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Former FBI Agent Says Physicians Unprepared for Compliance Rules

The federal Department of Health and Human Services (DHHS) recently issued a draft of guidelines for small and mid-sized physician practices that recommends how physicians can comply with regulations regarding Medicare reimbursement. While the 47-page guidelines from the DHHS Office of Inspector General (OIG) help to explain many issues particularly troubling to physicians, the guidelines tell only part of the story. (Titled *Compliance Program Guidance for Individual and Small Group Physician Practices*, the document is on the Internet at www.hhs.gov/oig/new.html).

Many physicians are so worried about failing to comply with federal regulations that they undercode, a practice that helps them to avoid a federal audit but that also guarantees they will be paid less than they should be paid for Medicare-eligible expenses.

Most physician practices are currently unprepared on compliance issues and so are still at risk of an audit or fine, says Charles Colitre, a former FBI agent who has overseen Medicare fraud investigations. He retired last year as the FBI's senior supervisory agent for all health care fraud investigations in seven counties of Ohio. After he retired, he started his own consulting firm, Med-Management Group Inc., in Akron, Ohio, working with hospital systems and physicians on Medicare compliance.

"From my experiences at the FBI, I'd say that very few—if any—practices now have a formal compliance program," Colitre says. "By a compliance program, I mean one that begins with an assessment of the risks at the practice, and includes benchmark audits of risk areas, with organized creation and application of policies and procedures ensuring that the risk areas are addressed on a continuing basis."

The benefits of developing a formal compliance program are many. "Physicians need to understand that having an effective compliance program at their practice substantially reduces their risk of being audited and investigated in the first place," Colitre says. Medicare, Medicaid, and large private insurers use computers to identify practices with questionable billing patterns, Colitre explains. "Therefore, keeping your submissions within acceptable parameters reduces your risk of investigation," he adds.

Identifying Targets

The inspector general's office and the FBI have three primary ways to identify physician practices for an investigation, Colitre says. The first way is from a complaint by a patient. "This is triggered by a patient getting a bill and questioning its authenticity," Colitre says. "If the procedure wasn't provided, it may get investigated. Many of these complaints come in each year, but because of the need to allocate investigative manpower, few actual investigations result from these infractions."

The best way to prevent a patient complaint of this type is to have a strong compliance program in place, Colitre explains. "A strong compliance program can reduce this pathway as you will be

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EDITORIAL

Two Contrasting Views of Physician Practice Today

Earlier this year, I experienced two contrasting and disorienting views of health care. First, I attended a conference sponsored by *The Wall Street Journal*, "Health Care Summit 2000: Medicine, Business, and Public Policy." Later in the same week, I visited a four-member physician group, Montgomery Medical Associates, in Olney, Md., about 20 miles from Washington, D.C.

The conference was dominated by talk of general and lofty ideas. There was little discussion of the gritty issues involved in how some physicians struggle today to deliver health care more efficiently while facing declining reimbursement for their efforts.

Edward F.X. Hughes, MD, a professor of management at the Kellogg Graduate School of Management at Northwestern University in Chicago, neatly summed up the conference by saying, "We'll not have dramatic change, as newspaper reporters might have us believe. We'll have unrelenting incremental change." To this I would add that change would be characterized by entirely new ways of doing business. It is clear that in the future, more transactions that physicians currently do by mail, fax, or phone will be done over the Internet.

Today, the health care system itself seems to make the practice of medicine more difficult than it should be. In California, for example, 30% of group practices will go bankrupt this year. The system imposes government regulations, angers employers, confuses patients, and frustrates physicians. It delays care, denies claims, causes overhead to soar, and pushes reimbursement levels down.

Montgomery Medical offers an excellent example. Since 1993, the number of full-time employees per physician has risen from 1.5 to 3.5. The practice manager's problems revolve less around resolving and refining patient's health care problems, than they do in meeting payroll every week. Managed care enrollment in the area around Baltimore and Washington, D.C, is high, meaning Montgomery Medical is struggling mightily. One of the hassles it faces is a conflicting set of rules created by the acquisitions Aetna Health Plans has made in recent years of U.S. HealthCare and Prudential.

I suggested that the group's practice manager might want to survey patients to get their e-mail addresses. Then, the group could use e-mail to register patients, refill prescriptions, and report lab results. The group also could establish a free site on the Internet to offer patient instructions and education. The group could introduce an automated coding and claims processing system to help increase revenue and avoid audits by the federal Health Care Financing Administration. It could investigate the use of speech recognition software to cut transcription costs and increase productivity. It could contact an application software provider to see how many administrative tasks and jobs can be outsourced. Lastly, it could try to offer such services as travel medicine, obesity treatment, fitness programs, and other niche services on a fee-for-service basis.

While these suggestions may not solve all of the group's problems, they will help to prepare Montgomery Medical for the unrelenting incremental changes that are coming in the future while also helping to make the practice itself just a bit more efficient.

Richard L. Reece, MD
Editor-in-Chief
Toll-free phone: 888/457-8800
E-mail: Rreece1500@aol.com

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Publisher
Premier Healthcare Resource, Inc.
888/457-8800
E-mail: publisher@premierhealthcare.com
Publishing Address: Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

Editor
Joseph Burns
508/495-0246
E-mail: editor@premierhealthcare.com

Computers Connect Sprawling Practice

By Richard L. Reece, MD, editor-in-chief

The expansion and consolidation of medical groups into large practices has become a common trend in recent years. Physicians seek to create or affiliate with large organizations that provide wide geographic coverage so they can leverage their ability to negotiate with managed care organizations. Yet many groups have experienced significant growing pains associated with expansion, two of which relate to difficulties in communicating and in maintaining common procedures.

One large primary care physician group, Carilion Healthcare Corp., in Roanoke, Va., has kept its physicians linked by using a multifaceted information system. The group includes 165 primary care physicians and 50 nurse practitioners and physician assistants in 54 locations throughout western Virginia. Through a common billing system, an intranet, and electronic patient records, the group has enhanced practice efficiency, facilitated communication among physicians, provided continuing education and improved patient care.

"Carilion Healthcare Corp. is the primary care group of our regional health system, the Carilion Health System," says James Nuckolls, MD, a practicing internist and the group's medical director. "Our central hospital system is in Roanoke, and our physician offices are located within a geographic span of approximately 250 square miles. We need to remain interconnected so that we can function as a true, cohesive group, rather than as some loosely aligned practices."

A Billing System

"We developed our information technology in three phases," says Nuckolls. "First, we developed a common billing system for all the practices in the group." The group worked with a vendor, Medic Systems in Raleigh, N.C., to develop the billing system for all offices in the group. "This allows for common billing practices across the group. In addition, each patient is registered in the system and does not have to re-register if he or she is seen in other practice locations." Once a patient is registered in the billing system, an electronic medical record is established automatically.

