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INSIDE

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To 'e' or not to 'e': Practices move cautiously toward the electronic age

Patients are demanding access to health care through the Internet

Your patients can book an airline flight, order a week's worth of groceries, or sell 100 shares of stock on the Internet — often in less time than they spend on hold when they call your office for an appointment.

They can use the World Wide Web to check out every vacation home for rent in the panhandle of Florida, gather enough information to write a research paper on almost any subject, or fill out and file their income tax return in the time it may take to get a reply to a simple question from your office. Survey after survey shows that patients would welcome an opportunity to correspond with their doctors and make appointments over the Internet.

"My doctor friends tell me that medicine is different, but my expectations are being raised by other industries. We continue to make health care pretty inconvenient for people. It's no wonder patients are getting angry and more demanding," says **Tom Aug**, a partner with Development Partners, a Cincinnati firm specializing in patient satisfaction improvement for physician group practices.

Internet technology is making tremendous changes in the way health care is delivered, and the trend can be expected to continue.

"As patients are increasing their use of the Internet, they are developing the expectation that physicians make electronic communication available," says **Gwen Hughes**, RHIA, practice manager with the American Health Information Management Association in Chicago. Communication by e-mail has its advantages, she points out. "When used in addition to, rather than a substitute for, face-to-face communication, e-mail may enhance the patient/provider relationship.

Here are some other advantages to using e-mail to communicate with your patients:

- It eliminates playing phone tag or leaving voice mail messages.
- Caregivers have the ability to attach educational material or test

results to the communication.

• Staff can print out the e-mail and put it in the patient's file to document a patient record, rather than relying on your recollection of the conversation.

"It's clear that technology is here to stay and will play a major role in health care. To deny that it is happening is to put one's head in the sand," says **Bob Waters**, a health and telemedicine attorney at Arent Fox Kinter Plotkin & Kahn, a Washington, DC, law firm.

While most physician practices are taking a wait-and-see attitude toward Internet correspondence with patients, a few have been pioneering the practice with admittedly mixed results. **Gregory Pecchia**, DO, with Family Practice Physicians Inc. of Orange, CA, has been corresponding via e-mail with his patients for five years. "With e-mail, patients are able to communicate their needs and questions within their own time and are not limited by the time constraints of an office visit or telephone call," he says.

Pecchia gets about 15 to 20 e-mails a day from patients who use the system to make requests for appointments, prescription refills, and general information. Corresponding by e-mail gives patients an opportunity to clearly state their needs, rather than relying on a staff member to transcribe their questions or concerns into a handwritten note, he adds.

However, Pecchia didn't initiate the process without drawbacks. When the practice was using paper records, the e-mail correspondence entailed extra work in printing out the correspondence and attaching it to the paper record. An integrated practice management situation solved the problem, he says.

The Perinatal Center in Des Moines, IA, gets about 10 to 15 e-mailed questions a month, mostly from people in rural Iowa who are seeking information on genetic counseling or diseases, says **Brad Hart**, practice manager. "Patients are becoming more astute in researching their own medical care. If their doctor tells them they have a certain problem, they look it up on the Internet and follow the trail to us," Hart says.

Physicians at the center took a visionary approach to electronic health care when they set up a Web page two years ago and added the e-mail function last year, he says. "They realize that e-health is where we are going. We're not waiting for everyone to get on the train. We're getting on it first." However, the practice has not had a lot of success in using the e-mail system for its own patients. "They expect the immediacy of a phone call," Hart says.

Mid-Iowa Fertility, an infertility diagnosis and treatment practice, regularly fields questions over the Internet, including information about treatment options, costs, outcomes, and expectations, says Hart, who also manages that practice.

Waters sees the Internet as a powerful tool that allows practices to provide more information to consumers and patients. But there also are risks, he points out. For instance, unless you have a sophisticated e-mail security system, you can't assume your correspondence is private. **(For more on security and other risks, see list, p. 84, and related article, p. 91.)**

But, because of patient demand, physicians such as **Michael Steinberg**, MD, a cancer research specialist and founding partner of Cancer Care Consultants, a Los Angeles area oncology practice, are developing e-mail capabilities.

Steinberg says many of his patients ask for his e-mail address on their first visit. "This technology is so new we're not sure what the risks are. But at the same time, we are developing a plan for using e-mail and the Internet to address patients' concerns in an efficient, safe, and confidential manner," he says. **(For stories on good and bad experiences with e-mail, see case histories, below and pp. 83-85.)** ■

Case History #1

After giving up on e-mail, practice is offering it again

After an unsuccessful experience with e-mail questions and answers, Cancer Care Consultants, an oncology practice in the Los Angeles area, is trying again.

This time, instead of answering generic questions from people who find the practice's Web site, the physicians are considering offering patients the opportunity to e-mail the on-call doctor to ask questions that would otherwise be handled by telephone.

"With our practice, patients can call up and get the on-call doctor in a matter of minutes. The e-mail will be more of a convenience for patients who have questions that could wait until their next visit," says **Michael Steinberg**, MD, a cancer specialist and founding partner of the practice.

For instance, a breast cancer patient who wants to know if she can lift weights wouldn't want to call the doctors at 10 p.m. but might not want to wait two months for her next follow-up visit. "If the doctor on call doesn't know the patient he can forward the e-mail to the patient's physician who can quickly answer the question, print it out, and insert it into the chart so it can be part of the medical record," Steinberg says.

Patients who call the office during the day can talk to the oncology nurse or wait for the physician to call them back later in the day. "We have a procedure to ensure that everybody is called back that day, but they may not get a return call until that night," Steinberg says.

The practice sees the e-mail questions and answers as a way to raise the service level, not necessarily to increase efficiency, Steinberg says.

Before they launch their new Web site and e-mail service later this summer, Cancer Care Consultants is grappling with the medical legal issues, he says. "We don't want to be dispensing information to patients we haven't seen, and we want to have the confidentiality issue solved before we go live." **(See related story, p. 85.)**

The practice is exploring ways to create a secure area for information interchange with patients and is working with an Internet professional to make sure that the communications will be confidential.

When Cancer Care Consultants developed its first Web page with e-mail capacity in the late 1990s, most of the questions were from relatives of patients looking for general information on the disease.

"Many of the questions we were getting contained inadequate information. After attempting to answer them, we ended up referring patients to other Web sites that answered generic questions. We realized that we were not doing a service for anyone. We didn't want to dispense information without having adequate information on which to base our answer," Steinberg says.

