Patients are increasingly enthusiastic about the idea of communicating electronically with their physicians. According to 2003 research by Harris Interactive, of the 67%–78% of U.S. adults with Internet access, 90% want to communicate with their physicians in this manner. Of these, 56% say it would influence their choice of physician.

We’ve promoted the benefits of online contact with patients before: mutually convenient doctor-patient communication, enhanced rapport, and even better quality care (see “Physician-patient e-mail offers more than convenience” in the December 2004 GPS).

Despite the demand, however, many providers are still reluctant to engage in online messaging and consultations because they don’t think they will be paid for such services.

True, not all payers—including the Centers for Medicare & Medicaid Services—recognize Category III CPT code 0074T for reporting online consultations between physicians and patients, which was put into effect by the American Medical Association in July 2004.

But a handful of major health plans do, and the number is growing, says Eric Zimmerman,1 senior vice president of marketing for RelayHealth, a provider of secure, Web-based, doctor-patient communication services currently reimbursed by 10 large health plans. In many cases, these insurers will help defray the cost ($50 per month) of RelayHealth to the practice, Zimmerman says.

(Note: Web messaging is not the same as e-mail. Unlike standard e-mail, Web messaging offers an encrypted, password-protected communication via common Web browsers such as Internet Explorer and Netscape.)

Research showing that beneficiaries who have Web access to their physicians cost plans less overall has motivated some to jump on board. A 2002 study by researchers at Stanford University and University of California–Berkeley found that California- and Connecticut-based patients in the RelayHealth treatment group saved more than $1 per patient per month when compared to matched control patients. Reimbursing health plans, including BlueShield of California, saw a more than five-to-one return on investment.

Even without insurance coverage, some patients will pay out of pocket for online access to their doctors for low-acuity health matters.

To make collections easier than in the office, RelayHealth and similar services allow practices to conduct real-time eligibility checks when patients log on to the site. The system instantly verifies patients’ coverage and informs them of their financial obligation (e.g., a copayment, full-visit fee) and securely collects their credit card information. The hosting company (like RelayHealth), in turn, pays the practice the sum it collected.

1 Contact Zimmerman at eric.zimmerman@relayhealth.com.
Web messaging

from the patient.

Reimbursement not the big prize

Although reimbursement is becoming more attainable for online care, “it is by no means the largest financial impact to the practice,” Zimmerman says. “The reimbursement helps get people’s attention, but practices can really benefit from enhanced clinical productivity. More productive practices are able to see more patients in the office and generate more [relative value units], and that translates to more physician revenue.”

Independent studies on patient-physician Web messaging, such as those led by Eric M. Liederman, MD, MPH, have reached the same surprising conclusion. “Getting paid for clinical visits is very important to doctors philosophically. But it turns out that the efficiencies and productivity increases swamp the financial value of the actual reimbursement,” he says.

Several elements of Web messaging contribute to overall efficiency of a practice:

• **Typing is faster than talking.** No matter how short a phone call might be, it almost always takes more time than sending a patient an electronic message, Liederman says. “Most [electronic] messages can be responded to in the time it takes to pick up a phone, dial a number, have a phone ring, and be answered. By the time the patient gets on the phone, you could already be done with your electronic message.”

• **Web messaging allows you to multitask.** For example, while waiting for your staff to find a room for a patient or holding on the phone with a health plan, you can potentially return several e-messages. Even if you are interrupted when composing a message, you can save the draft for later—a perk not possible with a phone call. During these snippets of free time, Liederman says he wouldn’t dare pick up a phone. “The patient on the other end could keep me on the phone for 20 minutes, and I’d be behind for the rest of the day.”

• You can answer e-messages anytime and from anywhere. Liederman found that many physicians, particularly those with families, prefer to send responses from home. “When you shift some work to home, it gives you great flexibility over your life,” he says, noting system use by providers tends to spike around the hours of 9 p.m. and 6 a.m.

• You get your most demanding patients off the phone. In most practices, 15%–20% of the patients generate 80% or more of the incoming calls, Liederman says. “If you can get some significant portion of that group into a more efficient communication medium, then you’ll realize substantial benefits for your overhead and personal productivity without having to necessarily include the rest of your patients,” he says.

• You stay in touch with infrequent flyers. Web messaging even benefits business with regard to the 80% of patients you rarely hear from, Liederman says. To make the most of marketing and public relations opportunities, he recommends collecting patients’ e-mail addresses as you enroll them into your Web-messaging program. For instance, RelayHealth gives practices the ability to automatically send electronic practice newsletters to either their entire patient base or tailored messages to a smaller demographic group.

