

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

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Communication Can Help Build a Practice

When the Harvard Medical School recently surveyed more than 2,000 patients about their office visits, poor communication with their doctors emerged as the most likely cause of dissatisfaction and for switching physicians.

The Harvard study highlights a need that America's medical schools acknowledge: Physicians need better communication skills. Approximately 75% of medical schools offer courses on this topic, which is an increase over the percentage that offered such courses in the past, experts say. Physicians long out of medical school are discovering that attending professional communication workshops can lead to more accurate diagnoses, better patient compliance, higher retention rates, more referrals, lower staff turnover, reduced malpractice premiums, and fewer lawsuits.

Educating Patients

Gains may be intangible as well. Asked to cite a benefit of communication training, Fred Husserl, MD, says the training he got helped in innumerable ways. In 1989, Husserl was burned out and considered quitting nephrology. "I used to see certain names in my appointment book and get a knot in my stomach," he relates. "The issue was being able to handle the parts of medical practice that have nothing to do with medicine, which can become more of a problem than the textbook part that I know well."

Husserl credits a communication

workshop he took with helping him to improve his skills. Understanding his own attitude about communication helped him learn how to help patients make changes in their health, to remain neutral when his advice was ignored, and to discover how he could be the best doctor for each patient. Convinced that becoming a better communicator enabled him to stay in nephrology, Husserl took an advanced workshop so he could train residents at the Ochsner Clinic Foundation in New Orleans, where he is acting head of the nephrology section.

Although he has limited his practice to nephrology, Husserl says his measure of success is that a few times each month, a patient or a member of a patient's family asks him to be his or her GP, something that didn't happen before.

Improving Communication

In the Harvard study, 12% of subjects had considered changing doctors. "Physicians underestimate patients' desire for health information and overestimate the amount of time they spend providing it," says lead investigator Nancy L. Keating, MD, MPH, a health care policy researcher. "Patients want to feel they are being heard. Providers' decisions to limit tests, procedures, or referrals are often entirely appropriate." In the article in the *Journal of General Internal Medicine*, in January, the authors suggest that communication strategies to increase discussion about such deci-

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Physicians Need Medical Malpractice Relief

Many physicians are facing a crisis as a result of rising medical malpractice insurance premiums. As we have reported, medical malpractice rates have risen 6% to 10% for many policies in force this year, and some physicians are now paying more than 70% more than what they paid last year. Runaway litigation is hurting the economy, reducing patients' access to medical care and forcing physicians to limit services, retire early, or relocate, says the AMA.

In response, legislators in some states and members of Congress are considering bills that would limit medical malpractice awards. Two bills in Congress, HR 4600 and S 2793, would limit the amount patients could get for noneconomic damages, such as compensation for pain and suffering, to \$250,000, according to *CongressDaily*. Punitive damages would be limited to \$250,000 or twice economic damages, whichever is greater. Economic damages would remain uncapped, and lawyers' fees would be limited by a sliding scale, the newspaper says.

President Bush has urged lawmakers to act on legislation that would limit malpractice awards in lawsuits against doctors, saying that unlimited awards increase health costs and force doctors out of business. Many observers attribute the high cost of medical malpractice premiums to expensive damage awards, although trial lawyers disagree.

In July, Bush proposed legislation that contains the same caps as HR 4600. Economic damages, such as medical expenses or lost income, would remain uncapped. Bush's plan also would allow providers to pay awards in installments instead of in a lump sum and would require juries to be informed whether a plaintiff has sources other than providers for compensation for an injury. This proposal is significant in that it calls for legal protections for patient safety and quality improvement programs, which are intended to prevent future medical errors by encouraging physicians to share information about potential problems, according to *The Los Angeles Times*. It is also significant because it would create the first federal limits on malpractice lawsuits and would override laws in any states that have set higher caps, says *The Washington Post*.

The AMA supports the HEALTH Act, which is federal legislation (HR 4600 and S 2793) based on the successful California law known as MICRA. MICRA has helped maintain stability in the California medical liability insurance market, the AMA says.

Physicians concerned about this issue can write to their congressional representatives and to members of their state legislatures and urge support of measures to reform the medical malpractice system.



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Misconceptions Can Lead to Trouble

Many physicians have misconceptions about the federal government's efforts to enforce their compliance with reimbursement regulations. The unfortunate result is that few physicians have taken steps toward implementing a compliance program, thereby leaving themselves open to an investigation or a fraud audit. Also, many physicians believe that if the government begins an investigation or enforcement action of any kind, the consequences will be minor. Both of these misconceptions can lead to trouble, experts say.

It is commonly believed by physicians, for example, that they will not be audited by either federal investigators or private payers, since they are not intentionally attempting to defraud the Medicare or Medicaid programs or any other insurer. This commonly held misconception has caused many physicians serious trouble, says Charles E. Colitre, CEO of Med-Management Group Inc., health care consultants in Akron, Ohio. Before starting Med-Management, Colitre worked as a senior supervisory agent for the FBI, overseeing all Medicare fraud investigations in northeastern Ohio.

Perception vs. Reality

In reality, most physicians are probably not billing or coding accurately, says Colitre. "The average practice is at risk if it is audited because most practices have been overcoding or

undercoding, or they have insufficient documentation to support a chosen coding level," he explains. "The fact that physicians think they are doing a good job is irrelevant. Either they know or they don't know." The only way to know whether a practice is billing and coding accurately is to conduct an internal audit or have a compliance program in place.

Mike Dobrovich, DO, says, "Many physicians believe that unless they are committing intentional fraud or making serious mistakes in coding, no one will pay attention. There is some truth to this belief. However, physicians could be making relatively small and innocent mistakes, but making them over and over and thus find themselves liable if they have not put forth a good faith-effort to screen for and correct problems." Dobrovich is president and managing partner of Westshore Primary Care Associates, an 18-physician primary care practice in Westlake, Ohio. Westshore Primary Care Associates recently established a compliance program.

"Physicians need to be able to demonstrate a good-faith effort to catch potential errors," Dobrovich continues. "I believe that you can walk into any physician office in the country and find some problems. Depending on the context and the way these problems are interpreted, they could result in the physician losing his or her ability to practice medicine and participate in federally funded programs."