After three years, the practice shut down its original Web page in 1997 and started last fall to develop a new Web page to provide patient education and answer questions for established patients.

"If the questions are easy to answer, we can refer the patients back into the Web site for the patient education information. Or we can tell them to make an appointment to see us in a day or two," he says.

Last November the practice started setting up the components for the new Web site and e-mail service. It uses a totally secure intranet that connects physicians in four offices. "We have an internal network. Without using patient names, we discuss cases, share our call schedules and peer review, and scan images for review by other physicians," he says. ■

Case History #2

Physicians use e-mail as marketing tool

When Mid-Iowa Fertility got an e-mail from a patient in Saudi Arabia, the physicians weren't that surprised. "Infertility is the type of situation where people will go anywhere and do anything to address fertility issues," says **Brad Hart**, practice manager of the Des Moines-based infertility diagnosis and treatment center.

After a series of Internet conversations, the patient decided to come to Des Moines for treatment. "We definitely get business from the Mid-Iowa Fertility Web site. Generally speaking, people are willing to travel significant distances for fertility treatments," he says.

The practice typically gets about 20 questions a month through the e-mail system. Hart screens the questions and refers them to the person in the practice who can best answer them. Questions to the Mid-Iowa Fertility site include kinds of treatments available, cost, and success rate.

Hart also is practice manager of Des Moines Perinatal Center, a prenatal care and genetic counseling practice, which also offers visitors to its Web site the option of e-mailing questions to the practice. "We consider it a part of marketing. Through our Web sites, we provide the option for people to e-mail us," he says.

Des Moines Perinatal gets 90% of its referrals from other doctors. That's why the practice views the Web site and e-mail system as primarily informational, Hart says. "Generally speaking, here in Iowa, in the rural areas, the family practice physician is doing the deliveries and they generally do fine. However, they are not trained in special issues that sometimes come up."

Most of Des Moines Perinatal's 10 to 15 e-mail questions a month come from patients or family members asking for specific information on

genetic counseling or diseases, Hart says.

Staff think of the Internet site and e-mail service primarily as a relationship builder. "Patients who are referred to us by other doctors can look at us before they come in and get a better feel for who we are. It increases the comfort level," he says.

Both practices have had Internet sites for about two years and added the e-mail capacity about a year ago. The Web pages contain registration forms that the patients can download and fill out before they arrive, saving time in the check-in process.

Both practices discourage patients from asking confidential questions over the Internet because the sites do not contain any kind of security technology. "We've made it clear to patients that they are dealing with generic e-mail. Most of the questions are not super-confidential-type questions. They're generally broad-based. If we start to feel the need to deal with patients on a more confidential basis, we'll look for encryption," Hart says.

Neither practice uses the Internet to relay test results.

"We would not be comfortable transmitting test results until we have encryption in place. Another factor that hampers us is that many of our referring offices do not have active use of the Internet and still rely on faxes," Hart says. ■

10 Risks Involved in Physician-Patient E-mail

1. Employers and on-line services have the right to inspect and archive information transmitted through their systems.
2. Either party could accidentally send an e-mail message to the wrong person.
3. E-mail could be left visible on an unattended terminal.
4. E-mail can be circulated, forwarded, printed, and stored in numerous paper and electronic files.
5. E-mail could be vulnerable to computer hackers who could use the information for illegitimate purposes.
6. An imposter can forge e-mail.
7. The sender doesn't absolutely know that his or her message was delivered or that it has been read by the intended receiver.
8. Phony e-mail could dupe legitimate users into voluntarily giving up sensitive information.
9. E-mail can be used to introduce viruses into computer systems.
10. E-mail attachments may be in a format the recipient's software can't read.

Source: American Health Information Management Association, Chicago.

Case History #3

E-mail increases work, but technology can help

When **Gregory Pecchia**, DO, began communicating with his patients via e-mail on his home computer five years ago, he found that the process improved patient satisfaction and enhanced patient care but created additional work for him and his office staff.

But with a new integrated electronic practice management system that operates through an application service provider, Pecchia says he has been able to incorporate the e-mail into the office work flow automatically, reducing additional work for the staff.

Pecchia is one of four physicians and a physician assistant, with Family Practice Physicians Inc. of Orange, CA. For a monthly fee, the office contracts with Alteer Corp. of Irvine, CA, for its Alteer Office, an Internet-based practice management model that integrates clinical and administrative functions of physician practices.

The system integrates the entire work flow of the doctor's office into one system. With patient e-mail, the system triages all e-mail communications, directing them to the appropriate staff. For example, requests for appointments go to the scheduler; prescription refills and lab report requests are directed to the nurse; and questions about patient care are sent to the appropriate physician. E-mail questions and answers automatically become part of the patient record.

Pecchia began the electronic communication process by writing his home computer's e-mail address on a prescription pad and handing it to patients. "I urged them to communicate in an appropriate manner in a situation that was not time-sensitive. I was trying to enhance the capability of our patients to feel empowered in being able to communicate with the health care team," he says.

The process allowed him to find out more about patient needs and increase his rapport with patients, he says. But the process created a new

challenge — how to incorporate the information into the patients' medical records without increasing the office workload.

At first, Pecchia printed the communication at home and either faxed it to the office or brought it in with him. Later, when the office had computers, he e-mailed the document from his home PC to the office PC. The e-mail and Pecchia's answer were attached to the patients' paper charts.

"It was absolutely inefficient. It required a task I didn't have before and that the office didn't have before. Even though on the front end, the patients' perception of quality increased, true delivery of quality was in some question," he says.

For instance, sometimes Pecchia couldn't reply to the patient immediately because he didn't have the chart. Even when he moved the e-mail system to his office, it still took time to get access to the chart. "Once the volume increased to about 10 e-mails a day, we found ourselves with a job description that we didn't have an employee for — a new routing function. Patients were benefiting, but staff found themselves taking on more work," he says.

Through his involvement in computer upgrade committees at the hospitals where he practices, Pecchia met the founders of Alteer Corp. and volunteered his office as a beta site for the new practice management system. The new system allows him to do everything but examine the patient from home, Pecchia says.