Customer service drives patient satisfaction

It’s a myth that electronic communication puts distance between physicians and patients, Liederman says, noting the positive experience of one physician who participated in his study who had 40% of her patients using the RelayHealth system. He describes her as being mainstream, not overly focused on technology, and a sensitive, patient-focused doctor.

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1 Liederman is the medical director of clinical information systems of University of California–Davis Health System in Sacramento, CA. Contact him at 916/734-2607 or via e-mail at eric.liederman@ucdmc.ucdavis.edu.

2 The study referenced in this article is a retrospective analysis of six “case” (i.e., enrolling patients in Web messaging program) and nine control internal medicine and family practice physicians’ message volume and a survey of 5,971 patients’ Web messaging with 267 providers and staff in 16 community primary care clinics in the Sacramento, CA, region from November 2001 to November 2002.
Some patients said they feel much closer to her now than they did before they started using Web messaging. And despite the fact that less than half of her patients were enrolled in the system, she still surpassed the 11% average gain in productivity typically realized by practices using Web messaging.

Liederman found message response time to strongly correlate with patient-satisfaction levels. Of patients in his study who reported receiving a response “right away,” 67.7% were “very satisfied,” as were 55% who reported receiving a response by the next business day.

Evidence of patient satisfaction is also found in the number of messages per string, Liederman says. “Usually when doctors are good at this, there are three. The third is always a thank you.”

It comes down to providing good customer service, he says. “The same folks who struggle to return their patients’ e-messages in a timely manner also struggle with phone calls. It’s not a technology-based problem.”

And contrary to what many doctors fear, the message volume from using a Web messaging system is not overwhelming. During the study period of November 2002 to May 2003, fewer than 10% of patients sent more than five messages, whereas 45.4% sent a single message.

It seems that for many patients, just having the option to e-message increases their satisfaction. The underlying theme is patient empowerment, Liederman says. “It’s really about providing better access to patients who are demanding it.”

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**AMA proposes guidelines for P4P programs**

The American Medical Association (AMA) says it has isolated five main components of an effective and well-structured pay-for-performance plan. Any successful plan must ensure quality of care for patients, foster the physician-patient relationship, offer voluntary physician participation, use accurate data and fair reporting, and provide fair and equitable program incentives, the AMA says.

“Pay-for-performance programs may serve as a positive force in the healthcare industry if the programs are designed primarily to improve the effectiveness and safety of patient care,” AMA Secretary John H. Armstrong, MD said in a press release posted on the organization’s Web site.

To view the complete set of the AMA’s new principles and guidelines, visit www.ama-assn.org/go/pdf.

**Does physician report card trend fail patients?**

When students load their schedules with easy courses just to improve their grade point averages, they only end up hurting themselves. But when the incentive to get good grades is applied to healthcare, some observers believe it’s clearly the patients who suffer.

A critique by two physicians, which ran in the March 9 Journal of the American Medical Association, cited studies that conclude that some doctors play pick-and-choose with their patients, purely to maintain high scores on the “physician report cards” being implemented by hospital systems throughout the country.

Article authors Rachel Werner, MD, and David Asch, MD, made specific reference to a 1997 survey of 104 New York heart surgeons in which two-thirds said that they selected healthier patients for surgery and rejected sicker ones following the initiation of a state policy requiring the reporting of patient death rates, according to the Associated Press (AP).

The results of that study and others suggests that the report card system may not offer truly representative measurements of doctors’ skills and abilities.

“I don’t want to come across as being against quality improvement,” Werner told the AP, “but we need more empirical evidence before we launch the universal projects that people are talking about.”

**Survey reminder!**

Don’t forget to go to http://hcpro.com/url/1044 to take our group practice quality-improvement survey. All participants who include their contact information will receive a FREE copy of HCPro’s HIPAA Security Training Handbook for the Physician Practice Staff. In addition, we will draw the names of five people, each of whom will receive a 20% discount off of any physician practice book.
It's 9:55 a.m., and you're 25 minutes late for your first patient. Meanwhile, a referring doctor is on the telephone waiting to discuss a patient he wants to send over. When you look at the chart of your first patient, you find that the result of the CT scan you ordered last week is not back in the chart. When you finally get in to see the patient, you address him as Mr. Jones, and he tells you he is Mr. Smith.

Such disarray has probably plagued every physician at one time or another. But for some, these scenarios continually repeat themselves. The difference between a well-run office and an office that catapults from one crisis to the next is that the latter often creates less satisfied doctors and patients and burnt-out staff.