Among all physicians who are subject to a federal fraud investigation, about 85% will be asked to take some type of remedial action, Colitre estimates. The physicians who are investigated are likely to have made a sufficient number of errors so that the government will apply penalties under the False Claim Act or will require the doctors to pay a substantial refund to the government, he says. "With penalties under the False Claims Act now set as high as \$11,000 per infraction, payments can exceed what a physician would see as reasonable, and U.S. attorneys apply the penalties where they can," he adds. Typically, physicians are shocked at the results of a federal audit.

Complex and Contradictory

Medicare regulations are long and complex. What's more, some experts find them contradictory, meaning it is extremely difficult to bill in a manner that would allow a physician group to pass a federal audit without a violation of some sort being found. Therefore, experts advise physicians to establish a compliance program because it may be their best defense in an investigation. Internal guidelines for U.S. attorneys state that the existence or lack of existence of a compliance program are factors to be weighed heavily when considering whether to pursue an investigation, experts say.

"A compliance program is what I'd term a legal, but not an impenetrable,

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"The average practice is at risk if it is audited because most practices have been overcoding or undercoding, or they have insufficient documentation to support a chosen coding level."

—Charles E. Colitre, Med-Management Group Inc.

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shield,” says Colitre. “If a group has an effective compliance program, it will be able to catch many of the errors. Even if it doesn’t catch all the errors, the group can show the government that it has made a good-faith effort to install a mechanism to watch the process. It is not uncommon for investigators to look at a practice and say, ‘It has a compliance program in place, so we are not going to probe beyond the original complaint.’”

Dobrovich agrees, saying, “Physicians need a compliance program of some sort to show that they are doing their best to bill accurately, even if the program consists of a one-page document stating the actions they are taking to eliminate errors and a way to demonstrate to others that they are following it.

“In physicians’ minds, it’s not fraud if they’re making an error unintentionally,” Dobrovich continues. “But the government sees it as fraud if they continue to make the error and have no program in place to monitor and reeducate themselves about coding practices.”

The Need for Accuracy

A compliance program will help all staff bill at the appropriate level for every patient encounter. Doing so will help prevent instances of billing for a higher level of care than was provided. Some physicians commit fraud in this way believing it is a safe practice.

“It is fraud if a physician does this, or instructed someone else to do it, after knowing that it was wrong to do so,” explains Colitre. “Did the staff tell the physician the code was wrong but continued to use it anyway? That

can be construed as fraud.

“Just because a physician works harder, doesn’t mean that he or she can bill higher,” Colitre continues. “If the documentation doesn’t support coding, it’s wrong. When the investigators come to do an audit, at a minimum they will downcode claims and make the physician pay back the difference.”

Many physicians believe that developing a compliance program is too difficult or that such a program is unnecessary. “Putting a compliance program in place does not have to be overly complicated,” Dobrovich notes. “Physicians may not need a complex compliance program, but they do need documentation to show an investigator that they have made a systematic effort to eliminate errors.”

For starters, the program can be simple and may need only minimal input from an attorney, Dobrovich says. Over time, the group can improve the program. “The essence of the issue is that the government is looking to see whether the physicians have made a reasonable effort and are moving toward improvement,” he adds.

Another misconception that is common among physicians is that once an investigation starts, their chances of being convicted of fraud are low, possibly as low as one in a million. “Physicians see themselves as a drop in the ocean,” says Dobrovich. “When they are in groups of three or four, they believe their chances of being investigated are slim.”

But Colire says that about 3% of investigations result in a criminal

indictment. And once a physician is indicted, the Justice Department wins most of its cases. “If a physician ends up in the criminal track of a federal compliance enforcement, his or her chances of being convicted of fraud are much greater than one in a million,” Colitre explains. “The Justice Department wins about 97% of the cases it takes to trial, in part because it takes to trial only the cases it is confident of winning. If a physician is audited and evidence of purposeful fraud is uncovered, the physician will most surely be indicted.”

Criminal Charges

Physicians also tend to believe that if they are investigated, a lawyer will be able to keep them out of trouble. “Maybe so,” says Colitre, “but an attorney once told me, ‘I’m not the one who goes to jail if they lose.’”

Health law attorney Amy Woodhall agrees. “Most of the time, the primary concern of the physician’s attorney is to keep the investigation from leading to a criminal charge,” says Woodhall of the firm Walter & Haverfield LLP, in Cleveland. “A lawyer’s goal is to convince the U.S. attorney handling the investigation that any errors were innocent errors, meaning remedial action should be limited to a return of overpaid money or, at worst, application of administrative penalties.”

According to Dobrovich, the risk once an investigation starts is similar to the risk involved in a federal tax audit. “Yes, you may have a good accountant or a good attorney, but it’s not good to have the government on your tail,” Dobrovich explains.

Medicare regulations are long and complex, and some experts find them contradictory, meaning it is extremely difficult to bill in a manner that would allow a physician group to pass a federal audit without a violation being found.

“Physicians need a compliance program of some sort to show that they are doing their best to bill accurately, even if the program consists of a one-page document stating the actions they are taking to eliminate errors and a way to demonstrate to others that they are following it.”

—Michael Dobrovich, DO, Westshore Primary Care Associates

“The government is bigger, it is on a mission to correct these issues in health care, and it has more resources. You may be able to defend yourself the first time around, but you’ll be on the government’s radar screen.”

Once the federal government starts an investigation, a physician group can assume that if it does not have a compliance program in place, there is a good chance that the government will levy a severe financial penalty. The attorney’s primary tasks are to avoid a criminal charge, to help keep the group from being excluded from Medicare and Medicaid, and to help the physicians retain their ability to practice.

If a physician is convicted of a felony or reaches a plea bargain agreement with the government, the physician or the group will be excluded from federally funded programs and the physician will lose his or her license, says Colitre.

“Even if a physician pleads guilty to a misdemeanor of failing to maintain proper documentation, the Office of Inspector General of the U.S. Department of Health and Human Services may automatically exclude the physician, and the state medical board is likely to review the physician’s license,” says Woodhall.

Whistle-Blower Suits

Among the most common—and potentially damaging—misconceptions that physicians have about federal fraud investigations is that their employees would never report to the government any instances of fraud.

