City, MO, keep up with ever-changing insurance company regulations and coverage for patients. The practice has contracts with about 80 HMOs and preferred practice organizations, according to **Ame Thatcher**, the clinic's practice manager.

"It got so overwhelming to keep track of all the insurers. The physicians needed a way to make them more autonomous and not dependent on somebody in the business office to look up the information," says **Lori Norris**, former practice manager, now employed by North Kansas City (MO) Hospital, owner of the practice.

Her solution was a huge wall chart that included the names of all the plans, a general phone number, a referral phone number and a pre-certification phone number for each, requirements for referrals, the names of the hospital and laboratory the plan utilizes, and other information.

"It's very helpful for the physicians and nurses. Anybody can walk up to the window in the business office and see what they need to do," Thatcher says.

Before the chart was posted, a physician or nurse would have to rely on someone in the business office to provide the information or plow through pages and pages of manuals to get the correct information. Sometimes the person who could help them was on the telephone. When the practice had after-hours clinics, no one was in the business office to help.

"The chart is a quick reference guide. It keeps people from making mistakes, and it eliminates having to dig the information out of a book," Thatcher says. Having the chart saves time for physicians and nurses and improves the patient flow. It eliminates the problem of sending patients to the wrong lab and having the insurer refuse to pay for the lab work.

"It makes it easy for the doctors to know what the requirements are so we get proper paperwork done in order to be paid," she adds.

The chart has evolved to include additional information such as durable medical equipment vendors, approved home health agencies, and physical therapy referrals.

"If we found ourselves having to go to the manuals frequently for the same information, we added another column on the chart," Norris says.

Eventually, the chart took up an entire wall in the business office. The practice also came up with the idea of using stickers that identify a patient's insurance company. The stickers are on the bottom right-hand corner of the patient chart. The copay information is also included on the stickers. "Every insurer is different, and it changes weekly," she adds. The stickers help the physician match the insurance company with the correct formulary and referral information.

"Insurance companies frequently merge and change names. If patients change insurance companies, the front desk changes stickers. We got so everybody was tuned into looking at the stickers," Norris says.

Typically, the insurance companies provide the stickers. If the company didn't give stickers out, the staff used different colored stickers to designate certain companies. ■

AMA joins Georgia lawsuit against Aetna

The American Medical Association (AMA) has joined the Medical Association of Georgia in a class action lawsuit against Aetna U.S. Healthcare for failure to pay physician claims in a timely manner.

The suit, filed in Fulton County Superior Court in Atlanta, charges that Aetna routinely delays payments of claims in violation of Georgia's prompt payment law and that the insurer is unjustly enriched by using the money due physicians for its own profits.

It is the first time that the AMA has joined with

a state organization to sue an insurer, but it is not likely to be the last time, an AMA spokesman says. The AMA joined the lawsuit through its Litigation Center, a partnership between the AMA and 49 state medical societies.

"It's time that insurance companies honor their contracts and pay physicians in a timely manner so that patients can continue getting the care they deserve," says **Donald J. Palmisano**, MC, a member of the AMA board of trustees.

Georgia's prompt payment law mandates that clean claims must be paid within 15 working days. If the claims are not paid within those 15 days, the insurance company must send written notice to the provider stating the reason for nonpayment. After the 15-day period, the insurer must pay an 18% per year late fee to providers.

"By delaying payment of a claim, Aetna increases the time it retains the funds due to the health care provider who has submitted the claim. Meanwhile, Aetna earns profits from use of the funds, profits that it would not earn if payment were made in a timely manner," according to the lawsuit.

Payment, plus interest

The suit asks for damages to the plaintiffs to compensate them for the unpaid claims along with 18% interest and an injunction preventing Aetna from continuing to delay payment of claims. "Through this lawsuit, we hope Aetna and other insurance companies understand that physicians, on behalf of their patients, are no longer to accept harmful business practices. Delaying payment of claims hurts Georgia's physicians by making payment for services rendered uncertain. Patients are also hurt. Some patients have lost their physicians because of Aetna's payment policies," says **Paul Shanor**, executive director of the Medical Association of Georgia.

A copy of the suit is available at the Medical Association of Georgia's Web site: http://www.mag.org. ■

NEWS BRIEFS

Do ethnic differences affect physician ratings?

Patients of different ethnic and racial backgrounds tend to vary dramatically in how they rate the performance of their doctors, a study funded by the Agency for Healthcare Research and Quality has concluded.

The study, conducted by researchers of the Kaiser Permanente Medical Care Program in Northern California and the University of California-San Francisco, included reports from 1,007 Asian patients, 836 African-American patients, 710 Hispanic patients, and 7,747 white patients who received care from general internists, internal medicine subspecialists, and family physicians at 13 Kaiser facilities.

The study was designed to evaluate difference in attitudes toward primary care physicians among patients of various ethnic and racial backgrounds.

Some of the conclusions were:

- Asian patients rated the performance of their doctors significantly less favorably than white patients did.
- African-American patients gave physicians use of the latest technology and of psychosocial and lifestyle health promotions a higher rating than white patients did.
- Hispanic patients gave physicians' accessibility and technical skills a lower rating than white patients.