If you or your partners feel overwhelmed, overworked, and underappreciated, look at the areas in which your group doesn’t achieve peak performance. You’ll probably find that a major overhaul isn’t necessary. By simply fine-tuning some of your processes, you can inexpensively “reengineer” your practice to obtain dramatic, positive results.

**Take a step back**

Practice management expert and author Michael Gerber writes in his book *The E-Myth Physician* that you need to “stop working in your practice and begin to work on your practice.”

When pulled in so many directions, we tend to spend most of our time letting our practices run us rather than the other way around. Many of us are like the proverbial duck, who looks calm and serene on top of the water, but is paddling like crazy under the surface just to stay afloat.

The constant bustle and time constraints of practicing medicine often make us feel like it is impossible to stop and take an outside look at what is truly happening in our practices. But that’s when it’s most important to give our office protocols, processes, and procedures a check-up—that is, if you have them in first place.

One of the best ways to accomplish this: Ask patients what they think of the practice and the services you provide. After all, without patients, we couldn’t exist as physicians.

I survey every patient on every office visit with a brief questionnaire (see “Thank you for helping us serve you better!” on p. 5). This simple six-question form allows
me to take a daily pulse on my practice. A nurse or office manager follows up on all comments everyday.

**Timing is everything**

Take seriously the information your patients provide. Make certain areas a priority, such as proper scheduling. Scheduling snafus can have a tsunami effect on your entire practice at worst and on the tone of your day at best. Establish protocols for your staff to follow when scheduling patients.

For example, look at your procedures for scheduling new patients. Are they given the same 15-minute slots you allot to established patients? Consider designating certain, less-rushed times of day for new patients, such as first thing in the morning or right after lunch, when physicians feel fresh and possibly less distracted.

**Attitudes are contagious**

Next, do a little introspection. If we come to the office grumpy or distracted, we pass the mood along to our staff who, in turn, pass that negative attitude to our patients. Let us not forget that we set the tone.

One way to maintain a good attitude is to be prepared for the day. This usually means arriving early. Get to the office earlier? I know what you’re thinking—it’s just not possible. If that’s the case, your schedule needs to change. You may have to start earlier in the morning or schedule patients later.

It may help to build in a cushion of 15–20 minutes before your first appointment to review the charts or electronic medical records for patients whom you will see that morning. Then you can leave notes for staff to check that the necessary test results or reports are included in the record, that equipment you will need for office procedures are ready and that elements are in place to meet the special needs of certain patients, such as those requiring wheelchairs, when the patients arrive.

This simple preplanning will give you a better handle on your practice, make your staff more efficient, and streamline your process of care—all of which ultimately leads to improved patient satisfaction and better outcomes.

Many doctors resist making changes and adjustments in the processes or procedures that they have used for so many years.

But remember, you can’t repeat past performances and expect to achieve new results. Reengineering your practice means taking a leap of faith. You have to rid yourself of that hurried, rushed, distracted behavior that results in burnout and lost enjoyment that so many of us experience.

By being proactive and making an effort to control your practice instead of being a slave to it, you can have a practice that is enjoyable, emotionally rewarding, profitable, and one that makes you proud.

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**Thank you for helping us serve you better!**

Was it easy for you to get an appointment?  ☐ Yes  ☐ No

Is your general impression of this office favorable?  ☐ Yes  ☐ No

Were office staff friendly and concerned?  ☐ Yes  ☐ No

Did the doctor adequately answer your questions?  ☐ Yes  ☐ No

Would you recommend this office to someone else?  ☐ Yes  ☐ No

Do you have any additional comments? (Please write on reverse.)

Source: Neil Baum, MD. Printed with permission.
Recruitment

Nonphysician practitioners offer groups growth opportunity without merging or adding more doctors

Merging is an attractive option for group practices looking to increase their profit margins and find some relief from increasingly hectic appointment schedules, but it’s not the only solution.

One alternative is to add nonphysician practitioners (NPP) such as physician assistants (PA), nurse practitioners (NP), clinical nurse specialists, nurse midwives, clinical social workers, and certified registered nurse anesthetists, among others, rather than more doctors.

Hiring NPPs allows you to increase your provider headcount, but it costs less because you pay lower compensation. Further, NPPs don’t usually seek partnership or coowner status, and in many states they are not allowed to be coowners of a medical practice with physicians, says healthcare attorney and consultant Vasilios “Bill” Kalogredis.1

From an efficiency standpoint, it is good management to have lower-level providers care for less acute patients, making the doctors available to see a larger number of more serious cases per day, he says.