“This is a big myth among physicians,” says Dobrovich. “Most physicians feel that they have good and loyal employees who are treated well, and that these employees would never think of filing a whistle-blower lawsuit. As physicians, we sense that our biggest liability is with dissatisfied patients. Physicians are in denial about this. To a certain extent, it’s hard for me to accept that even if I am doing the right thing by my employees, that there may be one who is unhappy with the way he or she has been treated and is uneasy with something that’s happening in billing. That employee may feel his or her attempts to remedy the situation have been rebuffed and dismissed.”

In truth, about 70% of investigations of physicians are triggered by a whistle-blower action brought by a current employee, a former employee, or a physician colleague, explains Colitre. “It’s a major risk,” he adds.

The corollary to this misconception is that a physician can simply fire an employee who files a whistle-blower lawsuit. “I understand how physicians would feel in this situation,” says Dobrovich. “If you feel someone has betrayed you, justly or unjustly, the first reaction is, ‘Why would I want that person working for me? There’s no loyalty to me.’ It’s just human nature to think of getting that person out of the organization.”

But whistle-blower lawsuits are filed under court seal, meaning a physician would have no knowledge that an investigation is underway until charges are brought, Colitre

explains. “The law provides for specific protections for those who file whistle-blower lawsuits, regardless of the legitimacy of their charges,” Colitre says. A physician cannot fire, demote, or take prejudicial action of any kind against a whistle-blower, he adds. What’s more, the remedies are specified clearly in legislation, and the Justice Department rigorously enforces these regulations. “A physician’s best strategy is to immediately implement a compliance program and see that it is applied rigorously,” he advises.

Risk Management

Many doctors are proceeding with the topic of compliance in a state of ignorance, and this ignorance can be costly, Colitre points out.

Dobrovich agrees, saying, “One of the biggest impediments to physician practices having a compliance program is that they feel in good conscience that they are not engaged in purposeful wrongdoing. They believe they’re safe, and think, ‘What could possibly happen?’ The fact is that they could be at risk.”

“Any practice in the country is likely to have innocent billing errors,” Dobrovich points out. “Medical billing has become so complex and voluminous for many physician practices that it would be foolish to think there would not be an error and that someone could not find something wrong.”

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

Report Outlines Malpractice Problem

Americans spend far more per person on litigation costs than the residents of any other country. That observation is made in a recent report on medical malpractice, which also says that the excesses of the litigation system are an important contributor to “defensive medicine” (when physicians use costly medical treatments to avoid litigation).

“As multimillion-dollar jury awards have become more commonplace in recent years, these problems have reached crisis proportions,” says the report, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System*. “Insurance premiums for malpractice are increasing at a rapid rate, particularly in states that have not taken steps to make their legal systems function more predictably and effectively. Doctors are facing much higher costs of insurance, and some cannot obtain insurance despite having never lost a single malpractice judgment or even faced a claim.”

The report, which was prepared by the Office of Disability, Aging, and Long-Term Care Policy of the U.S. Department of Health and Human Services, is available online (at www.hhs.org).

Limiting Practice

Many physicians are responding to this malpractice insurance crisis by limiting their practice to patients who have no health conditions that would increase the litigation risk; others are moving to states with a more equitable legal system and

where insurance is less costly. Impeding efforts to improve quality, hospitals, physicians, and nurses are reluctant to report problems because they fear being dragged into lawsuits, even if they have done no wrong, the report says.

Some states have enacted laws that set limits on liability awards. But, the report says, federal action and further action by states are essential to help Americans get high-quality care when they need it, at a more affordable cost.

Trial lawyers, among others, argue that this crisis has little to do with whether limits are imposed on medical malpractice cases. Sufficient data are not available to know how severe the problem is or whether patient care is suffering as a result, Maxwell Mehlman, director of the Law-Medicine Center at Case Western Reserve University, told the Ohio legislature in September, according to *The Plain Dealer*, in Cleveland.

Ed Lazarus, senior director of state affairs for the Association of Trial Lawyers of America, told the *Times-Union* in Jacksonville, Fla., that capping noneconomic damages limits the ability of certain patients to get just compensation for their injuries. Also, there’s no correlation between a state’s malpractice insurance rates and whether it has a liability cap, he said.

The HHS report contends that the high cost of malpractice insurance is a threat to health care quality for all Americans. “This broken system of litigation is also raising the cost of health care that all Americans pay, through out-of-pocket payments,

insurance premiums, and federal taxes,” the report says.

Extreme judgments in a small number of cases and the settlements they influence are driving this litigation crisis, the report says.

The litigation crisis is affecting patients’ ability to get care not only because many doctors find the increased premiums unaffordable, but also because liability insurance is increasingly difficult to obtain at any price, particularly in states that have not enacted reforms, the report says. Exacerbating the problem is the fact that several large insurers have stopped selling malpractice insurance. Among them is the St. Paul Cos., which was the largest malpractice insurer in the nation, covering 9% of U.S. physicians. Other companies that have left the malpractice business include MIXX, PHICO, Frontier Insurance Group, and Doctors Insurance Reciprocal.

States that had not enacted meaningful reforms (such as Georgia, Mississippi, Nevada, Ohio, Oregon, Pennsylvania, and Washington) were particularly affected, the report says. In Mississippi, for example, 15 insurers have left the state’s market in the past five years.

Moving Out

In Nevada, the crisis caused the University of Nevada Medical Center to close its trauma center in Las Vegas for 10 days this summer. Surgeons quit because they could no longer afford malpractice insurance after their premiums rose sharply, some from \$40,000 to \$200,000. The

Many physicians are limiting their practice to patients who have no health conditions that would increase the litigation risk or are moving to states where insurance is less costly.

States with limits of \$250,000 or \$350,000 on noneconomic damages have average combined highest premium increases of 12% to 15%, compared with 44% in states without caps on such damages, the report says.

trauma center re-opened when some surgeons agreed to become county government employees for a limited time; doing so capped their liability for noneconomic damages. Access to obstetrics and other types of care also have been threatened in Nevada. More than 10% of all doctors in Las Vegas are expected to retire or relocate their practices this year. Cheryl Edwards, MD, for example, closed her obstetrics and gynecology practice in Las Vegas and moved to Los Angeles because her annual insurance premium jumped from \$37,000 to \$150,000.