The billing system is used to track and analyze physician productivity data used in calculating compensation. "The system creates a series of reports that allow us to determine our physician productivity, physician charges, payer mix, and collection rates," Nuckolls explains. "Those data drive our physician compensation package and overall practice profitability calculations. Physicians' salaries are directly proportional to how much work they do and to the profitability of their practices."

The system allows the group to track illness patterns among patients. "We treat about 4,000 patients a day," Nuckolls says. "At the end of each day, we can determine the most common diagnoses that we billed, and, within each diagnosis, the most common tests ordered. For example, according to our 1999 data, our physicians treated almost 150,000 cases of upper respiratory illness, including 75,000 cases of bronchitis and community acquired pneumonia. We did 55,000 routine physical examinations. We know the number of diabetic, hypertensive, back pain, and other categories of patients we've treated."

The billing system information also helps guide practice management decisions. Nuckolls notes, "Since the billing system reveals our most common disease states, we can develop templates and flow charts for the electronic medical record system that will enable us to better document and analyze the most common illnesses we treat."

Intranet Development

In the second phase of Carilion's information technology strategy, the group linked all of the 54 practice locations together over an intranet, which provides a wealth of group-specific information that helps physicians manage their practices. An intranet is a private network of computers that uses Internet protocols for sending and receiving information.

"For example, we include contact information for all of the group's physicians on the intranet," Nuckolls says. "We provide maps to their practices and even pictures. The system also includes e-mail, which allows us to communicate with all the group physicians, other clinicians, office managers, and other administrators. We also post notes from central administration's business meetings so that the doctors can review them."

"Physicians' salaries are directly proportional to how much work they do and to the overall profitability of their practices."

—James Nuckolls, MD, Carilion Healthcare Corp.

Moreover, the intranet has individual physician productivity statistics. "We include a list of six-month productivity statistics by physician, from number 1 in the group to number 165," Nuckolls says. "We want to show physicians how productive they are in terms of their charges and patient volume and allow them to compare themselves to their peers. Not surprisingly, we have doctors who are very highly motivated, who see a lot of patients and generate significant billings, and doctors who balance their

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home and work lives and don't see as many patients. But at least the doctors can see where they fall compared with other doctors in the group. This posting has been somewhat controversial, but it's been enlightening."

Electronic Communication

Physicians use the intranet throughout the day. "Physicians e-mail other Carilion doctors when they are referring patients to them," Nuckolls explains. "They also can click on my page, where I post updated information about the group or about new clinical developments profiled in the medical literature. Physicians also can complete continuing education programs over our intranet. They can get updates about the group, such as minutes from our board meetings and advisories from the group administrator. These are only some examples of the ways physicians and office staff can use the intranet for education, referral, and communication."

The third piece of the group's information system is an electronic medical record (EMR), which MedicaLogic in Hillsboro, Ore., developed. "An electronic medical record system is crucial for maintaining and accessing records and updating them in a timely way," Nuckolls asserts. "This system is a comprehensive physician office medical record that will ultimately improve the care we give to patients through better documentation, proactive clinical strategies for managing disease types and preventive care, and retrospective analytical capability to develop best practices." Currently, the group has EMRs on more than 350,000 of its patients.

A significant benefit of the EMR is that the group can query the system to gather specific patient care data. Earlier this year, for example, Nuckolls' practice in Galax, Va., performed an analysis of its diabetic patients.

"We searched the database and found that we care for 1,532 diabetic patients," Nuckolls explains. "Then we wanted to find out how many of those patients had a hemoglobin A1C level of greater than 10, indicating that their diabetes was not under control; 23 patients met this criteria. We asked ourselves: 'What do we need to do to get the disease under better control for these 23 patients?' So we sent them each a letter, had them come in for special office visits, and now we are working with them to get their A1C levels down. We do a similar analysis and care plan for other disease states and for disease prevention strategies."

Such analyses are driven by a desire

Group, Health System Build Successful Relationship

Today, many acquired physician groups are financial drains on hospital systems. But, the Carilion Health System and its primary care group, the Carilion Healthcare Corp., in Roanoke, Va., have proven to be successful partners.

"Our group currently includes 165 primary care physicians, including internists, family practitioners, pediatricians, obstetricians, and 50 physician extenders, including nurse practitioners and physician assistants," says James Nuckolls, MD, the group's medical director. Nuckolls still practices as an internist three days a week.

The majority of the group, originally called Blue Ridge Primary Care, affiliated with the Carilion system in 1996. "Around 1994, a large group of primary care doctors, called Blue Ridge Primary Care, was formed with 120 physicians," Nuckolls says. "At the same time, the Carilion Health System was acquiring several primary care practices in the area. These practices were affiliated with the hospital via a hospital-owned practice management arm. Some of the practices were in trouble financially and needed an infusion of capital to build up the physical plant and recruit additional physicians. The system also started acquiring additional hospitals and negotiating management contracts with other health care facilities. Currently, the system owns, has an equity stake in, or is managing 12 hospitals."

Blue Ridge Primary Care had several reasons for seeking a partner. "We were looking for a hospital management system to partner with us to infuse some capital in order to build an infrastructure for our practices and help us leverage our negotiating position with managed care organizations and other insurers," Nuckolls says.

Eventually, the group partnered with the Carilion Health System. "The driving force in our partnership was the fact that our large group just seemed like a natural strategic and geographic fit with the Carilion Health System," Nuckolls explains. "In addition, we were able to retain the ability to continue to manage our own practices, rather than having the health system manage our practices." Daily operations and governance, such as decisions regarding hiring, firing, and capital equipment purchases, remained under the control of the individual physicians.

Still, changes were inevitable. "Of course, a good deal of 'corporatization' occurred," Nuckolls says. In addition, the health system's existing primary care practices joined the group, which became a for-profit subsidiary of the Carilion Health System.

As the group's owner, the system has provided capital for expansion to enhance physician capacity and patient access and, in particular, to help develop an information system.

Aware that many large integrated hospital systems have often lost money on physician practice acquisitions, Nuckolls hopes his group can be a strong financial partner for the Carilion system. —DJN

"We want to provide the best care possible—and demonstrate that we do it—especially to those who need it most."

—James Nuckolls, MD, Carilion Healthcare Corp.

among group members to enhance and document quality of care. "We want to provide the best care possible—and demonstrate that we do it—especially to those who need it most," Nuckolls says. "By examining electronic data, our doctors can analyze how they care for their entire population of patients, rather than just having to concentrate on caring for the few patients they see on any given day."