Patients are less picky than you think

Concerned that your patients won’t accept seeing anyone other than a doctor? Rest easy, Kalogredis says. Although this perception may have once been valid, most patients appreciate getting an appointment quicker and not necessarily having to wait for the doctor’s schedule to open.

In most cases, patients are delighted with their experiences with NPPs and even report feeling more satisfied with NPs or PAs because it seems these providers spend more time with them than physicians do.

In reality, the time spent with patients is probably about the same, says consultant Debra McGrath,2 MSN, CRNP. As an NP for several years, McGrath says she would typically see 30 patients in a day—a number comparable to many physicians’ productivity models.

The difference, she says, is in the approach: “We get to the heart of the matter—which is often much more sociological than it is scientific—more quickly and therefore it seems like we’re spending more time [with patients].”

Despite the often positive feedback NPPs get, don’t mislead patients into thinking that NPPs are physicians or that they are getting appointments with physicians when they’re not, Kalogredis says. Just be honest.

When a patient calls for an appointment for a matter that doesn’t require a physician, offer the first available appointment with the NPP, as well as the physician’s next available slot. Some patients will choose to wait until they can see the doctor, “and that’s okay,” Kalogredis says. “You can’t force anyone to see [an NPP].”

No need to fear ‘healthy’ competition

More often than not, patients like seeing the NPPs—and that sometimes makes physicians nervous. Although it may not be flattering to physicians to have patients request a likable NPP (perhaps more often than they do the doctors), you should still be pleased to know that those patients remain loyal to your practice, Kalogredis says.

“If a practice is busy enough, the physicians should be happy to have [an NP] or [PA] who helps free the doctors up to see more patients themselves,” he says. “It shouldn’t be competitive”

A sound NPP-physician relationship is based on collaboration and an even playing field, McGrath says. “There’s a misconception that NPPs want to elbow their physician colleagues out of the marketplace as primary care providers, which isn’t true.”

Physicians sometimes hand off patients to NPPs and vice versa. It’s important to recognize that both kinds of providers bring something unique and equally valuable to patient care, McGrath says. “There are plenty of patients to go around.”

Nonetheless, consider including a restrictive covenant (if allowed in your state) in NPPs’ employment agreements, Kalogredis says. “You don’t want them leaving your practice and taking a percentage of your patients with them.”

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2 McGrath is a manager with the Coker Group and is based in Pennsylvania. Contact her at 800/345-5829 or via e-mail at dmcgrath@cokergroup.com.
Do your homework

Vast distinctions exist among different NPP roles. For instance, NPs are individually licensed, whereas PAs may have to work under the physician’s license (regulations vary by state), McGrath says.

Before hiring an NPP, find out what you may delegate to him or her and what you must supervise. Regulations for NPPs’ scope of practice and physician supervision vary by state and insurer, so understand your responsibilities as a physician, Kalogredis says. For example, you may be required to be present and accessible in the facility or suite when NPPs provide care. At the least, expect to spend some time at the end of the day reviewing and signing NPP patient charts.

McGrath points out that NPs may treat patients unsupervised—in collaboration with the physician—if the practice chooses to individually credential them through health insurers. The credentialing process is intensive, McGrath admits, but she recommends that groups go the extra mile for their NPs to obtain greater flexibility in staffing, especially with regard to call, vacation, and maternity-leave coverage.

You can also hire a NP who is already credentialled and activate those credentials at your practice. Note that NPs credentialled with Medicare who don’t bill under their number during the course of a year lose their provider number, so it’s a disservice to NPs if you don’t allow them to bill individually, McGrath says.

Don’t be beguiled by billing

Knowing how to bill for NPPs’ services is probably the area that practices find most daunting, McGrath says. Medicare and individual carriers have their own requirements for appropriate billing and reimbursement for services performed by NPPs, and improper billing for NPP services has caught the eye of the Office of Inspector General in recent years. So it’s crucial that you understand just what information payers want.

Deciding between the two forms of billing outlined by Medicare—“incident-to” billing and “not incident-to” billing—comes down to whether you place more value on time or money (see sidebar below for requirements for both kinds of billing).

Incident-to v. not incident-to

**Incident-to.** When nonphysician practitioners (NPP) bill incident-to, you’re eligible to receive reimbursement at 100% of the Medicare Physician Fee Schedule (PFS) for services provided. When you bill this way, however, you don’t always reap the benefits of NPPs as time-savers because you must more closely supervise them.