Combining Internet technology and electronic medical records has allowed the practice to reduce staffing by two full-time equivalent positions with a savings of $50,000 to $60,000 a year, while allowing physicians to increase the time they spend with patients, he says. ■

E-practice harbors murky legal issues

Legal and regulatory issues must be resolved

So you've decided to join the 21st century and bring your practice into the e-health marketplace. Here are some dilemmas you may face:

1. A patient you have treated for a chronic illness e-mails you from his vacation home in another state about his disease. You e-mail recommendations back to him and relay a change in medication to a pharmacy near him. Are you practicing medicine in a state where you aren't licensed?

2. Your practice Web page includes a section with information on AIDS and its treatment. Can one of your sponsors track the "hits" to the Web page and market information to your patients?

3. If a patient sends you a vague question via e-mail and you base your reply on what you think he is asking, can you later be held liable for giving out the wrong advice?

"Like many other areas, health care is having to adapt to the e-world. Given that the health care industry is a highly regulated field, there are a number of legal and regulatory issues that need to be addressed by physicians before they embark upon an e-mail system," says **Bob Waters**. He is a health care and telemedicine attorney with Arent Fox Kinter Plotkin & Kahn in Washington, DC.

Some of those regulatory issues include:

❒ **Licensure.**

If you're providing any type of diagnostic or treatment by e-mail or the telephone, you need to make sure you are licensed in the jurisdiction where the patient is located.

Licensure is an issue that has largely been ignored in the past, Waters says. For instance, physicians who live near the border of a state may have patients who live in surrounding states. If a patient calls the physician from home and the physician advises him to do certain things, technically, the physician could be practicing in a state in which he or she is not licensed.

"State medical boards have been increasingly concerned, as have state legislatures, that doctors who practice electronically need to be licensed not only where the physician is located, but where the patient is located," Waters says. More than 25 states have already passed laws to deal with licensure and electronic practice of medicine, he adds.

❒ **Standard of care or appropriateness of care.**

When you deal with patients over the Internet, make sure that you have adequate information to make a diagnosis or decide on a course of treatment, Waters says. "Some conditions may be easily treated or diagnosed based on information obtained electronically," he adds.

For instance, if it is allergy season and Joan Smith has previously been treated for allergies by a physician, she may be able to e-mail her doctor and get a prescription via fax, telephone, or e-mail.

"This is an issue also being looked at by both medical and professional groups and state boards to ensure that the physician has obtained

AMA, Intel team up for encryption service

The American Medical Association (AMA) in Chicago is working with Intel Corp. of Santa Clara, CA, on a form of electronic credentialing to protect patient and physician privacy and confidentiality in Internet communications. With the program, the AMA will be able to offer physicians digital credentials that uniquely identify individuals over the Internet.

Intel provides the software that encrypts the message contents. The AMA will check the applicant's profile against the AMA master file of all physicians to verify the identity of doctors applying for the credential. The system puts an electronic stamp on all Internet e-mail messages and attached files sent by physicians enrolled in the program, verifying that the message was sent by the doctor. The service is available to AMA members at no charge.

"The potential for the Internet to be used to obtain lab results, send prescriptions to pharmacies, and receive patient files makes it vitally important that systems are in place to ensure that the patient's privacy and confidentiality are protected," says **Richard Corlin**, MD, speaker of the House of Delegates for the AMA. ■

adequate history and physicals in order to make the recommendations," Waters says.

Where the issue becomes more complex is when the first physician-patient relationship is via the Internet, Waters says. For instance, a physician's Web site may supply general information, but providers should be careful not to supplant the physician-patient relationship by becoming very patient-specific in providing information, he adds. "The question is whether the information on which the doctor is making a recommendation is adequate if there subsequently is a court suit."

The issue will become more complex as evolving technology makes it possible for physicians to treat patients by telemedicine, Waters adds. "When we talk about treating a patient over the Internet, the image that comes up is a questionnaire-type relationship. But as the Internet evolves, that experience is going to be more like telemedicine."

For instance, there are already a number of services to help patients manage their own health care conditions, whether it's diabetes, congestive heart failure, or other chronic conditions where lab data, other test results, and information such as weight can be routinely updated via the Internet. "Physicians who are going to use these types of monitoring tools need to structure the relationship very carefully to make sure they are not taking more risk or liability than they originally had contemplated," Waters says.

❒ **Liability.**

One pitfall of dispensing advice via e-mail is that patients who e-mail you a question may be vague and incomplete, points out **Gwen Hughes**, RHIA, practice manager with the American Health Information Management Association in Chicago. This could put you in the position of having to spend a lot of time responding to e-mail to cover the topic completely and not make an error in response.

"Eventually, a physician could find himself in court because of a response that was well-intended at the time. It may have been a good response, based on the information the patient gave him, but the doctor will still be in the position of having to defend himself or settle," Hughes says.

"As physicians strive to provide more customized information to particular patients or groups of patients, they should be careful how they structure [that information] and be cognizant of the potential liability," Waters says. He suggests that physician work with competent counsel to resolve any legal issues.

❒ **Privacy and confidentiality.**

"Physicians have the legal and ethical responsibility to protect their patients' privacy," Hughes says.

In addition to making sure the patient information you transmit is secure, be careful as you establish other types of Internet services that may not seem like a physician-patient relationship, Waters suggests.

Internet sites have the technical capability to generate a list of people who have accessed the site to whom they could conceivably market.

"As doctors develop contracts with vendors for Web sites, they should very carefully to cover that issue and receive firm assurances that the consumer can be confident that this information

(Continued on page 91)

Physician's Capitation Trends™

• Capitation Data and Trend Analysis •

Capitation slips, slides on Colorado's peaks and valleys

Business pushes for more cap amid controversies

Like beginning skiers who are too eager to race down the intermediate hill, health care players in Colorado are finding capitation a dangerous and more slippery slope than they had anticipated.

"One of the big problems we've had is independent practice associations [IPAs] going out of business under capitation," says **Nancy Ryan**, spokeswoman for the Colorado Division of Insurance in Denver.

Despite these failures, Ryan points out, many physician groups want to continue to offer direct contracting via capitation without an insurance license. That leaves consumer advocates fearing financial collapse will leave patients — and providers — uncompensated, while insurers fear over-reaction and overregulation.

In the short-run, CIGNA HealthCare of Colorado, based in Denver, has dropped all its capitation contracts.

That's not to say everybody hates capitation, but there are clear capitation crashes and bangs that need to be worked out before all the players can be assured it will work smoothly and equitably for everyone. Colorado's trailblazing is expected to inform similar capitation-related disputes across the country.