Carilion has spent more than $40,000 per physician to develop its EMR, Nuckolls says, and more than $15,000 per physician per year to maintain the system. "We currently have approximately 50 people in an information technology division," Nuckolls says. "Since we're still rolling out the system, we have an education center where four information technology staff members train physicians, nurses, and front office personnel before the electronic record comes to their practices. When it's introduced into their practice, information technology personnel are with them on site during the first several days as they get online and move from a paper system to an electronic system.

"Ultimately, it will be a huge infrastructure to maintain," Nuckolls continues. "We will have 600 or 700 computers just in examining rooms, not including physician offices, front offices, and nursing stations."

Still, Nuckolls believes, the system is well worth the cost. "As offices come online, those physicians become more efficient and, as a result, they move patients through care more quickly," he says. "In addition, transcription costs have fallen fairly dramatically in some of the practices. Finally, we are now involved in several clinical research studies. We're hoping to leverage some of the infrastructure costs through clinical research projects, since we now have a huge patient care database from which specific clinical information can be obtained quickly."

Clearly, internal technology is having a significant effect on the practice of medicine. "As a practicing internist, I welcome the Internet-savvy patients who come to me laden with the latest information gathered from the Internet," Nuckolls says. "The smarter my patients are, the more informative our dialogue can be. It's much easier to present someone with alternative treatment choices if he or she understands the issues involved."

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

Attorneys Offer Compliance Advice

Physicians familiar with the draft guidelines on reimbursement compliance that the federal Department of Health and Human Services (DHHS) issued in June know that the guidelines suggest that physicians develop a compliance plan. They also know that fulfilling all of the government's recommendations will require a significant amount of effort.

Moreover, many physicians may be worried that simply by releasing the guidelines, the government has signaled its intent to investigate health care fraud more vigorously. In fact, physicians should consider the release of the guidelines a warning that the government will increase the quantity and aggressiveness of investigations of small and mid-sized physician practices, says L. Stephan Vincze, a lawyer and compliance expert. The president and CEO of Vincze & Frazer, a company in Montgomery, Ala., that specializes in health care compliance issues, Vincze has worked extensively with the DHHS' Office of Inspector General (OIG), which issued the guidelines. He wrote the first draft of the OIG's medical billing compliance guidelines released in 1998.

"If you understand that the minimum standard for success is diligence—not perfection—it makes the process more palatable."

—L. Stephan Vincze, Vincze & Frazer

Increased Scrutiny

"In 1996, U.S. Attorney General Janet Reno and the inspector general for DHHS held a press conference," Vincze relates. "In one hand, Reno held up the first model compliance plan, and in the other hand, held up one of the first major multimillion-dollar settlements for alleged improper Medicare billings. The message was clear: Comply or pay. The government has followed this same pattern consistently with every sector of health care, from clinical labs, hospitals, billing companies, nursing homes, durable medical equipment companies, and managed care organizations. Now the government has turned its focus, energy, and resources on physicians, and physicians should take note.

"We know from our sources that physicians have been targeted and that the FBI, the OIG, and other federal agencies are working in unison on this in an unprecedented manner," Vincze continues. "This enforcement effort is well funded, and after violent crime, it's the number one priority of the federal Department of Justice."

Since the guidelines were released, physicians have been asking themselves, "How do I get my arms around this compliance process, do it right, and then focus on practicing medicine?" says Vincze. The first step for any physician practice is diligence, he says.

"First, it is important to understand that the standard for success for an effective compliance program is that you are taking the necessary, 'due-diligent steps to prevent and detect illegal conduct,'" he says. The 'due diligent steps...' is a quote from the standard outlined by the U.S. Sentencing Commission, the agency that established the minimum standards for effective compliance programs, Vincze explains. "If you understand that the minimum standard for success is diligence—not perfection—it makes the process more palatable," he adds.

One of the best ways physicians can ensure compliance is to use a consultant or attorney to serve as a compliance officer, as the guidelines suggest, helping the practice meet the new federal regulations. This strategy has advantages and disadvantages, however.

"There are a number of pluses and minuses to outsourcing this function," explains Kalisa B. Barratt, a lawyer with von Briesen, Purtell & Roper, a law firm in Milwaukee that specializes in compliance and other issues. "On the plus side, you get someone who understands the issues and already has the expertise, and they can look at your practice objectively, with no historical baggage or ownership of problem issues.

"Of course, these experts may not understand the specifics of your practice," Barratt continues. "If you are a cardiologist, the compliance officer has to understand that kind of practice and the particular coding rules that apply to you," she says. "In addition, if you decide to share a compliance officer with another practice or hire from an IPA (as the guidelines suggest), conflicts of interest could arise in the future."

Before any physician practice begins designing and implementing a compliance program, Vincze believes the practice can begin to ensure compliance by following five specific steps:

1. Physicians need to recognize and fully accept their responsibility for compliance. Physicians need to understand that no matter how much billing and operational management they delegate to subordinates, the government will hold the physicians responsible for any failure to comply.
2. Physicians need to devote time and money to compliance, Vincze says. Physicians need to educate themselves and their staff members about compliance. A number of Internet sites offer free advice, including the OIG itself. The 47-page document—*Compliance Program Guidance for Individual and Small Group Practices*—is at www.hhs.gov/oig/new.html. A speaker and author on compliance, Vincze offers a number of articles for free at his site (www.billingcompliance.com).
3. Physicians should seek assistance and expertise from those who are knowl-

edgeable about compliance issues for their particular practice.

4. Physicians should take courses on compliance. A practice group of four or five physicians may want to conserve resources. If so, courses in how to design and implement an effective compliance program are available from a variety of organizations, including Continuing Education Inc., in St. Petersburg, Fla., (www.continuingeducation.net), the Medical Group Management Association in Englewood, Colo. (www.mgma.com), or the Healthcare Billing and Management Association, in Laguna Beach, Calif. (www.hbma.com).
5. All physicians should conduct a thorough assessment of their operations to determine the status of all issues relating to compliance. Compliance includes more than billing. It involves gifts and gratuities accepted from vendors, rental agreements with other health care providers, and self-referral issues.

Positive Results

Many physicians may have a bleak outlook regarding compliance given that the guidelines are extensive and the government has increased its investigative activity. But those experts closely involved with compliance issues believe the increased scrutiny may be beneficial to physician practices. A compliance program may result in increased practice efficiency.

Simply having a compliance program in place at a practice can work in the physician's favor in the event of an investigation, says Charlie Colitre, a former FBI agent who has supervised Medicare fraud investigations. Colitre is the founder of Med-Management Group Inc., a consulting firm in Akron, Ohio, that works with hospital systems and physicians on compliance issues. "In the rare instances where we approached practices with well-thought-out compliance programs in place, there was an understanding that we were less likely to find the problems common in most practices," he says. "The result was a reduction in immediacy of the investigation, and the net effect always worked in the practice's favor."