If you decide to have NPPs bill for services as incident-to, they must observe the five main criteria for doing so. Services must be:

1. an integral, although incidental, part of the physician’s personal professional services
2. commonly rendered without charge or included in the physician’s bill
3. of a type commonly furnished in a physician’s office or clinic
4. furnished under the physician’s direct and personal supervision
5. furnished by an individual who qualifies as an employee of the physician

Additionally, for incident-to billing, NPPs must perform their services in a doctor’s office or clinic, not a hospital. Hospitals have their own rules for reimbursement, and the use of incident-to billing in that setting is strictly prohibited.

**Not incident-to.** If you decide to have NPPs bill “not incident-to,” you can only receive up to 85% of the PFS (although consultant Debra McGrath, MSN, CRNP, notes that there is currently a large lobbying effort going on to raise it to 100%). However, physicians will likely make up the difference because of the extra time afforded by not having to closely supervise NPPs and the ability to see more patients themselves.

The employment rules are different for not incident-to billing. For example, physician assistants are still required to be employees of the practice, but nurse practitioners can be independent workers.

And most helpful to physicians, the rules about supervision aren’t nearly as stringent. The physician needs only to be accessible by phone and not in the building during a procedure.
Consultant’s perspective

Can your group fire an associate?

Make sure your contracts don’t hamper this important power

By Leif C. Beck, JD, CHBC

A reader recently asked me to discuss a group’s power to fire one of its physicians. For example, what can a group do if its newly hired nonpartner employee turns out to be a poor fit?

Many associates leave

Even if you carefully interviewed, checked references, and exercised all other due diligence in hiring a new doctor, it’s anyone’s guess whether the new doc will actually fit with the practice and how long he or she will stay with the group. Based on my experience, I estimate that one in every four physician hires leaves the hiring group before becoming a partner.

Doctors leave for their own reasons, of course, and you can’t contractually prevent that. But if your group decides an associate should go, your legal documents should permit the group to make that happen.

I urge groups to face up to terminating a doctor’s employment as soon as possible after concluding that the doctor won’t last for the longer term. Acting promptly almost always serves the associate better than stringing out the process.

Nonnegotiable power

To ensure that prompt termination can happen when necessary, go back to your practice’s contracts. Check your partner-level documents to be sure they permit terminating a nonpartner’s employment on less than unanimous approval.

Surprisingly, many corporate bylaws and shareholders’ agreements (or “operating agreements” if your practice is a limited liability company or limited liability partnership) require a unanimous vote to terminate any physician’s employment, not just that of a coowner. Even in small groups, one or two members all too often either disagree with the decision or lack the will to vote on it.

The associate’s employment agreement matters even more. Don’t bite when a young doctor’s lawyer suggests contract language requiring specific faults to justify termination. Instead, insist upon full and complete power to terminate the employment for any reason. Make it nonnegotiable.

Requiring fault simply opens you up to a potential lawsuit. It also weakens the chance of enforcing your contract’s noncompete provision if the associate leaves in dispute. That’s because judges have discretion to uphold or disregard restrictive covenants as “equitable” matters, and an argument that your group failed to follow the employment contract may weigh against you.

While urging the power to fire a nonpartner “at will,” I also suggest asking your lawyer what your state’s employment laws permit. Some states prohibit firing even highly paid professionals at will or without following specific protocols. Make your contract as strong as possible within the allowable limits.

Provisions to avoid

Lawyers too often feel most comfortable with relatively ineffective provisions that only permit the employer to terminate employment upon events such as:

• criminal conviction
• loss of one’s medical license
• dismissal from hospital staff membership
• bankruptcy
• drug conviction

Don’t accept such restrictions; they deal with situations that rarely crop up and take too long to occur. They virtually lock in the employment for the entire contract term.

Similarly, provisions calling for the due-process-like specification of why you seek to terminate the employee will almost surely kill any momentum to make it happen. For example, it’s far too difficult to quantify and fully defend why a group that depends on close clinical interdependence (as well as interpersonal “chemistry”) would fare better without the doctor, and yet that’s what such due process provisions would require.

Once an employed physician’s involvement will no longer likely succeed, either party should have the freedom to recognize that fact and terminate the relationship.

Contract provisions limiting this right are not useful to either party—they can lead to internal difficulties at best and lawsuits at worst.

1 Beck advises on top-level group practice matters. Contact him at Leif C. Beck Consulting at 610/355-0797 or via e-mail at leifbeck@comcast.net.