From the business perspective, many Colorado employers and benefits management experts still heartily support capitation, notes **Chris Watts**, a principal in the Denver office of William M. Mercer Inc., a benefits management company used by many Fortune 500 companies. Employers believe in the ability of capitation to lower costs and maintain quality of care. **(That's understandable, given the pressure of costs going up for businesses providing insurance, as described in related story, p. 88.)** Several recent trends are creating some challenging market inconsistencies in Colorado — many of which are surfacing in similar patterns in other states as well. Consider these recent events in the Rocky Mountain state:

- In February, CIGNA HealthCare dropped all capitation contracts and began paying primary care physicians on a fee-for-service basis.
- Within the past two years, 13 IPAs have folded in Denver. The Paramount Physician Network, representing 865 physicians, and the Millennial Colorado Physician Alliance, with 755 physicians, are examples of two IPAs that dissolved. Both groups cited capitation as the key reason for calling it quits.
- At the same time many employers continue to want capitation — particularly self-funded employers, who argue they are exempt from state insurance restrictions. These powerful business entities often show a particular preference for direct contracting (on a capitation basis) with physician groups.

On one hand, robust employers prefer capitation's cost advantages for them, so they are pushing for it. On the other hand, if the risk agreement gets too aggressive, and cap rates fall too low, then the plan cannot meet its costs. When collapse occurs, no one relishes the thought of having to make the back payments if the whole contract falls through.

Protections collide with market ambitions

To protect against having no one accountable for a failed capitation contract, these backup measures are in place in the state:

- Own up to debts if you go broke. The state's "double-pay" statute says that HMOs (and any other carriers) are liable to pay physicians whose

contracting organization has gone bankrupt.

This is the case even in capitation agreements, in which cap payments are made to IPAs in advance.

• IPAs cannot capitate without an insurance license. Health care providers or provider networks such as IPAs are not allowed to enter into capitation contracts with health plans — including self-insured health plans — unless a licensed insurer accepts the ultimate responsibility for the risk. This is also the case in many other states.

This statute exists, says **William J. Kirven**, Colorado insurance commissioner, to prohibit employers and health plans from shifting all their health care risks to physician groups, which may not be equipped to manage the utilization or bear the risk.

• There are no loopholes, i.e., no funneling a capitation contract through an IPA without an insurance license. The Colorado Insurance Commission ruled in 1999 that when an IPA or other provider, which does not hold an insurance license, directly accepts a capitation contract from another unlicensed entity, it is breaking the law. The commission says that by accepting capitation from an IPA or other non-insurance (typically physician practice) provider, then such acceptance actually is the same thing as practicing in the business of insurance without an insurance license.

Do ASOs make things different?

A division of CIGNA recently challenged that "loophole" ruling, citing the use of an ASO, or "administrative-service-only" entity. CIGNA's ASO was providing administrative services to several self-funded employers. Through that ASO, CIGNA opened up its provider networks to those employers. This ASO agreement works on a capitated basis. CIGNA's ASO officials argue the ASO's offering of provider networks limited health care services on a prepaid, capitated basis is not an insurance role.

Kirven responded in a declaratory order that he disagreed. He ruled that within the ASO agreement, self-funded plans are pooling risks and then transferring them to the provider network. That structure, Kirven says, "possesses the hallmarks of a classic insurance arrangement."

Businesses pushing for capitation are counting on their self-funded status (government by the federal government's ERISA laws) to preempt any intrusion from states regarding who can hold a capitation contract. In the meantime, Kirven is appointing a task force to explore these and a host of other capitation disputes. He says he hopes the task force can work out the issues itself rather than turn to more state regulatory pressure, and ensure that physicians get both the protection and the business flexibility they need.

The state task force is now meeting to attempt to reconcile these and other capitation issues — and not just related to self-insured populations, notes Ryan. "The question becomes how much risk can a group assume, and at what level do they have appropriate solvency to make payments if their plan fails. We're hoping to find some common ground." ■

Employers see 7% hike in insurance costs

Average costs top $4,000 mark

Employer-sponsored health plan costs increase by 7.3% in 1999 — close to three times the rate of general inflation — and there is no relief in sight, according to the Mercer/Foster Higgins National Survey of Employer-Sponsored Plans.

Average costs per active employee increased from $3,817 in 1998 to $4,097 in 1999. That followed the previous year's 6.2% increase. For 2000, these employers are budgeting for an overall 7.5% hike, according to **Blaine Bos**, a consultant in one of Mercer's Chicago offices and an author of the survey.

Capitation losing its kick

Part of the problem, Bos says, is that capitation is loosing its financial kick in the pants. Throughout most of the 1990s, most employers moved employees into lower-cost managed care plans. But migration out of fee-for-service has nearly bottomed out — down to 11% in 2000 compared to 13% in 1999. With nine out of ten employees already in a managed care plan, employers are looking for other ways to reduce costs.

Rather than shifting pocketbook costs to employees, employer are taking these steps, Bos says:

• Changing pharmacy benefits, particularly by

increasing financial incentives to use generic drugs or drugs listed on the plans formulary.

• Limiting or excluding coverage for certain new prescription drugs, tests, or medical treatments.

• Adding chronic disease management and alternative medicine options.

Yet when push comes to shove, larger employers are inclined this year to pay more rather than risk offending their work force, says Bos. In the past year, many employers added vision plans (now offered by 46% of employers, up from 42%); long-term care insurance (16%, up from 12%); and health care spending accounts (60%, up from 56%).

Retirees are the ones bearing the brunt of high costs, the survey indicates. For the sixth consecutive year, the percentage of large employers providing coverage to Medicare-eligible retirees fell in 1999 from 30% to 28%.

Coverage to retirees not yet eligible for Medicare slipped from 36% to 35%. Employers who require pre-Medicare-eligible retirees to pay the full cost of coverage jumped from 36% to 42% in 1999.