Vincze agrees. "Our experience with our clients has shown that an effective compliance program in place at your practice may cause the FBI or OIG to go down the road to other, easier targets," he says.

"Some physicians feel that a compliance program is only about government red tape and staying out of trouble, and that the only reason to do it is that the government is making you do it," Vincze says. "But if done properly, a compliance program can increase the accuracy, precision, and efficiency of your practice, translating into increased revenue."

Many physician practices are so unfamiliar with the nuances of regulations that they are billing and coding conservatively, Vincze continues.

"Effective compliance programs—while certainly reducing exposure to future liability—increase quality in the form of more accurate and precise documentation and efficient communications," Vincze says. "Ultimately the result will be increased revenue through better billing and higher patient trust. This is not a theory. It is a reality and we have seen positive operational and business benefits realized with our clients."

—Reported and written by David Kettlewell, in Akron, Ohio. More information on practice strategies is available on our Web site (see page 16).

OIG Says Government Does Not Prosecute When Errors Are Made

Recognizing that physicians are worried about complying with the federal guidelines for compliance with Medicare reimbursement regulations, the federal Department of Health and Human Services (DHHS) made an effort in issuing its compliance guidelines earlier this year to say that it does not prosecute physicians for mere errors. It is interested, however, in pursuing cases in which physicians knowingly have violated the law with intent to defraud the government.

"Some physicians feel that federal law enforcement agencies have maligned medical professionals and are focused on innocent billing errors," says the DHHS' Office of Inspector General, which issued the guidelines. "These physicians are under the impression that innocent billing errors can subject them to civil penalties, or even jail. These feelings and impressions are mistaken."

The government will calculate what is owed by identifying erroneous billing patterns over a period of perhaps one month and will extrapolate what this error would amount to over a number of years. Many physicians believe this methodology of calculating settlements is onerous.

Later in the same document, the OIG says, "We do not disparage physicians, other medical professionals, or medical enterprises. In our view, the great majority of them are working ethically to render high-quality medical care to our Medicare beneficiaries and to submit proper claims to Medicare." While physicians worry, the OIG says, "under the law, physicians are not subject to civil or criminal penalties for innocent errors, or even negligence. The government's primary enforcement tool, the civil False Claims Act, covers only offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard, or deliberate ignorance of the falsity of the claim.

"The False Claims Act simply does not cover mistakes, errors, or negligence," the OIG continues. "The other major civil remedy available to the federal government, the Civil Monetary Penalties Law, has exactly the same standard of proof. OIG is very mindful of the difference between innocent errors ("erroneous claims") on the one hand, and reckless or intentional conduct ("fraudulent claims") on the other."

—DK

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eliminating many of the errors, and thus the number of complaints," he says.

The second way regulators identify physicians for an investigation is when a disgruntled employee has seen a series of fraudulent acts or is upset about perceived unfair treatment by the physicians and reports a wrongdoing. "If it appears to be a personal beef, not much would happen," Colitre says. "But we would look closely at billing patterns or misconduct." A practice that has a strong ethic toward meeting compliance standards will have few such complaints, he adds.

"In the case of a patient or employee complaint, the FBI or other investigators would interview the individual, preferably off site, and without the physicians' knowledge," Colitre says. "If it's an anonymous complaint, investigators would look to see if there's any validity. But if someone being interviewed says that improper billing was going on daily, and that they regularly upcoded, investigators would be more aggressive."

The third way regulators identify physicians for an investigation involves a complaint from a fiscal intermediary, insurer, or managed care company. When a fiscal intermediary reports an irregularity, it will usually have documentation and statistical evidence of possible wrongdoing, Colitre says. "Almost all of these complaints are followed up," he adds. The best way to prevent such complaints is to have a rigorous compliance program in place.

The Investigation

Once an investigation starts, it will fall into one of four categories. The first category involves cases in which there is no basis in fact for the allegation. In general, these represent only about 5% of all cases, Colitre says. In the second category, the OIG, the FBI, or other investigating agency will find a basis for the allegation but no indication of fraud. The investigating agency may find that mistakes were made, and physicians will be asked to repay any money paid erroneously. These cases represent about 40% of the total.

In the third category, investigators uncover gross mistakes or find an indication of some fraudulent activity, intentional or otherwise. In these cases, the U.S. District Attorney will request repayment, issue fines, and may impose on the physicians a corporate integrity agreement requiring specific behaviors and certain oversight provisions for as long as three years. These cases represent another 40% of the total.

In the fourth category, investigators find evidence of intentional fraud. In these cases, the government will bring a criminal case against the physicians involved, seek full restitution, levy fines, institute a corporate integrity agreement, and exclude the physicians from participating in federally funded health care programs. The government also will seek prison terms if appropriate. These cases represent 15% of the total, Colitre says.

Erroneous Assumptions

Many physicians assume that because they operate small practices, they will never be targeted. This assumption is false, says Kalisa Barratt, an attorney with von Briesen, Purtell & Roper, in Milwaukee, a firm of 25 attorneys that helps physicians with risk management, compliance, and other issues.

Before working with von Briesen, Purtell & Roper, Barratt was the assistant general counsel for the Wisconsin Medical Society. "I talked with hundreds

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Steps To Take To Help Ensure Compliance

Experts who have advised physicians on complying with federal regulations for Medicare reimbursement say there are many steps physicians can take to help ensure that they will not be the target of an investigation for fraudulent billing. One is to work closely with an attorney or consultant who specializes in compliance issues to develop a compliance program.

"To fail to have a good health care compliance attorney is negligent on the part of the practice," says Charles Colitre, a former FBI agent who founded Med-Management Group Inc., in Akron, Ohio, a consulting firm that works with physicians on compliance issues. "It's very difficult to make any business moves without a compliance implication. I know this sounds like I'm making a great case for health care attorneys, but it's true."

Another step is to be certain that the physician group does not delegate too much responsibility to staff members on compliance issues.

Colitre explains, "In many practices, no one is paying attention or holding the staff's feet to the fire to ensure that the right actions are being taken."

Problems can result from a lack of understanding of the basics of compliance or failure to follow up on and analyze rejected claims. "In many practices, no one central person goes back to review rejected claims to find the pattern," Colitre says. "They may be the same codes or from the same payer, but these rejected claims must be analyzed. In addition to lowering your compliance exposure, you could actually increase your income."

Physicians also should be rigorous when credentialing new physicians, says Colitre. "We saw situations in which a practice would hire a new physician and the credentialing would take three months or longer," he explains. During this time, the new physician may be billing for work done under the supervisory provider's identification number. If so, the supervisory physician could be charged for wrongdoing by the new physician.