Frank Jordan, MD, a vascular surgeon, in Las Vegas, also closed his practice. "If I were to stay in business for three years, it would cost me \$1.2 million for insurance," he says. "I obviously can't afford that. I'd be bankrupt after the first year, and I'd just be working for the insurance company. What's the point?"

Physicians in Pennsylvania are also leaving their practices. At Frankford Hospital's three facilities in Northeast Philadelphia and Bucks County, all 12 active orthopedic surgeons stopped practicing after their malpractice rates nearly doubled to \$106,000 per physician for 2001, the report says.

Rising Rates

In Ohio, many physicians saw their malpractice premiums triple in 2001. James Wilkerson, MD, a urologist in Akron, retired, saying he would have spent seven months working to pay for an \$84,000 premium.

Residents of West Virginia also face problems of access to urgently needed obstetrics care. In rural areas,

such as Putnam and Jackson counties, the sole community provider hospitals have closed their obstetrics units because the physicians there cannot afford malpractice insurance.

Many physicians in Mississippi who specialize in family medicine and obstetrics and gynecology, particularly in rural areas, have stopped delivering babies because of rising insurance costs.

In Georgia, the 80-bed Bacon County Hospital in Alma took out a loan to cover a premium that more than tripled. Memorial Hospital and Manor in Bainbridge, Ga., which operates a hospital and a nursing home, saw a 600% increase in its malpractice insurance, the report says.

In New Jersey, 65% of hospitals reported that physicians were leaving because of increased premiums.

In states that have not enacted medical malpractice reforms, premiums rose sharply, the report says. For example, in Virginia, physicians had a 75% annual increase. In North Carolina, physicians had an annual increase of 50%; Mississippi, 40%; Pennsylvania, 30% to 40%; and physicians in Florida, Illinois, Nevada, and Ohio had increases of 30%, the report says.

The insurance crisis is less acute in states that have reformed their litigation systems. States with limits of \$250,000 or \$350,000 on noneconomic damages have average combined highest premium increases of 12% to 15%, compared with 44% in states without caps on noneconomic damages, the report says.

Insurance premiums are largely determined by the expensive litigation

system, which is linked with the malpractice insurance system, the report says. The litigation system is expensive, unpredictable, largely random, and lacks standards, it says. Unless a state has set limits on noneconomic damages, juries can award huge damages based on sympathy, attractiveness of plaintiffs, and the plaintiff's socioeconomic status, the report adds. As a result, the number of large verdicts is increasing rapidly, the report says. The average award rose 76% from 1996 to 1999; the median award in 1999 was \$800,000, a 6.7% increase over the 1998 figure of \$750,000. Between 1999 and 2000, median malpractice awards increased nearly 43%, according to the report. Certain physician specialties have had disproportionate increases in damage awards, especially obstetrics. The median award in cases involving obstetricians and gynecologists jumped from \$700,000 in 1999 to \$1 million in 2000, the report says.

The report recommends that states follow the example of California, which has had a reform measure in place for more than 25 years. It also says that Congress should act on HR 4600, a measure that would limit medical liability awards. In California, the Medical Injury Compensation Reform Act of 1975 sets a limit of \$250,000 on noneconomic damages while continuing unlimited compensation for economic damages and provides for periodic payment of damages.

—Reported and written by Joseph Burns, editor.
More information on physician practice strategies is available on our Web site (see page 16).

Tufts' Plan Builds on Innovation

The Tufts Health Plan, a 900,000-member nonprofit managed care organization in Waltham, Mass., is known as an innovative company that has been honored frequently as being among the best HMOs in the nation.

Part of the plan's success is due to its working relationships with physicians and to the strategies it uses to help physicians practice high-quality, cost-effective medicine. "The Tufts Health Plan started as a provider cooperative," explains Harris A. Berman, MD, chairman and CEO. "Although we have migrated past that model now, our roots are very much in working with doctors and the local hospitals. There is a real advantage to being a local organization instead of a national organization. So we tread very lightly and try to work with providers to win their

Physician Interests

For Berman, careful consideration of physicians' interests is important, especially in a city such as Boston, where financial struggles among health care delivery organizations are common. "Managed care was in a crisis mode in Boston a couple of years ago when Harvard Pilgrim Health Plan went into receivership and faced an uncertain future," says Berman. "Now, the plan is more stable, and that crisis seems to have died down." (But, more recently, the hospital systems are finding themselves in crisis. One large organization—Care-Group—has been in severe financial trouble and has considered significant restructuring. Another organization—Partners Healthcare—has faced questions from state Attorney General Tom Reilly for possible anti-competitive activity.)

physician. The hope is that physician groups will use this information to improve their performance against their peers. Eventually, I expect that this would be repeated biannually."

Health plan administrators spent several years working with physicians to get their support for the report card effort. "We let them check our numbers to make sure that the data we were using were real," Berman says. "In fact, we issued the report card results on a trial basis to the physicians so they could make corrections. A few physicians showed us that their mammography rates, for example, were higher than our records showed, so we made those corrections.

"We did not want the report card project to fail because of faulty data," Berman continues. "Still, we were a little worried when we published the report card that we would face a physician uproar, but we didn't." The report card initiative has been well received among physicians and among consumers as well.

"We have not yet tied physician payments to report card results," Berman says. "This is a sensitive issue for physicians. Before we consider doing that, we will want to be absolutely sure that we are comfortable with the data, and that the data reflect real physician performance. The report card is meant to be a tool for improvement, not punishment."

Improving Processes

Another improvement effort involves an initiative in which Tufts is seeking to develop a new information system and is working with Boston-based deNovis Inc. to do so. "Together we will create a state-of-the-art system for operating an HMO," says Berman. "The system will include everything from a claims engine to real-time interaction with physicians' offices to

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—Harris A. Berman, MD, Tufts Health Plan

approval." Berman, who graduated from Harvard College, received his medical degree from Columbia University's College of Physicians and Surgeons and completed an internship in medicine at the New England Medical Center in Boston.

When Berman was named CEO of Tufts Health Plan in 1986, the plan had 60,000 members. While beefing up enrollment, Berman also has helped lead the development of a number of the plan's programs aimed at improving the quality of care physicians and other providers deliver.