Participating in the survey were 3,166 respondents, representing about 600,000 employers and more than 90 million employees. ■

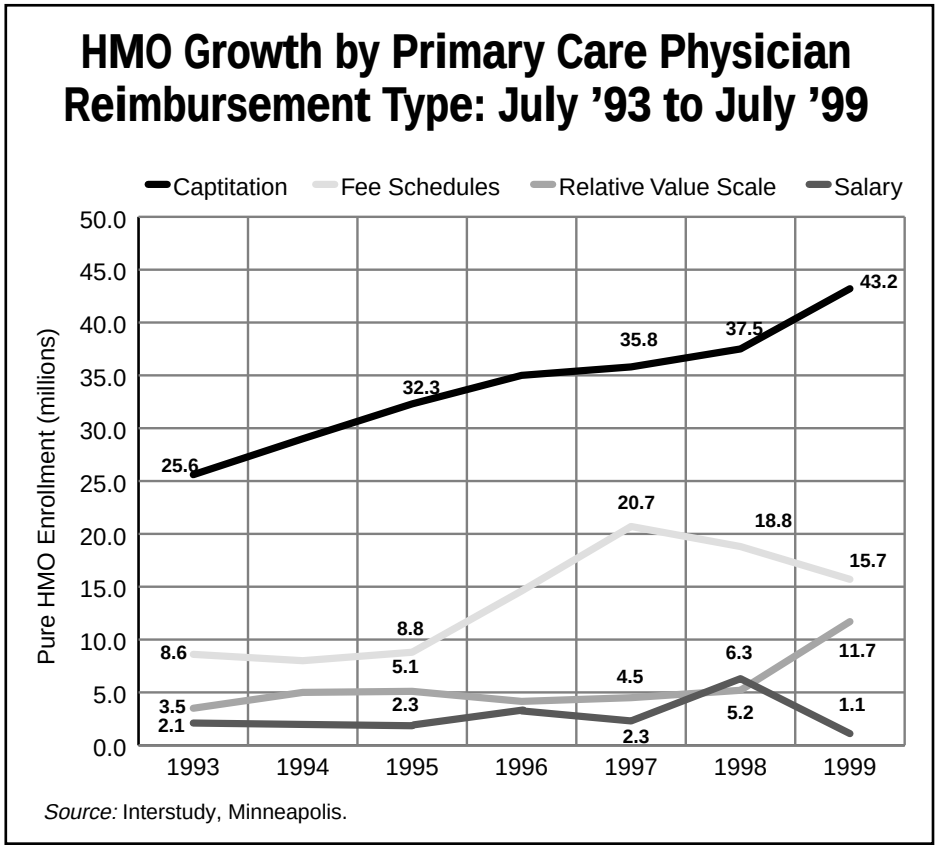
HMOs using a combo of physician pay plans

RVS and capitation used together

In the last two years, HMOs have shifted toward paying physicians through two payment systems — capitation and a relative value scale (RVS), according to InterStudy, one of the nation's leading trend analysis firms of HMO activities, based in Minneapolis.

"The latest trend between 1997 and 1999 shows that relative value scale and capitation have both become increasingly important to HMOs," says **Tammy Lauer**, lead author in InterStudy's most recent trend report. "Increasingly, HMOs are applying both systems simultaneously."

"The RVS reimbursement method is used to reinforce the importance of front-end [preventative] patient care by improving the payment doctors receive for working with patients to prevent, detect, and treat health care conditions earlier and more efficiently," Lauer and colleagues report. (**See chart, below**, which reflects that overall HMO enrollment growth was driven by capitated primary care systems between July 1993 and July 1995, but fee-for-service primary care systems drove growth between 1995 and 1997.)



Source: Interstudy, Minneapolis.

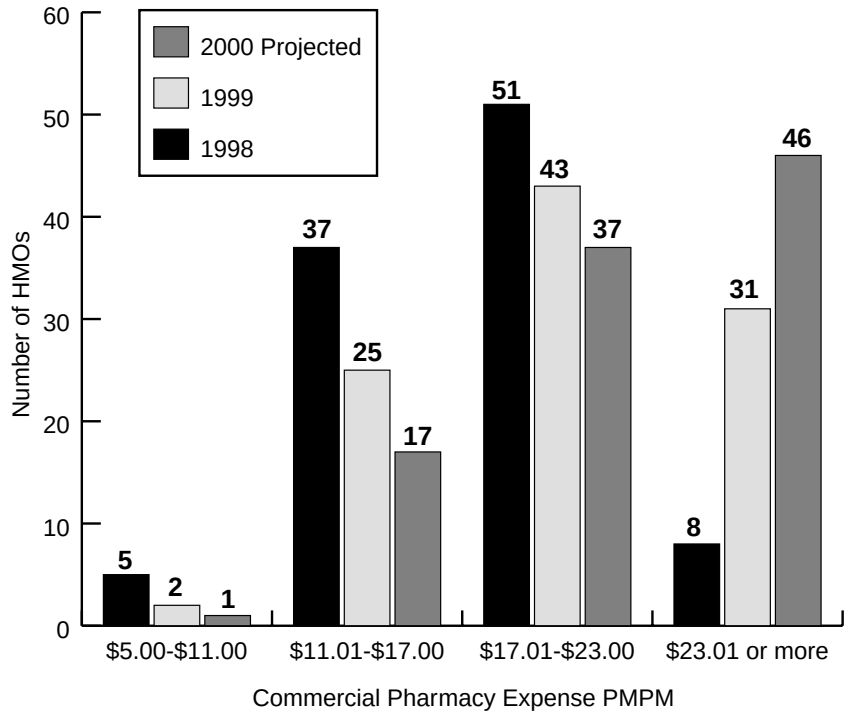
In HMOs using only one type of reimbursement for primary care physicians, RVS is the most used method, utilized by 38.8% of HMOs.

Here are other trends regarding capitation vs. fee-for-service payment in HMOs, based on InterStudy's survey of 338 responders. (Figures in the following text do not add up to 100% in all cases because other payment methods such as non-RVS fee schedules and salaries are measured in the study but they are not highlighted in the report):

• Primary care physicians are reimbursed by HMOs almost as often through fee for service (30.6%) as capitation (27.2%).

• The majority of HMOs that use only one type of reimbursement for specialty care physicians are relying on a fee-for-service structure, which is used

HMO Commercial Pharmacy Expense PMPM



Source: Interstudy, Minneapolis.

by 58.6% of HMOs.

• 34% of HMOs use RVS exclusively to pay specialty care physicians, while only 7.4% report using capitation.

• Approximately 46% of HMOs reimburse primary care physicians through a combination of two reimbursement methods. Of this group, 107 HMOs use both fee for service and capitation for primary care services, while 31 HMOs reimburse primary care doctors through a combination of capitation and RVS.

Overall for HMOs, their prior skyrocketing growth rates are in a clear reversal. For the first time, the semi-annual growth rate of HMOs has dropped — decreasing 0.6% — from Jan. 1, 1999 to July 1, 1999 for a net total enrollment loss of 508,000 members, InterStudy reports.