Compliance involves much more than simply coding and billing. Physicians should review carefully any potential for self-referral and any transaction in which the physician gets services at less than fair market value, such as renting space from a hospital, Colitre explains.

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"One assumption that has gotten many physicians into trouble is believing they are too small to warrant government scrutiny."

—Charles Colitre, Med-Management Group Inc.

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of physicians and none believed it could happen to them," she says. "It was a bit of a hard sell. With the new guidelines and the fact that many practices have been investigated, some paying settlements, and some physicians serving jail time, more physicians understand it's a reality now. And a scary one at that."

Colitre agrees. "One assumption that has gotten many physicians into trouble is believing they are too small to warrant government scrutiny," he says. "There was one instance of a small group specialty practice where we responded to a complaint about Medicare. Investigation showed they were doing a considerable amount of upcoding, and they ended up with a civil settlement in excess of $100,000, opting not to go to court."

Another erroneous assumption involves arrangements with billing and collections companies. Many physicians believe that because they have arrangements with these companies, they are operating within the law. But practices that pay billing and collections companies a percentage of revenue may be subject to an audit, Colitre says. Therefore, it would be preferable to pay such companies for each claim processed.

Once targeted for investigation, almost all practices pay some form of settlement. "Nearly all the practices that are investigated owe money to repay improper billing collections," Colitre says.

Facing an Investigation

Many physicians want to know what to do if targeted for an investigation. The first step, of course, is to determine that an investigation has begun. "Most of the time, if an employee has lodged a complaint, the FBI will meet with them off site, possibly at home," Colitre says.

"If you learn that your employees are being interviewed, you can ask the employee what topics were discussed, and what information was desired," Colitre explains.

Then, the physician being investigated should call his or her attorney, explain that the FBI, the federal OIG, or other investigators have contacted an employee, and describe what was discussed, Colitre counsels. "At this point, you may want to hire an independent consultant to perform an internal investigation in the area being questioned," he adds.

Once an investigation begins, it is important that physicians take steps not to impede the investigation. Physicians should not destroy or hide records, Colitre says. Do not tell employees not to talk to investigators but also do not answer any questions that have not been asked, he advises. "Be cooperative, but don't give up," he explains. "If the investigators ask a question on a particular billing procedure, answer it, but don't get into areas not asked about."

Also, physicians under investigation should not make assumptions, Colitre says. "Do not assume you will walk out of this clean, do not assume you will not be repaying money or will not have to pay a fine, and do not assume that because your practice has hired people to keep you compliant that you're covered," he says.

In fact, it's best not to make any assumptions about compliance. For this reason, physicians need to be involved in all compliance-related issues, Colitre concludes. And, they need to ensure that all staff members are complying with federal guidelines and cannot simply delegate this oversight to others, he adds.

—Reported and written by David Kettlewell, in Akron, Ohio. More information on practice strategies is available on our Web site (see page 16).

Seven Elements of Compliance

In its recommendations, the federal Department of Health and Human Services (DHHS) presents what it calls "The Seven Basic Compliance Elements" that physicians need to include when developing a comprehensive compliance program:

1. Establish compliance standards by developing a code of conduct and writing policies and procedures
2. Assign compliance monitoring to a designated compliance officer
3. Conduct comprehensive training and education on practice ethics, policies, and procedures
4. Use internal monitoring and periodic audits to focus on high-risk billing and coding issues
5. Develop lines of communication, such as discussions at staff meetings regarding fraudulent or erroneous conduct issues, to keep employees updated
6. Enforce disciplinary standards by making clear that compliance is treated seriously and that violations will not be tolerated
7. Respond appropriately to detected violations by investigating allegations and reporting incidents to appropriate government entities.

The DHHS also lists the operational areas in a practice that leave physicians open to the highest risk, meaning they have been the most frequent targets of its investigations:

- Billing for items or services not rendered or not provided as claimed
- Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary
- Double billing
- Billing for noncovered services as if covered
- Knowing misuse of provider identification numbers, which results in improper billing
- Billing for unbundled services
- Failing to use coding modifiers properly
- Upcoding the level of service provided.

Hopkins Transforms Its Practice Plan

By Thomas M. Gorey, JD

The Johns Hopkins School of Medicine in Baltimore has had some form of clinical practice association for a number of years. But until several years ago, the practice association served primarily as a billing and collections entity. In light of the many changes taking place in health care and the need to become more competitive and business-like, a group of faculty physician leaders met in the mid-1990s to plan for a new practice organization, one that would do much more than billing and collections. New bylaws were adopted in July 1997, laying the groundwork for the transformation of The Johns Hopkins Clinical Practice Association (CPA).

To understand the current organizational and operational dimensions of the CPA, it is necessary to know the history of the School of Medicine. Hopkins traditionally has been oriented as a research and postgraduate institution. It has a culture of strong, independent-minded department chairs and a pervasive department-level focus that continues to this day. It is no surprise then that the 1,200-member CPA is organized as a decentralized, departmentalized practice plan.

Goals and Objectives

The practice association is organized as a unit within the School of Medicine and is authorized by the board of trustees of The Johns Hopkins University. The paramount purpose of the CPA is to support the academic mission and educational processes of the School of Medicine. To fulfill its purpose, the CPA has identified a number of key objectives, including: attracting a patient base necessary to sustain clinical and academic programs; improving organizational effectiveness and fostering medically appropriate referrals within the clinical practices; enhancing relationships with community physicians to ensure referrals; and managing and allocating the financial risks associated with managed care contracts.

When the practice plan was reorganized in 1997, there was a high level of faculty dissatisfaction with billing and collections, and so they focused their attention on this area in particular. After addressing most of the major concerns about billing, the CPA moved on to broader issues, such as: enhancing all phases of patient care, including efficiency, outcomes, and patient satisfaction; continuing to strengthen external relations with referring physicians, payers, and others; improving internal relations and support systems; and enhancing management and administration. The dean of the School of Medicine invited four faculty members to assume primary responsibility for addressing these goals. Workgroups have been organized around these four goal areas and nearly 40 faculty members are involved in the process.

Several years ago a new entity, Johns Hopkins Health Care (JHHC), was formed to handle managed care contracting for the Johns Hopkins Health System and the School of Medicine. Owned jointly by the health system and the medical school, JHHC is one of only a handful of approved Medicaid capitated providers in Maryland. As the risk-holding entity for the School of Medicine, JHHC takes the full premium, handles enrollment, and then pays CPA providers on a fee-for-service basis. In addition, it negotiates contracts for all CPA providers.

Several years ago, when anxiety about managed care was rising, the CPA sought HMO and PPO contracts aggressively to ensure patient flow. But because Hopkins currently is at or exceeding physical capacity, there is less of a concern that failure to sign a particular contract will have a negative effect on patient volume. Therefore, JHHC and the CPA are being more selective in contracting, assessing the financial effects of each contract on the hospital and professional fees.