To show how the health plan works with physicians, Berman describes how plan administrators introduced report cards on physicians last year. "The report card tracks not only patient satisfaction information, but also rates of breast cancer screening, cervical cancer screening, and diabetic eye exam screening," Berman explains. "The information is posted on our Web site (at www.tuftshealthplan.com) and is available to everyone. At this point, the information is given by provider groups and not by the individual

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give physicians updates on when individual patients need repeat screenings. Most health plans are operating on legacy systems that are 20 to 30 years old, as we are. Our system was built in the 1980s, but it was based on 1970s architecture, and we are trying to run a \$2 billion business on it.”

The new system will enable the health plan to introduce a number of innovations, such as collecting information from doctors over the Internet and paying them electronically, thereby eliminating the paper-based system

information that we have from our claims data to help doctors offer higher quality care. For instance, if Mrs. Jones arrives at the office and the staff swipes her member card so that the system can confirm that she is a member of the Tufts Health Plan, the system will also be able to indicate that she has not had a mammogram in the last three years.”

A fellow of the American College of Physicians, and a clinical professor of medicine and of community health at Tufts University School of

ple elect to get routine care at very expensive teaching hospitals. Costs at an academic medical center run between 60% and 100% above those of community hospitals.”

To address the health care cost issue, Tufts has been one of the leaders in using a tiered health plan product, which assesses a surcharge on patients who choose to be treated at teaching hospitals. “The product requires a larger copayment for people who elect to go to teaching hospitals for their care,” Berman

“If we can automate systems for physicians so they don’t need as many office staff, we will help them reduce expenses and offer real hope to physicians that they can make it financially in managed care, not necessarily because reimbursement will increase but because expenses will fall,” Berman says.

that delays payments. The system will auto-adjudicate claims, speeding payment to providers and removing some of the hassle of dealing with MCOs, Berman notes.

Reducing Overhead

What’s more, the new system will also reduce overhead in the physician’s office, Berman continues. “Health plans can whittle away at their own operating costs, but they are causing doctors a lot of pain,” he says. “If we can automate systems for them so they don’t need as many office staff, we will help them reduce expenses and offer real hope to them that they can make it financially in managed care, not necessarily because reimbursement will increase but because expenses will fall.

“We are also hoping that the system will help the doctors by providing information that they may not have readily at their fingertips but can help them enhance their quality of care,” continues Berman. “We are looking into coupling the clinical

Medicine, Berman has long been committed to helping to provide affordable, quality care. He co-founded one of New England’s first HMOs, Matthew Thornton Health Plan in New Hampshire, and one of his first initiatives there was to develop an outpatient intravenous antibiotic program for patients with chronic infections. The program later became a standard practice nationwide.

But providing quality affordable care may be a bigger challenge in Massachusetts than it was in New Hampshire because Boston is home to a number of teaching hospitals. Statistics show that 40% of Boston’s patients go to teaching hospitals for their care, compared with 18% nationally. Such market activity can pose problems for HMOs.

“The presence of so many teaching hospitals is clearly the reason health care is more expensive in Boston than anywhere else in the world,” Berman explains. “The high costs of care here are not driven by the unit cost of care, but by the fact that peo-

ple elect to get routine care at very expensive teaching hospitals, and it will be interesting to see how it works. The hope is that the surcharge will prompt a change in consumer behavior. We want consumers to think twice before they decide to get their hernia fixed at a famous teaching hospital, as opposed to going to a community hospital and being treated by a surgeon who has been doing this operation for 25 years and is very good at it. Community hospitals, and the physicians who practice in them, provide excellent care.”

Academic Understanding

Still, the cultural issues involving managed care and academic medical centers remain. Three years ago, Harvard University researchers reported in the *New England Journal of Medicine* the results of a survey in which they found a universally negative view about managed care among deans, heads of residency programs, professors, and medical students. The negative attitude toward managed

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sions may result in fewer patients leaving the office feeling they were not provided a needed service.

In fact, patient frustration or disappointment could signal a potential legal problem. "Risk appears related to patients' dissatisfaction with their physician's ability to establish rapport and communicate effectively," says Gerald B. Hickson, MD, and his colleagues at Vanderbilt University School of Medicine in an article in *JAMA* (June 12), in which they examined the association between patients' complaints and doctors' risk management experience.

These issues raise the question: Why is dialogue so difficult? "Most medical training involves learning about disease, but much of the time, we also deal with the person wrapped around the disease," says Frederic Platt, MD. "Pathophysiology encompasses all the sciences related to disease. The science of dealing with the rest of the person is communication." Platt, a general internist in Denver, teaches communication skills at the University of Colorado School of Medicine.

Acquiring Better Skills

Fortunately, the essentials of good communication—such as listening, understanding, exchanging information, and showing empathy—can be learned, and more courses are being offered to physicians who are choosing to acquire them.

The Bayer Institute for Health Care Communication Inc. in West Haven, Conn. (at www.bayerinstitute.com), the leading firm in this specialty, has trained more than 40,000 clinicians and health care staff since 1989. "Compared with an unskilled communicator, who frequently will not get

significant health problems to surface, a truly skilled physician will get different diagnostic information," says the institute's associate director Vaughn Keller, EdD. "Communication also affects adherence to a therapeutic regimen because the doctor never really talked it through with the patient. Skilled communicators can have a tremendous impact on whether a patient makes lifestyle changes." Keller also is a lecturer at the Yale University School of Medicine.

Platt concurs. "Too often, doctors get the story wrong," he says. "Asking a patient, 'Was the pain more on the right side or the left side?' helps lead to a correct diagnosis, which is critical to treatment. People want to be heard and understood. Patients feel better right away if you give feedback showing your understanding and confirmation. The key value of better communication is improving the quality of patient care and the likelihood of a good outcome."

Stephen Zebrowski, MD, a general internist in Plainville, Conn., has a private practice affiliated with ProHealth Providers, an 80-office group practice in Middletown, Conn. He, too, is pleased to see higher compliance rates and better quality of care as a result of taking a communication course. "It takes less time to listen initially than to have patients come back in deteriorating condition and not get better," he says. "If people are comfortable calling you, they'll come for treatment earlier than they might otherwise."