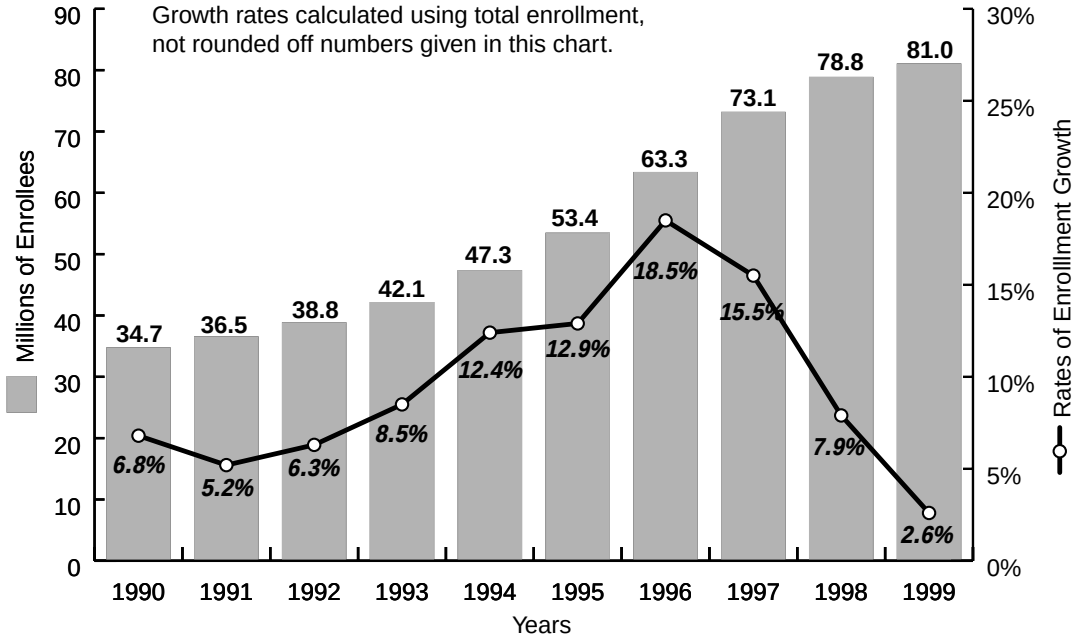
At the same time, the annual growth rate continues to decline, dropping to 2.6% from July 1, 1998 to July 1, 1999.

In every domain of HMO business, graphs of growth rates bear the bell-shaped curve effect. For example, the growth peaked in the mid-1990s, and then steeply declined in late 1999. **(See chart, below.)** Overall, highest growth hit 18.5% in 1996, and trickled down to 2.6% in 1999.

Looking at Medicare HMO exclusively, the bell curve for growth is more jagged but also more extreme: 6.7% growth in 1991; 25% growth in 1992; 35% growth in 1996; and 4% growth in 1999.

Medicaid HMOs reflect more ups and downs: 27.3% growth in 1992; spiking up to 42.1% in 1994; dropping down to 22.2% growth in 1995; climbing back up at 57% in 1996; and nosing down to 14.3% in 1999. ■

Total Enrollment and Growth Rate: July '90 to July '99



Source: Interstudy, Minneapolis.

(Continued from page 86)

will not be adversely used," Waters says.

There are a lot of concerns that patient-specific, personally identifiable information should be protected in any kind of transactions and in a large number of federal and state laws addressing this issues, Hughes adds.

Most recently, the U.S. Department of Health and Human Services issued proposed regulations under the Health Insurance Portability and Accountability Act of 1996 that set minimum standards that must be met if identifiable patient information is going to be transmitted electronically.

And as use of the Internet increases, it is likely that more government agencies and governing bodies are going to create more laws to deal with it. "We are adapting 19th century laws to 21st century technology. In some cases, the law may overshoot and prohibit practices that are widely beneficial. In others, it may undershoot. It's likely to take a number of years to work through a system that's most acceptable," Waters says. ■

Snares to watch for on your e-practice path

Be cautious before e-mailing your patients

Before you exchange the first bit of electronic mail with your patients, your practice should do a risk assessment to identify the risks involved and have a plan to address them, advises **Gwen Hughes**, RHIA, practice manager with the American Health Information Management Association in Chicago.

Set up infrastructure

"Risks include information leakage, data integrity violations, and others. Providers can implement safeguards against most threats but they should know all the applicable laws and standards, as well as the risks before they proceed," she adds.

Hughes suggests that providers establish an information security infrastructure that sets out policies and procedures, training and awareness for staff, and methods to protect the health information against unauthorized access and threats to security.

Here are some elements you should consider:

- Establish rules on who will see the e-mail messages and how they will gain access to the system. This may include office staff, consultants, or whoever covers for the physicians during their absence.
- Explore different vendors who say they can provide a measure of secure e-mail between patients and physicians. Look at encryption methods and passwords to make sure the communication is secure.
- Be careful about leaving e-mail documents visible when no one is at the computer. Consider using screen savers with automatic sign-off so e-mail messages can't be left visible by accident.
- As you write and reply to e-mail, keep in mind that all e-mail is discoverable in legal proceedings. Don't open yourself up to liability.
- Explain the inherent risks and benefits of electronic communication to patients. Point out that the information may not be secure. Let them know that e-mail correspondence will be printed out and placed in their paper record.
- Develop written guidelines explaining how and when they should use e-mail and when they should not.
- Have patients who want to communicate by e-mail sign a consent form, indicating that they understand the risks.
- Strongly suggest that your patients confine personal e-mail communication to their home computers, rather than e-mailing you from work.
- Inform your patients how long they should expect to wait for a response to their message.
- Set up an automatic reply that acknowledges receipt of an e-mail message and indicates when the patient can expect a reply.
- Maintain a list of patients who send you e-mail so you can notify them if your system has technical difficulties or will be shut down for maintenance.
- When you send e-mail to a group of patients, send blind copies to each recipient so they won't learn each other's identities.
- Never forward patient e-mail to a third party without permission from the patient.
- Encourage patients to print a hard copy of e-mail correspondence for their records.
- Always double-check the e-mail recipient's address before sending a message.
- Consider listing frequently asked questions on your Web page. If patients tend to ask the same questions, it will save you a lot of typing to refer them to a section of your Web site. ■

Tips for making a good first impression

Don't chance patients voting with their feet

Are the magazines in your reception area older than some of your patients? Does anyone on your staff sport a nose ring, long jewel-encrusted fingernails, huge dangling earrings, or spandex in any form?