Rather than pursue managed care aggressively, the practice carefully assesses the potential financial effect of each contract.

Billing and Collections

In the past, all billing functions have been handled at the department level, but in a restructuring in 1995, departments lost certain billing functions when they were moved to a centralized facility about 10 miles from the campus. The medical school administration had mandated this change, promising that billing and collections would be more efficient and less expensive. The move had little support among the faculty, however.

Because the billing issue was such a major source of discontent among the faculty when the new practice plan was formed in 1997, it was clear that the billing issue needed to be addressed before other strategic goals could be pursued. CPA leaders believed that unless the billing problems were resolved effectively, there was no chance of developing other CPA functions.

Over six months, the CPA thoroughly reviewed its billing and collections

Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development. This article is adapted from Case Study Analysis of Faculty Practice Plans, *which readers can get by contacting Kristin Sabec at the Michigan State Medical Society (517/336-5769). The report costs $95. More information on physicians' organizational options is available on our Web site (see page 16).*

Some might argue that the high level of departmentalization has helped to establish Hopkins as a world-renowned institution, and that becoming more centralized would impede its ability to attract the strong-willed, entrepreneurial department chairs who have built Hopkins' reputation.

processes, involving each department administrator. Every step of the billing and accounts receivable process was analyzed to see whether it was appropriate for that task to be handled within the department or centrally. The one criterion the administrators set was whether specialty-specific knowledge within a department would provide a benefit in performing the function. Coding was seen as an appropriate departmental function because it is specialty specific.

The physicians created a matrix that outlined the major billing and collections tasks and assigned responsibility—either centrally or departmentally—for each one. In January 1998, a new billing and collections system was implemented. Under this system, a group of core billing support services is performed centrally and other services are done within the departments. Since implementing the new billing arrangement, net collection rates and satisfaction with billing and collections have increased significantly.

Having resolved the billing crisis, the stage was now set for the CPA to begin addressing related issues, including redesigning the registration function for all patients. The current lack of consistency in registration was affecting billing, because of the different types of data being collected during patient registration among departments. Using its experience in fixing the billing system, the CPA expects to use a similar model for patient registration.

Challenges Ahead

To achieve its vision, the practice plan must not only put into action the strategies and long-range objectives outlined in a recently adopted strategic plan, but it also must make sure that its strategies and objectives are integrated and interdependent. While the CPA can boast of having outstanding clinicians, state-of-the-art equipment, and demonstrated outcomes, important obstacles remain, and the practice plan is limited in its ability to overcome these obstacles.

The challenges the CPA faces are related to external forces, maintaining the mission, physician integration, and location.

External forces. Primarily, the external forces are declining reimbursements from public and private payers. These represent the biggest challenge for the CPA, yet the CPA is relatively powerless to effect what happens in the external market. As payers continue to drive down reimbursement levels, it is becoming harder for the practice plan to provide care for indigent patients, something that has always been an important part of Hopkins' mission.

Maintaining the mission. The increasing pressure to generate clinical revenue may impair the faculty's ability to carry out the medical school's teaching and research missions. Generally, physicians have joined the Johns Hopkins faculty knowing that they would be expected to be involved in clinical work, teaching, and research, but in the present environment it is increasingly difficult for most faculty to do all three. Additional steps may be needed to recognize formally the important role clinician-teachers play and to accommodate fully those faculty within the Hopkins system.

Physician integration. A significant issue for the CPA involves how far it should go along the continuum toward true integration. In adopting new bylaws for the CPA in 1997, the organization recognized the ultimate desirability of fully integrating the clinical practices within the School of Medicine to function as a multispecialty group practice. Yet, the culture and traditions of Hopkins have placed a premium on strong, relatively autonomous departments. Some might argue that the high level of departmentalization has helped to establish Hopkins as a world-renowned institution, and that becoming more centralized would impede its ability to attract the strong-willed, entrepreneurial department chairs who have built Hopkins' reputation.

It is likely that the CPA will continue to move cautiously toward clinical integration, which is understandable considering its tradition and culture of strong departments and department chairs. In doing so, it will need to balance the potential benefits of integration—including facilitation of seamless patient care, a unified patient record, and a multidisciplinary service line capability—against the benefits that have traditionally been associated with Hopkins' strong departmental model.

Location. Because Hopkins is in an urban area with limited potential for expansion and limited parking for patients, it faces challenges that its suburban competitors do not. Recent and ongoing improvements to facilities and parking have helped to ameliorate this problem, however. In addition, the CPA has taken significant steps to overcome these limitations by undertaking a joint venture with the health system to establish highly successful community-based satellite offices in rapidly growing suburban areas, for example. These offices attract patients who prefer to receive care from a Hopkins physician, but who may not be willing to travel downtown to the main Hopkins campus. Also, Hopkins is aggressively marketing its services to an international audience with considerable success. These and other innovative strategies will become increasingly important as the CPA competes in a fast-changing, competitive marketplace. ■

Career Counselors Say Options Open to Physicians Seeking New Opportunities

Bill Frank is founder and chairman of CareerLab, a national career management firm in Denver. Since 1978, he has consulted to more than 250 corporations of all sizes in all industries, including AT&T, Coca Cola, Columbia/HCA, and Ernst & Young. Frank helped to start an Internet site devoted to career management issues (www.careerlab.com) that receives more than two million visits per week. Frank has a bachelor's degree in liberal arts and a master's degree in philosophy from Colorado State University.

Lorne E. Weeks, MD, is executive-in-charge of Physician Career Network, a division of CareerLab. Prior to joining CareerLab, he practiced as an orthopedic surgeon for 17 years, serving on the orthopedic faculty at the University of Kentucky in Lexington and subsequently in private practice in Denver. He attended medical school at the University of Rochester in New York and completed a general surgery and orthopedic surgery residency at Massachusetts General Hospital in Boston. Richard L. Reece, MD, editor-in-chief, conducted this interview.

Q *Bill, what was your mission when you set out to start CareerLab?*

Frank: My father and grandfather were physicians, and my mother was a nurse, so I have had a long-term interest in health care. I began CareerLab in 1982. We offer career counseling, management testing and assessment, coaching and performance improvement assessments, team building, and outplacement services. In addition, we develop Internet-based career management centers for hospitals and other health care organizations.

Q *How many employees do you have in your organization?*

Frank: We have 400 consultants delivering career counseling and job search advice worldwide. We also have strategic partners providing related services. For example, we have partners who offer compensation statistics to our clients to help them determine their market value. We have legal partners who help our clients with employment contracts. We also have financial and investment advisers who help our clients with their investments.

Q *What is your primary mission as a firm?*

Frank: Our mission is to bring more career success into the lives of everyone with whom we work.