Last year, staff turnover was 33% at ProHealth, which has 200 providers throughout central Connecticut. Since communication training began last November, turnover is down by

50%. "We were very pleased," says Zebrowski. "It's so expensive to recruit and train new staff. We have to make staff retention a company priority."

Communication training at ProHealth involves all physicians and staff at each facility. The atmosphere in the office has been enhanced as a result of more harmonious communication between physicians and staff, and the increased harmony has had a strong influence on patient satisfaction and retention, Zebrowski says.

Negative Implications

When a patient is dissatisfied, the reason for the dissatisfaction likely can be traced to poor communication, and if the practice loses the patient as a result, it also can lose all of the potential referrals the patient could have made otherwise, says Susan Keane Baker, author of *Managing Patient Expectations* (Jossey-Bass Publishers, San Francisco, 1998). A health care consultant who specializes in service quality and patient satisfaction, Baker believes one of the biggest stumbling blocks to improving physician-patient communication is that patients may be reluctant to voice complaints because they fear being perceived as difficult. "Without being asked, they may not share important information," Baker explains.

Recognizing that good communication can improve a physician's legal standing with patients, Physicians' Reciprocal Insurers (PRI) of Manhasset, N.Y., a medical malpractice insurer, has offered communication training to the physicians it insures. "Our principal reason is to support our doctors in their practices," says Marjorie Thomas, a spokesperson for PRI (at www.primedmal.com).

Physicians find that communication training can lead to more accurate diagnoses, better patient compliance, higher retention rates, and more referrals, among other benefits.

Resources for Readers

For more information about communication training programs, physicians may call their malpractice insurer, medical association, or affiliated hospitals. Communication training is also available through the following:

- American Academy on Physician and Patient in McLean, Va. (at www.physicianpatient.org or 703/556-9222) is dedicated to research, education, and professional standards in patient-doctor communication. The academy has physicians who teach

communication skills to medical school faculty.

- Susan Keane Baker, a consultant and communication trainer in New Canaan, Conn. (at www.susanbaker.com or 203/966-4880), is also author of a report entitled, *100 Ways To Make Your Organization More Patient-Friendly*.
- The Society of Teachers of Family Medicine, in Leawood, Kan. (at www.stfm.org or 800/274-2237), was established in 1967, and has more than 5,000 teachers of family medicine. —CM

“Diagnosis and treatment rest in large part on communicating with a patient. We believe—and the data support this belief—that a physician who is better able to communicate will find more adherence to treatment. The literature points to minimized instances of malpractice, and we believe it will help to decrease the number of malpractice cases.”

The training, part of PRI's Risk Management Education program, allows a physician to earn a 5% premium credit for completing both the workshop and the follow-up home study. Similarly, Colorado Physicians Insurance Co., in Denver, also considers good communication essential and encourages its insured doctors to attend communication workshops. Physicians then get a reduction in premiums of about 5% upon completion.

Training Options

Communication training ranges from a few hours to week-long workshops. When changing communication behavior, participants need a course that is not unlike language training, says Keller. To improve skills, all trainers stress the necessity of role-playing, practice, and feedback. Listening exercises are crucial. Programs can be offered through hospitals, national and state medical associations, and insurers, or at a training firm's facility. Large group practices sometimes hire a

trainer to present an on-site program to physicians and other staff. Some individual trainers, such as Baker, will work with a small group practice staff of six or more employees, in sessions of several hours.

CME credits may be available as certified by the Accreditation Council of Continuing Medical Education, for example. The American Academy of Family Physicians gives credit to members who take a recognized communication course. Some training programs provide credit that meets state risk management requirements or count as points in a particular insurer's system.

Fees vary widely. Bayer's one-week program costs \$2,500, which includes all materials and most meals. When presented by a sponsoring organization (such as the American Academy of Orthopedic Surgeons or PRI), the same communications workshops are usually free to participants. In addition to providing instruction, the sponsoring group typically covers the cost of materials and CME credits.

To measure improvement in communication skills, physicians can use a patient satisfaction survey. “Our data show that 75% of people in the one-week program jump at least one quartile on surveys; 40% jump two quartiles,” Keller explains. Patient satisfaction surveys are also an excellent diagnostic tool.

Personal Rewards

As a result of her research, Keating, a primary care general internist at Brigham & Women's Hospital in Boston, tries to be more aware of how she interacts with patients. “I try to identify what their expectations are during a particular visit or conversation,” she says. “At the start of each interaction, I say, ‘Tell me what's on your mind today,’ which gives the patient the chance to shape the agenda.” Before her research, she was less conscious of trying to elicit a patient's concerns; she believes she is far better at doing so now. “My belief is that it will make my patients trust and respect me more, have more faith in my recommendations, and come to see me more freely,” Keating says.

Nephrologist Husserl, too, is more concerned about ensuring that each patient is heard. “How many times do I leave a patient with the sense that our relationship is sour or strained?” Husserl asks. “Almost never. I may have time pressure, but no feeling of a situation I really can't handle. Communication skills have given me the satisfaction of making medical practice pleasant, and the control and confidence to handle difficult issues that come up with patients.”

—Reported and written by Carol Milano, in Brooklyn, N.Y. More information on physician practice strategies is available on our Web site (see page 16).

“We work with physicians to teach them how to manage senior patients, how to operate their offices, how to make their offices senior friendly, and how to keep appointments available so that seniors don’t simply go to the emergency department,” says Berman.

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care among those in academia can be a difficult cultural barrier for an HMO to address.

“This negative attitude results from many misperceptions about managed care and what the alternatives to it are,” Berman notes. “For example, people may believe that a single-payer system will solve the health care industry’s cost and quality problems, but it is not at all clear that either the public or physicians would like a single-payer system. Certainly the physicians in Canada are not very happy with their single-payer system, even though Canada is very proud—and should be—of the fact that 100% of the population has coverage. And many physicians in England migrated to Canada and the United States to escape their systems.”

Exposing Negative Views

Although the participants in the Harvard survey had a negative view of the quality of managed care, they had practically no firsthand exposure to managed care and no training within a managed care system, Berman notes.