If so, it may be time to revamp your image, says **Diane Peterson**, president of D. Peterson & Associates, a Houston-based health care consulting company. She repeats humorist Erma Bombeck's advice to avoid a doctor whose plants have died. "Visual appearances make a powerful impression. Impressions are made instantly and instinctively within a few seconds, and they are hard to alter," she says.

If patients are kept on hold too long, feel uncomfortable in your office, or believe they have gotten the brush-off from you or your staff, they're likely to vote with their feet, she adds. In today's highly competitive health care market, it's not just enough to get on a managed care panel. Patients in the plan still have a choice of doctors, and most of them rely on the recommendations of friends and families.

"Medicine is no longer the simple exchange in the past of a chicken for medical care. Now, there are all kinds of intermediaries to consider, as well as sheer competition," she says. "The summary is that patients refer patients; other doctors refer patients; hospital employees refer patients. If you want to build volume or maintain your volume, you need to make a good impression on all your customers."

"Patient" is too narrow a term to describe the people you need to please. Peterson points out. "Physicians should think of the customer as anyone who has dealings with the practice. This includes family members, referral sources, payers, the hospital, and hospital employees." Count hospital nurses among your customers, she suggests. "Nurses direct more patients to doctors because of their perception of how they are treated."

Don't forget to take the baby boomers into account, Peterson adds. "Depression-era people were much less challenging and much more satisfied. Boomers are health conscious and questioning. They want it their way, right now."

Here are some areas where your office's images may need polishing:

✔ **Professional appearances.**

Clothing should be appropriate to the environment, neat, clean, and pressed, and must fit proper and be comfortable. The way staff dress communicates how well you handle details in your practice, Peterson says. Nose rings, tattoos, cornrow hair, and spandex may be hot trends, but none of them belong in an office, she says.

"This is particularly true when your practice deals with older patients. They may think that nose ring is darling on their grandson, but they don't want it on their health care professional," she adds. Have a group in your office develop a policy about what is professional dress. "You shouldn't have the doctor dictate what length skirt is too short. Even if it's a solo practice with three people in the office, let those three write the dress code," Peterson says.

Dress and grooming should be an issue for everyone on your staff, whether they're the physician or the janitor, Peterson says. "Visual appearances are such powerful images. It doesn't matter what job you're in, you should look professional," she says.

✔ **Office's appearance.**

Of course, everything in a physician's office should be neat and clean, but other facets of the appearance of your office are equally important, Peterson says. She advises physicians to walk a fine line between plush and comfortable. "If the office is too well done, people will worry about the fees being too high."

Patients want a telephone they can use, tissues, and plants in an office. A television and a bowl of candy are little extras that go a long way toward keeping patients happy and comfortable while they wait, she adds. And the magazines should appeal to a variety of interests and be up-to-date, not several years old.

✔ **Written communications.**

Make sure the written materials you provide to patients, referral sources, and managed care companies depicts you as a professional who pays attention to details. Fuzzy, overcopied materials give a poor impression. Make sure your patient handouts are clearly printed, easy to read, and attractively presented.

The same is true of reports to referral sources or managed care companies. They should be clearly written, attractive, and sent in a timely manner. ■

Communication is the key to happy patients

Stop, look, and listen for better rapport

Traditional physicians can learn from their alternative medicine counterparts, and it has nothing to do with St. John's Wort or acupuncture. Alternative practitioners may be taking away your patients by capitalizing on the fact that patients want better communication with their health care providers.

"Alternative health providers recognize that the are treating the whole person and not just the diseased organ or broken bone," points out **Tom Aug**, a partner with Development Partners, a Cincinnati firm specializing in patient satisfaction consulting.

Patients often can't assess the technical quality of care they receive unless they have a medical background. That's why it's so important for physicians and their staff to develop good communication techniques, he adds.

"The thing that people can assess very clearly is the interpersonal aspects of care. They can tell if you listen, if you return phone calls, and if the time you give is quality time," Aug says.

Don't rush that patient

Aug suggests that physicians begin the office visit with a brief amount of small talk about a matter not related to the visit so that the patient feels like they're getting the doctor's full attention. "When a patient comes in, the physician shouldn't appear rushed or hurried. Stopping to chat is not so much to find out more about the patient but to establish a trusting relationship." Patients have to trust you to tell you everything you need to know. Feeling that you are really concerned about them motivates them to cooperate with you, he adds.

One study of 10,000 internists determined that they arrived at their diagnosis in an average of 30 seconds and started interrupting patients after 18 seconds, says **Diane Peterson**, president of D. Peterson & Associates, a Houston-based health care consulting firm.

"Doctors think in 15-minute segments, but 18 seconds is not sufficient. People don't trust you to unload their serious matters until three to five minutes," Peterson says.

Even if the doctor has seen a dozen patients with the same symptoms that day, patients need to feel as though they've gotten a thorough examination before the prescription is issued. "As soon as patients start feeling more comfortable during their visit and start to get into their symptoms, there's a major disconnect from the doctor. That probably helps create the declining trust in doctors and hospitals," she says.

Communication should start long before the physician comes into the room, Aug asserts. "If the physician is running behind, he or she should communicate with the staff who can in turn communicate with patients and give them a reasonable estimate of the amount of time they'll have to wait." People don't mind waiting as much if they feel like somebody cares they're waiting, he says.

The telephone call someone makes to your office for an appointment is often your patient's first contact with your practice and his or her first — and sometimes only — chance to form an impression, Peterson says. "From a patient standpoint, a telephone call is a quick visit to your office."

Patients complain that when they call a doctor's office, they can't get through, that they have to talk to machines, or use automated services, and that they are put on hold for long periods of time. "But the worst part is returning telephone calls," Peterson says.

The office nurse can probably take care of most of the calls, but patients should be given the option to talk to the doctor, she adds. "They should be advised that the nurse can call back in an hour but it will be after 5 p.m. before the doctor can call," she says.

Many physicians are afraid that they'll have 30 calls to return, but Peterson asserts that most patients don't want to impose on the doctor for refills and other issues and will opt for the nurse. "We act so controlling in practices that it's no wonder the consumer gets a little turned off."

Peterson suggests that physicians occasionally call their office to see how the phone is answered and monitor oral communications between the staff and customers. Make sure whoever takes the call asks patients when they'll be available to take the return call, she adds.