Q *How did you develop your relationship with Dr. Weeks?*

Frank: Dr. Weeks was referred to me as a physician interested in career options outside of traditional clinical medicine. So we met and began a transition plan for him, including an employment skills evaluation, and we tested the national market to determine the applicability of his skills. Through that process, we determined that he had superb communication, teaching, counseling, learning, and people skills. As our relationship unfolded, it became apparent that we had an opportunity to work together to offer career counseling services to physicians.

Q *Dr. Weeks, after 17 years practicing orthopedic surgery, why did you decide to close your orthopedics practice last fall and launch a new career?*

Weeks: First and foremost, I needed more time to be with my wife and our five children. And the hours I spent swimming upstream against the managed care waters were offering me less and less personal and professional satisfaction. Frankly, the long days were taking their toll both on my marriage and my family.

I found the effect of managed care on medical practice to be most disturbing. In this present managed care environment, where health care decisions are being dictated to a greater extent by the insurance industry, I had progressively less control over the treatment decisions that were affecting the care of my patients. Yet I retained the medical and legal responsibility and liability for the outcome of those treatment decisions. The combination of loss of control with increasing responsibility is very disturbing. In addition, I was working longer and longer hours for less and less compensation, an experience not unique to me as a physician.

Q *What are some of the other frustrations physicians express about managed care?*

Weeks: With reimbursement rates falling, physicians have to see more patients in order to remain financially solvent. This results in an inability to spend a sufficient amount of time with each patient. Time constraints imposed by managed care preclude us from developing relationships, giving patients a sense that they were shortchanged in terms of their opportunity to ask questions and get to know the surgeon. These weakening relationships are a formula for legal action should the outcome of treatment be less than optimal.

In addition, the gatekeeper system embraced by most managed care plans has denied patients access to specialists until the patient has obtained a referral from a primary care physician. This is frustrating to specialists, especially since the delay in specialist care can have a detrimental effect on patients. By the time a referral is made, the patient often suffers a poorer quality outcome than would have occurred if the specialist had been involved from the beginning. Although the gatekeeper system was developed in the interest of cost con-

"The combination of loss of control with increasing responsibility is very disturbing. In addition, I was working longer and longer hours for less and less compensation, an experience not unique to me as a physician."

—Lorne Weeks, MD, CareerLab

tainment, the irony is that health care costs have actually increased because of the redundancy of services.

I often hear physicians express these and other frustrations. Many physicians have expressed a personal and professional need to extract themselves from patient care. They want to have more personal time, be more available to their families, and pursue interests that have been on the back burner because of the fast pace of private practice.

Q: *You offer a number of services on the Internet, such as testing, assessment, online books for sale, and practical skills such as how to write a cover letter. How many visits do you get per week on the site?*

Frank: We get about 1.8 million hits per week on the site, translating to about 150,000 individual visitors per month. Part of the reason we are so popular is that the site is designed to give away some of our information. Everything we use in our corporate career programs is essentially given away on the Internet site. A user can log onto the site, do a skills assessment, or write resumes and cover letters.

Q: *At the start, your site approaches career change somewhat informally. You ask physicians to describe their professional situation before even sending you a resume. What is your intent in approaching physicians that way?*

Frank: We wanted to instill a sense of immediacy, in that a physician could send us a note in the middle of the night about his or her career situation. Since we posted this page, we've had a number of physicians sending us their background information asking for help. This service is highly confidential.

Q: *I notice on your site that you have a psychologist, Jim Jonell, PhD, who does testing and assessment. Is this type of service one avenue for putting physicians in touch with their skills?*

Frank: Yes. We have some sophisticated written tools that give us a profile of a person's personality, behavior traits, and future prospects. The Birkman Method is one such tool. To use an analogy, I would say it is somewhat like getting a complete blood cell count, chest x-ray, MRI, and CT scan rolled into one. Extremely detailed, it explains unusual behavior, underlying needs, and stress behaviors, and it lays out an exact match to several hundred careers in descending priority order. This tool gives us very good baseline information upon which to build career discussions.

Q: *There is a statement on your site that says physicians go to CareerLab for many reasons, including making the transition out of clinical medicine altogether. How difficult is it for physicians to do other work that is rewarding and satisfying if they choose not to practice medicine?*

"The individual who has selected a career in health care has a tremendous foundation on which to build a new career simply based on his or her work ethic and underlying personality."

—Bill Frank, CareerLab

Weeks: As a profession, we physicians have far more transferable skills than we realize. All too often we hear from physicians, "I am highly specialized in a very specific area of medicine, and what else could I possibly do with my career?" Our response is, "Almost anything."

Still, putting physicians in touch with their other skills that enable them to pursue alternative forms of gainful employment is a challenge. Such skill review takes physicians out of their comfort zone and causes us collectively to explore what else is out there that taps into the particular aptitudes of those physicians.

Q: *You say that physicians have transferable skills. What are some of those skills?*

Frank: First, the individual who has selected a career in health care has a tremendous foundation on which to build a new career simply based on his or her work ethic and underlying personality. These men and women are highly motivated, highly educated, industrious people for whom potential is unlimited. They're exceptionally good learners, so the learning skills themselves are transferable. They are also scientists, so anything in a scientific realm, for example, working for a medical device manufacturing company or in research, is an obvious option. But in general, our goal is to put physicians in touch with other career options that are a good fit for their particular abilities and interests.

Q: *What are some of these positions outside of medicine that would be attractive, available, and appropriate for physicians making a career change?*

Frank: That type of a list is very specific to the individual person, based on his or her personal interest and personality. For example, quality assurance in a medical device manufacturing company is a role that could be filled nicely by an orthopedic surgeon, such as Dr. Weeks, who has performed hip and

(Continued on page 14)

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joint replacements. In addition, many physicians are moving into executive roles as hospital administrators or even CEOs of technology and biotechnology companies.

Physicians are also doing medical research in such places as Battelle Labs in Columbus, Ohio, an organization that at any given time has several hundred different research projects going on. Physicians are involved in many of those research projects. The projects span many topics, everything from corporate research into what one company wants to learn about a competitor's products, to contracted work for organizations such as NASA.

Physicians also are becoming either executives or CEOs of companies that operate Internet sites. One site owned and hosted by a physician is www.physicianpages.com. Physicians are becoming consultants to law firms. They're teaching biology and other science courses in high schools, colleges, universities, and medical schools. Some are opting for military medical careers. Some are electing to leave the country to practice medicine outside of the constraints of the U.S. economy. Some are moving to rural areas or to areas that are less penetrated by managed care and will keep practicing medicine.