“At Tufts, we have tried to do something about this problem,” Berman explains. “We funded the start-up and much of the continuing cost of an organization called the Tufts Managed Care Institute (www.tmci.org), located at the Tufts University School of Medicine. This is an academic institute that employs nine full-time staff members who develop materials and promote them for use in medical schools and in residency programs to teach physicians-in-training what managing care is all about. Residency programs are very

interested because they are required to train residents in certain aspects of managed care, and the medical board exams include questions on managed care. Interest at medical schools has been somewhat spotty. Most medical school faculty members do not have a lot of experience in the financial aspects of practice.”

Managing Senior Risk

One of the biggest challenges for any health plan is providing quality, affordable care to seniors. Since 1994, Tufts has administered a Medicare-risk product, Secure Horizons. “Secure Horizons has been a very successful program for us,” Berman says. “Years before, we had been involved in a Medicare-risk contract on which we lost a lot of money and pulled out in 1988. But by the mid-1990s, we decided that we ought to be back in this market because we were much bigger, and we knew that it would be an appealing program to seniors.”

To develop expertise in the senior care area, Tufts formed a partnership with PacifiCare in Santa Ana, Calif., which operates one of the largest Medicare-risk programs in the country. “We have a license to use the name of its product, Secure Horizons, and PacifiCare assists us with its management,” Berman explains. “I attribute a lot of our success in this area to the things we learned from PacifiCare about how to manage risk profitably, and ensure high quality of care, for the Medicare population.”

And, once again, the health plan was concerned about how physicians would respond to the program. “We

made participation totally voluntary,” Berman says. “The primary care doctors who participate are very heavily capitated, so they are at risk. We and PacifiCare work with them to teach them how to manage senior patients, how to operate their offices, how to make their offices senior friendly, and how to keep appointments available so that seniors don’t simply go to the emergency department. This helps the physicians manage the contracts profitably and ensures that they are offering high-quality care to seniors.”

A Continuing Challenge

Today, Tufts’ Secure Horizons provides insurance coverage to more than 105,000 members. “Although in the last two or three years membership has not grown, it has not shrunk the way other health plans have, and we have not had to vacate any markets,” says Berman. “But the product remains a challenge because Medicare continues to increase reimbursements each year by only 2%, while our costs increase 8% to 10% annually.”

While Tufts has been developing solutions to some of the most difficult issues in health care, Berman remains wary about the future. “I know that with health care prices going up at double-digit rates, there is a crisis brewing,” he says. “I don’t know what the answer to it is because there is no magic solution. We simply must continue to innovate at managing care, to control costs while assuring quality.”

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

Internet Helps Physicians Improve Efficiency, Compete Effectively



Tom Ferguson, MD, is a senior research fellow for online health at the Pew Internet & American Life Project, in Washington, D.C. (at www.pewinternet.org). He is also editor

and publisher of The Ferguson Report (at www.fergusonreport.com), a free newsletter that is published, Ferguson says, at unpredictable intervals for his friends and associates. An adjunct associate professor at the University of Texas' School of Health Information Sciences, Ferguson received his medical degree from Yale University. He lives and works in Austin. Editor in chief Richard L. Reece, MD, discussed with Ferguson the Internet and its effect on practicing physicians.

Q: When we last spoke in December 1999, you remarked that many physicians were not using the Internet. Has that situation changed?

A: Many more physicians are using the Internet now. Two thirds of them use the Web daily, and the average number of hours that physicians spend online each week has been steadily increasing, from 4.3 hours in 1997, to 7.1 hours in 2001.

Q: What effect has the Internet had on health care in that time?

A: There seems to be much more interest in reconsidering some of the basic aspects of medical care. Open the newspaper on any given day and you may find an article about pervasive medical errors or about another state that's posting doctors' malpractice records on the Web, or other critiques of the health care system that go far beyond what we have seen in the past.

When we last spoke, the Institute of Medicine had just issued *To Err Is Human: Building a Safer Health System*. Since then, we've seen a growing willingness to examine health care's deficiencies and to consider serious reforms. And more physicians are realizing that a growing number of patients are using the Internet for health care information and to communicate with physicians, which is having a major effect on the doctor-patient relationship.

Q: You're now writing a report about online consumer health information for the Robert Wood Johnson Foundation, in Princeton, N.J. How did you begin working with the foundation, and what is the nature of your project?

A: Over the past few years, several of the staff of the Robert Wood Johnson Foundation attended my lectures and workshops. Last year, a group of the foundation's staff asked

Q: What is the proposed title of the report that you are writing?

A: Right now, the working title is *Online Health and the Search for Sustainable Health Care*. I'll be working with a team of advisers who are experts in various aspects of online consumer health. So our final product will be a synthesis of the perspectives of many of the pioneers and leading thinkers in this area. The report will be distributed for free over the Internet when it's completed early next year.

Q: How much do we know about the ways patients are using the Internet for health care services and information?

A: My colleagues and I at the Pew Internet & American Life Project have done research on this question. Here's some of what we've found so far:

Seventy-three million American adults use the Internet to look for

“Seventy-three million American adults use the Internet to look for health information, up from 52 million in the fall of 2000. About six million Americans do so every day, which means that more than twice as many people seek health care information online every day as go to see their doctors.”

me to help them identify and understand some key trends in this area. They also wanted me to suggest ways in which RWJ or other foundations might make a useful contribution to online health. So I'm currently writing a white paper for them.

health information, up from 52 million in the fall of 2000. About six million Americans do so every day, which means that more than twice as many people seek health care information online every day as go to see their doctors. These e-patients use

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“Even though most doctors won’t send e-mail to their patients, it’s not too hard for Internet-savvy e-patients to find a doctor who is willing to answer their questions online. Eventually, it may be that doctors who refuse to exchange e-mail with their patients will have a hard time getting patients.”

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the Internet to research prescription drugs, to explore new ways to control their weight, to prepare for their doctor’s appointment, and to read about many aspects of health conditions after they see their doctor. Many say the Internet has helped them or someone they know. There have been very, very few reports of e-patients being harmed as a result of acting on bad information they found online.