"It's the same as with the washer repairman. People don't want to wait the whole day. Most patients will be satisfied with a call-back four hours later if they're told in advance," Peterson says. ■

OIG tightens screws on enforcement actions

Fines would climb steeply

The Office of Inspector General has issued a final rule eliminating much of the wiggle room providers had when defending themselves against unknowingly submitting inappropriate claims.

For starters, the rule increases the maximum civil monetary penalties (CMPs) on providers for submitting illegal or inappropriate claims from $2,000 to $10,000 per false claim.

Under the rule, providers and individuals can be held liable under the CMP even if there is no proof they intended to defraud the government. In other words, ignorance will not be considered a defense.

In fact, the rule says providers and other individuals can be held liable if they act in deliberate ignorance of the truth or falsity of the information; in reckless disregard of the truth or falsity of the information.

The final rule also:

❒ extends current CMP provisions to include all federal health programs;

❒ allows CMPs to be assessed for incorrect coding, medically unnecessary services, plus offers of remuneration to beneficiaries to influence their choice of a particular provider or supplier;

❒ establishes a new CMP for physicians' false certification of eligibility for Medicare-covered home health services;

❒ authorizes a fine up to $10,000 a day when an individual excluded from participating in a federal health program is retained in a prohibited relationship with a participating health care entity.

The full text of the rule is available at http://www.hhs.gov/oig/new.html. ■

No-cause firings out, CA high court rules

Major victory for physicians

The California Supreme Court has ruled that managed care plans cannot arbitrarily terminate physicians from provider panels and that any removals must be "both substantively rational and procedurally fair."

Marie Kuffner, MD, president of the California Medical Association (CMA), called the ruling "a great victory for physicians and patients. The California Supreme Court has upheld a basic CMA tenet that basic fairness must be assured before decisions are made that adversely affect a physician's status — and patients' access to their physicians in a managed care situation."

The ruling was issued May 10 in a lawsuit filed by Louis E. Potvin, MD, now deceased, against Metropolitan Life Insurance Co. Potvin, an obstetrician and gynecologist, received notice in 1992 from MetLife saying that it was terminating his preferred provider status.

The company said that his termination was consistent with the contract, which allowed termination "without cause" and did not respond to Potvin's request for a hearing.

In filing the suit, Potvin charged that MetLife had devastated his practice. He said he had been required to reveal his termination to other insurers, which also removed him from their preferred provider list.

The American Medical Association and the CMA filed briefs in support of Potvin, asserting that insurance companies "hold substantial economic power over physicians and their patients" and that "the control exercised by managed care organizations makes access to provide panels a practical prerequisite to any effective practice as a health care provider." ■

COMING IN FUTURE MONTHS

- How your practice can improve its patient safety record
- Steps that help you minimize claims denials
- The most effective ways to serve a diverse patient population
- How some practitioners are using telemedicine to serve rural patients
- Why and how to use benchmarking techniques to improve your practice

NEWS BRIEFS

AHIMA unveils new coding standards

The American Health Information Management Association in Chicago has updated its Standards of Ethical Coding giving providers a new set of guidelines to follow when faced with coding questions. Under these new standards coders are expected:

- to support accurate, complete, and consistent coding practices;
- to adhere to ICD-9-CM coding conventions and coding guidelines approved by the American Hospital Association, the Health Care Financing Administration, and the National Center for Health Statistics;
- to only assign and report codes that are clearly and consistently supported by physician documentation;
- to consult physicians for clarification and additional documentation when there is conflicting or ambiguous data in the health record;
- to not change codes or the narratives of codes on the billing abstract so the meanings are misrepresented. ▼

Providers seek prompt payment of medical claims

The Medical Group Management Association and 20 other health care and physicians organizations are urging Congress to require prompt payment of health insurance claims to physicians, hospitals, and other providers. "Thousands of medical group practices, hospital, physicians, and other health care providers must struggle each day just to get the insurance payments that are legally owed them," says **William F. Jessee**, MD, president and chief executive officer of the Englewood, CO-based association.

The coalition is urging lawmakers to include language in the managed care conference agreement to specify that a medical claim must be considered "clean" unless the claimant is notified within 10 days after initial receipt of the claim. ▼

Reminder increases Pap smear testing

Women who receive a reminder from their doctor are more likely to schedule their annual Pap tests, according to a survey conducted by the Gallup Organization for the College of American Pathologists.

Of the 1,000 women surveyed by telephone, 54% said they receive a reminder to schedule their Pap test. By contrast, 70% of those surveyed say they receive reminders to schedule a dental exam. Among those who did not receive a reminder, 62% said they would be more likely to make an appointment if reminded.

Women who say their primary care provider is an OB/GYN were more likely to report getting a reminder about the life-saving test. ▼

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Physicians seek investigation of health plans

The Pennsylvania Medical Society and the American Medical Association have asked the Anti-Trust Division of the U.S. Department of Justice to launch an investigation into anti-competitive practices of two Pennsylvania-based health plans.

Independence Blue Cross is the dominant health plan in southeastern Pennsylvania and Highmark Inc. is the dominant plan in western Pennsylvania. The medical associations contend that the two plans have maintained market dominance by agreeing not to compete with each other.

"When a health plan controls over 50% of the market, doctors just can't drop out of a network to redress the health plan's anti-patient-care policies. Without sufficient competition, patients in Pennsylvania have been forced to receive their health care from a controlling insurer, which means many patients have very little choice," says **Donald H. Smith**, MD, president of the Pennsylvania Medical Society. ▼

New process proposed for making coverage decisions

The Health Care Financing Administration (HCFA) has published a proposed rule setting new criteria it and local carriers would use to make certain coverage decisions.

The notice also announced that HCFA would not be adopting as final rule an earlier 1989 proposal it had made setting criteria to be used for making Medicare coverage decisions.

HCFA hopes the new rule will result in a more precise definition of what qualifies a "reasonable and necessary'' medical service, procedure or technology eligible for Medicare coverage. Under the proposed rules, two tests would have to be met to qualify for reimbursement:

• Clinical evidence would have to exist showing medical benefits.

• The service or product must have an "added value" over existing coverage such as lower cost, improved health outcomes, or a new treatment choice such as medication in place of surgery.

The public has until June 15 to make comments on the proposal. Mail written comments (one original and three copies) to: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-3432-NOI, P.O. Box 8016, Baltimore, MD 21244-8016. ■

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