The sky's the limit. It's just a matter of learning carefully what their individual interests are. We also look at personality. For example, we have people who work better not being tied to a desk, people who like to move around, and people who love traveling. On the other extreme, we have people who like the comfort and security of sameness.

Q: *What effect do you think the Internet and the information revolution has had on generating new opportunities for doctors?*

Weeks: The information revolution has opened many new opportunities that didn't exist even three years ago. It would not surprise me to see 30% of physicians in the future employed in some kind of Internet-related business. Physicians are filled with information, and that's what the Internet is all about.

Patients often will come to the physician's office armed with information that they have gleaned from the Internet pertaining to their particular malady or symptom complex. Patients as a whole are far better educated now because they have medical information that is easily available. What would have required a trip to the medical library of the local university can now be culled from one's computer at 2 a.m. in the privacy of one's home. Patients avail themselves of that information with impunity and may be better informed about their symptom complexes and potential diagnoses than their physicians. Just to practice in this age of the Internet, the physician has to be facile with those particular skills.

Q: *Do you think it's a good policy to tell physicians to become knowledgeable about the Internet or at least computer literate as a precondition for a more promising career inside and outside of medicine?*

Weeks: I think the train is leaving the station and you're either aboard it or standing at the depot. There is no ground in between. Physicians should become Internet savvy now, without question. People without computer skills, and indeed Internet capabilities, will lose their effectiveness overnight.

"Physicians should become Internet savvy now, without question. People without computer skills, and indeed Internet capabilities, will lose their effectiveness overnight."

—Lorne Weeks, MD, CareerLab

Q: *What about the physician who is approaching retirement age? What kind of counseling can you offer someone in this circumstance?*

Weeks: Not infrequently we have the opportunity to work with a physician who has been retired for a year and for whom retirement has not turned out to be as fulfilling as he or she thought it would be. These physicians will come to our office and say, "I need something to do. I need another career. I enjoy playing golf but it's not fulfilling enough for me." In fact, Bill's father experienced this very same situation.

Frank: Yes. My father had been retired as an internist for two years when he approached me looking for something else to do. In the space of about two months we recruited him into a position as the head of health care education for the Colorado chapter of the American Association of Retired Persons (AARP). That position enabled him to travel the state, lecturing to seniors on health issues and at the AARP's national conventions. He held that position for five years. He was very stimulated by this second career. It allowed him to keep his social skills up, and it was the perfect job at the perfect time.

Weeks: You can't judge a person by age. Some doctors who have retired at age 65 are still full of energy and have a high level of mental acuity, and need something stimulating to occupy their time. In my practice I meet old 29-year-olds and young 75-year-olds almost every week.

In general, physicians as a whole are not the type of individuals who find fulfillment in rocking away their remaining time on the front porch. Physicians tend to be motivated, goal-oriented individuals, and if they are not practicing medicine, then surely there is another targeted goal in store for them. I believe that having something to do every day keeps older individuals active, healthy, and satisfied. It's a thrill to put these individuals in touch with new endeavors.

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

Why Do Hospitals Fail at Management?

Question: I am a 45-year-old family practitioner in a group of two in Tennessee. In my career as a physician, I have worked as a solo practitioner and in large groups, including physician-owned and hospital-owned groups. To my mind, the most satisfying practice is in doctor-owned groups of one or two physicians. In 1994, a hospital system acquired our practice and those of 50 other physicians. As physicians, we viewed the managerial abilities of the hospital administrators as pitiful. Today I have a physician partner and we are free of the hospital. As a result of our earlier experience, we would never think of expanding our group or having an organizational alliance with a hospital. Is my experience unusual? Why do hospitals have such difficulty managing doctors?

Answer: There continues to be profound skepticism among physicians about the ability of hospitals to manage groups they acquire profitably so that all parties are productive and satisfied. A study by Ernst & Young, CPAs and health care consultants in New York, has shown that 96% of hospitals have lost money on the physician practices they have acquired. These hospitals have lost an average of $111,000 per doctor per year.

Unfortunately, your experience is not unusual, says Daniel Beckham, president of The Beckham Co., physician and hospital consultants, in Whitefish Bay, Wisc. "As you know, hospitals and physician practices are very different businesses," he explains. "There's a belief among many hospital executives that a good manager can manage anything. Unfortunately, in my experience, that's not the case. A physician practice is really a small retail business and must be run as such. Margins are slim and there's usually little room to trim expenses. Pile a hospital's typical overhead structure and operating style on top of that and you've got a recipe for disaster."

Editor's note: Readers of Practice Options *are invited to call our toll-free line to speak with Richard L. Reece, MD, editor-in-chief. Reece poses questions from readers to members of the newsletter's editorial Advisory Board.*

"We need a different model—other than buy and employ—for physicians and hospitals. The model must grant physicians substantial clinical autonomy while relieving them of the distraction and pressure of practice management."

While hospitals are obviously essential in large communities, organizing the health care delivery system around physician and hospital organizations is flawed logically, primarily because running a hospital and running a medical group require different sets of competencies

Questioning Integration

Health care is making a turbulent transition from care organized around hospitals to care organized around physicians connected over the Internet to other health care professionals. The biggest obstacles to making this transition are hospitals' understandable reluctance to relinquish control and physicians' current lack of comfort and skill with the Internet. The transition will never be complete because hospitals need physicians and physicians need hospitals. Therefore, the nature of the relationship between hospitals and physicians remains the central question among those who would reform the health care delivery system.

One fact appears fairly clear: Tightly and vertically integrated delivery systems featuring hospitals, HMOs, and physicians in one organization are not the answer. The answers probably lie in cooperative and collaborative contractual relationships that do not interfere with each other's autonomy.

"The real tragedy of what's happened with physician practices over the last decade is that physicians do need to come together more forcefully," Beckham adds. "While a two-physician practice may be the most satisfying experience, I have my doubts about whether it's a sustainable model. Furthermore, hospitals and doctors need each other if they are going to withstand the onslaught of insurers and regulators with little respect for the importance of the physician-patient relationship.

"We need a different model (other than buy and employ) for physicians and hospitals," Beckham continues. "The new model must grant physicians substantial clinical autonomy while relieving them of the distraction and pressure of practice management. It also must glue physicians together in sufficient numbers to enjoy market leverage. Finally, it will need to create practice standardization so that clinical results can be demonstrated with consistency."

In closing, Beckham adds that it's important to understand the needs of hospital administrators. "Although they may not be good at practice management, most of them had reasonable intentions when they pursued practice acquisition over the past decade," he says. "They were looking to fortify a relationship with their most important partners. Many, if not most, hospital administrators have learned a great deal from their experiences with practice management. They are looking for new models through which to relate to physicians. I'd encourage you to stay open to the possibility of working with your hospital. Hospitals may not be ideal partners, but they also may be the best allies you've got in the current environment." ■

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