Women are more likely than men to look for health information online. The typical e-patient starts her hunt for medical information at a general search site, not a medical site. On average, she visits two to five sites each time she goes online. She usually spends 30 minutes or more on each search. She feels reassured by advice that matches what she already knows about a condition and by statements that are repeated at more than one site. And she typically turns away from sites that seem to be selling something and those that don’t clearly identify the source of their information. About one third of health seekers who find relevant information online bring it to their doctor for a final quality check.

Last time they searched for health advice, 81% of e-patients started at a search engine or used the search function of a general portal, such as the Yahoo home page, the Microsoft Network, or America Online. Among seekers of health information, 15% started their search at a site that specializes in health information, most commonly WebMD (at

www.webmd.com). Of those who used a search engine, 45% started at the top of the search results and worked their way down; 39% read the results list and then clicked on the items that seemed most relevant; and 12% clicked on certain sites because they recognized the sponsor or the name.

Among e-patients, 82% say they find what they are looking for always or most of the time.

Q: *Doctors seem wary about using the Internet to communicate with patients. Will you address this in your Pew report?*

A: We certainly will. One section of the report will focus on both electronic communication between physicians and patients and the online patient services some health care systems are beginning to develop. One interesting finding is that even though most doctors won’t send e-mail to their patients, it’s not too hard for Internet-savvy e-patients to find a doctor who is willing to answer their questions online. Eventually, it may be that doctors who refuse to exchange e-mail with their patients will have a hard time getting patients.

Q: *What types of online interactions occur between physicians and patients?*

A: Physicians who are experts in their area will often answer questions in their specialty. For example, a mother may send an e-mail question to a doctor who is a specialist on pediatric gastroenterology because her daughter has an

intestinal problem. And it turns out that such experts can, in as little as three or four minutes, provide very useful information.

Another type of doctor-patient interaction is represented by a site run by a physician who is helping with our Pew report: Alan Greene, MD, a pediatrician at Stanford University Hospital. Greene runs a site (at www.drgreene.com) that he developed to provide his patients with additional information that he did not have time to give them in the clinic. The site now gets more than 2 million visits a month, and Greene spends an hour a day answering questions in a chat room on his Web site.

Q: *How should physicians respond to the increasing consumer use of the Internet for medical research?*

A: Physicians should ask their patients if they’ve used the Internet to research their medical concerns, and physicians should encourage and support these online searches. Such searches clearly do a lot of good and very rarely cause harm. Physicians should also ask patients what information they found in their searches and what they think about it. This is a wonderful entree into answering their patients’ questions and helping them understand their condition.

In certain cases, such as with patients facing a new diagnosis of a complex or serious disease, a physician might suggest that they could benefit from learning more about their condition online or from joining an online support group for their

condition. Online support groups can be a godsend for patients who face life-threatening conditions. And if they haven't done so already, I'd advise physicians to try exchanging e-mail with one or two patients, just to get their feet wet. Doctor-patient e-mail is going to be a very important part of our medical future.

Q: *Can physicians use consumer interest in the Internet to enhance their income?*

A: They certainly can. Want to double the size of your practice? Just let all your patients know that you'll gladly answer their e-mailed questions—and all of their friends' e-mailed questions—for free. The big surprise here is that they won't abuse the privilege, it will take only a few minutes per week, and many of those who send you questions will end up in your examining room. And if you feel you'd need to get paid for your e-mails, check out the new system run by Medem (at www.medem.com), which lets you bill to the patient's credit card.

Q: *You seem particularly interested in the patient's point of view. Why is that?*

A: Nearly all health professionals look at the medical enterprise from the professional's point of view. But since most of us professionals share the same perspective, we tend to overlook anything that doesn't occur within the clinical encounter. This is actually a fairly small part of our health care system. If we limit ourselves to this perspective in trying to develop a vision of the next health

care system, we start with both hands tied behind our back.

Q: *Can online communication be a more efficient way for patients to obtain health care?*

A: It can be a much more effective way to communicate with a physician. Many of the questions patients have are relatively simple. So if they can get a quick answer without coming to the office and wasting half a day of their time, so much the better.

Q: *Your newsletter offers tips for e-patients for online health searching, such as "don't search alone." Should searching for online health information be a collaborative effort on the part of patients and other family members or friends?*

A: It often is. In the beginning, when people are just learning how to do online searches, they often get help from a friend or family member. When they're dealing with a serious illness, they often rely on online support communities. Many experienced e-patients spend most of their time on the Internet communicating with other people, e-mailing friends and family members, connecting with members of their online support communities, or e-mailing online health professionals or the Web masters of their favorite sites.

Our Pew report will describe the phenomenon of the online patient-helper. These are e-patients who have reached a certain level of mastery and knowledge about their own health concerns and have found a way to make themselves available to

help others with similar concerns.

Q: *Do you know of any medical schools that are putting e-health in their curriculum?*

A: There are a few. I recently lectured at a class in online medicine sponsored jointly by the Massachusetts Institute of Technology and Harvard Medical School. But, in general, the young men and women who are medical students today already know much more about the Internet and how to use it than their professors.

Q: *What other important trends will physicians see?*

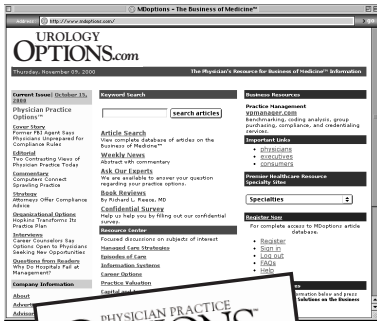
A: A lot of physicians are walking away from their previous jobs in complex health care systems to open small, innovative practices—some of them in storefronts—that rely heavily on physician-patient e-mail. There are all kinds of variations, but most of the developing models bring the doctor and the patient back together directly, bypassing insurers as much as possible, and cutting out many layers of bureaucracy.

The people who designed the Medem system of physician-patient e-mail understand these trends. I will be watching these new models of medical practice with great interest. Some of these pioneering physicians will help us discover what we need to do to drag our old industrial age health care system, kicking and screaming, into the information age.

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

“Want to double the size of your practice? Just let all your patients know that you'll gladly answer their e-mailed questions—and all their friends' e-mailed questions—for free. The big surprise here is that they won't abuse the privilege, it will take only a few minutes per week, and many of those who send you questions will end up in your examining room.”

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