The researchers say that the study may point out actual difference in the quality of care or that the responses may be due to differences in patient perceptions or expectations. They called for more research to access whether health plans are meeting the needs of a diverse patient population. ▼

COMING IN FUTURE MONTHS

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- Tips on how you can ensure your claims will be paid promptly
- How to conduct a performance improvement review
- The best technology to adapt for your practice
- Why a happy office staff means a more efficient practice

Physician practices rate low for many lenders

Lender confidence in the health care industry has sunk to a new low, with 85% of commercial lenders saying they would not lend to a health care concern, according to the latest Phoenix Lending Survey.

More than half of the 95 lenders participating in a survey ranked health care as the least attractive industry among a list of 16 to which they lend. It was the third quarterly survey in which the health care industry was ranked at the bottom of the heap.

Physician practices were ranked as unattractive entity to which to lend by 45% of lenders responding to the survey.

This was the first time the Phoenix survey asked about specific categories within the health care industry.

Not-for-profit hospitals headed the list of health care segments with 56% of lenders saying they were unattractive to their lending institutions. Ratings of other segments were managed care companies, 53%; home health agencies, 45%; and nursing homes, 43%.

Other industries that lenders consider unattractive included start-ups / new ventures, retail, and agriculture / forestry / fishing.

Industries that are attractive to lenders include light manufacturing, industrial distribution, and service companies.

Phoenix Management Services, a Philadelphia-based management firm, conducts its "Lending Climate in America" survey quarterly to gauge shifts in lenders' attitudes. ▼

Hindsight bias a problem in malpractice suits

Expert witnesses in medical malpractice lawsuits may be overconfident in their conclusions because of a phenomenon called hindsight bias, a University of Ohio professor of psychology has concluded.

"The jury and the expert witnesses are looking back on an event, and they know how it turned out. It biases their perception of what should have been done," says **Hal Arkes**, PhD, who does research on medical decision making and physician overconfidence.

Arkes, and Neal Dawson, a researcher at Case Western Reserve University in Cleveland, conducted a study of 160 doctors and medical students to determine if hindsight bias would affect a diagnosis.

Foresight vs. hindsight

In the study, half of the participants were asked to complete a questionnaire after the case was presented but before the cause of death was revealed. This group, called the foresight group, was given a list of five possible diagnoses and asked to assign a probability that each was the correct answer. The other group of participants, the hindsight group, was asked to fill out the

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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).
Editor: **Mary Booth Thomas**, (770) 394-1440, (maryboothт@aol.com).
Production Editor: **Ann Duncan**.
Editor of **Physician's Capitation Trends: Reba Griffith**, MPH, (rocky.top@worldnet.att.net.)

Editorial Questions

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

same questionnaire after the pathologist revealed the actual diagnosis.

People in the foresight group were less likely to select the correct diagnosis than those in the hindsight group.

"In hindsight, we underestimate how difficult the task was in foresight. It's unfair in hindsight to evaluate people who had only a foresight perspective," Arkes says. ▼

Employers report rising health care costs

Health care premium costs are rising by 9.7% in 2000, according to a survey of 503 employers representing 18 million employees and dependents.

However, the 953 health care providers responding to the same survey say the average fee schedule for services they provide is rising only 3% this year.

The survey was conducted by Watson Wyatt Worldwide and the Washington Business Group of Health with assistance from the Healthcare Financial Management Association.

The 6.7% difference between provider fees and plan costs to employees reflect two trends: changing utilization patterns and mix of services, and efforts by health plans to improve their profitability, says **Rich Ostuw**, global practice director of group and health care consulting at Watson Wyatt at its U.S. corporate office in Bethesda, MD.

According to the survey, 70% of employers are passing some of the increased medical costs on to the employees. Nearly all (99%) of the 69 major health plans responding to the survey report passing on increased costs while only 53% of providers say they are passing on cost increases. At the same time, employers are providing more information to employees to help them choose the right health plan.

"Employers are following a two-track strategy to combat prices increases. In addition to redoubling efforts to manage the vendor relationship for better results, they are preparing employees to be better health care consumers," Ostuw explains.

Other results of the "Fifth Annual Survey of Employers, Health Care Providers and Health Plans" are available at the Watson Worldwide Web site: www.watsonwyatt.com. ■

SourceKit

The following are names and contact information for sources quoted in this issue:

- **Michael J. Parshall**, Vice President, The Health Care Group, Plymouth Meeting, PA. Telephone: (610) 828-3888. E-mail: mparshall@healthcaregroup.com. Web site: http://www healthcaregroup.com.
- **Diane Peterson**, President, D. Peterson & Associates, Houston. Telephone: (713) 795-5800. E-mail: dpeterson@pdq.net.
- **Richard D. Hanson**, Health Care Consultant, Medical Group Management Association, Palo Alto, CA. Telephone: (888) 608-5601, ext. 877.
- **Rita A. Scichilone**, Practice Manager of Coding Products and Services, American Health Information Management Association, Woodbine, IA. Telephone: (312) 233-1502.
- **Todd Welter**, Coding Consultant, Medical Group Management Association, Englewood, CO. Telephone: (888) 608-5601.
- **Lori Norris**, Physician Recruiting and Marketing Director, North Kansas City (MO) Hospital. Telephone: (816) 691-1686. ■