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Consumer-Driven Care May be Dramatic

The age of consumer-driven care is upon us and cannot be ignored. That's the opinion of observers who cite a rising number of examples of insurers that are developing these plans for their employer customers who want them for their workers. Among the major national insurers that have developed these plans are Wellpoint, United Healthcare, Aetna, Cigna, and Humana. These insurers are offering high deductible plans linked to health savings accounts and employers are offering these plans (also known as consumer-directed health plans or CDHPs), along with more traditional HMOs and PPOs. So far, more than one million Americans have chosen to participate in such plans.

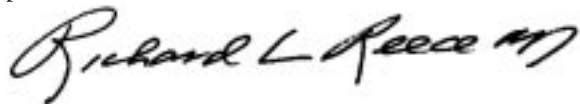
Jayne Oliva of The Croes-Oliva Group, a consulting firm in Burlington, Mass., says the changes that are coming as a result of these plans will have a significant effect on physician practices. Patients will seek and evaluate physicians using data available on the Internet to compare one physician against another and to monitor the quality of their care, she says. Also, since consumers will be spending their own money, they will have greater expectations and will demand practice efficiencies such as same-day access, no waiting time, and convenient hours.

The structure of care will change as well because patients will pay using debit cards, and the use of e-mail consults and telemedicine will rise, Oliva continues. Physicians and other providers will develop customized care centers, sometimes called "focused factories," to provide care for patients with chronic diseases. Investments in information technology will be imperative for survival.

While physicians will need to make some changes to accommodate these new plans, many are likely to appreciate some of the aspects of consumer-driven care. Caring for patients under a consumer-driven system, for example, may eliminate many of the burdens of pre-authorization and other forms of health-plan sponsored micromanagement. Also, health plans and banks are developing cards that contain information on each patient's health savings account (HSA) fund reserves and electronic health record, meaning physicians may see improved cash flow if they get paid at the point of care.

To take full advantage of such sophisticated technology, physicians would need to invest in information systems capable of managing electronic medical records, swipe cards, and allowing for communication with patients over the Internet.

Like any of the other major shifts in care processes that have occurred over the past 20 years, the change to a consumer-driven system is likely to be fraught with challenges for physicians and office staff. Fortunately, the resulting changes are likely to be mostly positive from a physician's point of view even if difficult and challenging during the transition from what we have now to what will be in place in the future.



Richard L. Reece, MD

Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

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Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

Neil Baum, MD

Urologist
New Orleans

Daniel Beckham

President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD

President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA

Executive Vice President
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD

Allergy & Asthma Specialists, PA
Minneapolis

Nathan Kaufman

President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley, PhD

Executive Director
Vanderbilt Center for
Evidence-based Medicine
Nashville, Tenn.

Peter R. Kongstvedt, MD

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President and CEO
Peak Performance Physicians, LLC
New Orleans

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Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD

Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

James M. Schibanoff, MD

Editor in chief
Milliman Care Guidelines
Milliman USA
San Diego

Jacque Sokolov, MD

Chairman
Sokolov, Sokolov, Burgess
Scottsdale, Ariz.

Preparing Patients—Not Just Bowels—For Colonoscopy

Certainly gastroenterologists are concerned about whether each patient is physically prepared for a colonoscopy. But should they also be concerned about whether their patients are mentally prepared as well? The answer is an unqualified, “yes,” given that patients who are anxious about the procedure may not follow bowel-prep instructions carefully, and in some cases, excessive anxiety may make the procedure itself more difficult.

“For patients with a very high anxiety level, an ounce of prevention is worth a pound of cure,” says Michael Oblinger, a gastroenterologist with Charlottesville Gastroenterology Associates, a six-physician single-specialty group in Virginia. “Patient anxiety and concern should be addressed before the appointment whenever possible. It is frustrating to both gastroenterologists and patients to schedule the procedure, go through the preparation and then not be able to obtain an adequate test because the patient didn’t understand the directions.”

Improved Understanding

Amy McDonnell, FNP, a nurse practitioner with Charlottesville Gastroenterology Associates, believes that providing thorough patient education before the colonoscopy is vital. “The more they learn, the more reassured they are,” she says, adding that patient education programs not only relieve anxiety, but also prevent misunderstanding of written materials and ensure that all patients receive the same information.

Two discrete groups of patients obtain colonoscopy, and while the actual patient education is the same for both groups, Oblinger notes that it

is useful to understand the different perspectives. “The first group includes patients who are experiencing symptoms, such as rectal bleeding or abdominal pain, and are seeking information as to the cause,” he explains. “These patients do not need to be convinced of the value of the test, and they are highly motivated to do the bowel prep correctly. Even more important, they are in the office to discuss their problem and concerns.

“The second group includes asymptomatic individuals who are undergoing colonoscopy for the purpose of colorectal cancer screening,” Oblinger continues. “This group is also highly motivated. After all, they are seeking the test. But especially in a common open access system, these patients may not have the same

In a study published in the *American Journal of Gastroenterology*, in June 2001, researchers demonstrated the cost effectiveness of pre-endoscopy education. The study population included 142 patients scheduled for colonoscopy, flexible sigmoidoscopy, or upper endoscopy. Ninety-one patients (64%) participated in a formal patient education session conducted by a nurse, 38 (27%) received written instructions only, and 13 (9%) received instructions via telephone. The researchers found that cancellations of procedures due to poor preparation occurred in only 4.4% of the patient-education group, compared with 26.3% in the written-instruction group and 15.4% in the telephone-instruction group. As a result, the overall costs for patients who partici-

Researchers found that cancellations of procedures due to poor preparation occurred in only 4.4% of a patient-education group.

opportunity to address their concerns face to face, and may be more likely to let their anxiety affect either their bowel prep or the follow-through with their scheduled appointment. This requires greater effort by the staff on the phone and that written instructions are especially clear.”

“If the colon is not clean enough to allow unobstructed views, the procedure will have to be postponed,” McDonnell points out. “Repeated examinations result in increased risk to the patient. Furthermore, cancelled exams cause additional office visits, phone calls, staff time, use of medications and equipment, and missed work or school days.”

pated in the patient-education program compared with patients who received written instructions only were 8.6% lower for upper endoscopy patients, 8.9% lower for colonoscopy patients, and 5.5% lower for flexible sigmoidoscopy patients.

Oblinger’s practice has researched optimal bowel prep methods. “Patients must follow the timeline for taking the portions of the preparation formula, so we go to great lengths to make sure they understand the instructions,” he says. “After all, it won’t matter how excellent the bowel prep method is if the patients don’t follow the instructions.”

Oblinger and his colleagues choose

(Continued on page 4)

In Practice, Open Access Presents Challenges

Given the rising costs of health care and the demand for colonoscopy, open-access colonoscopy, which involves scheduling a colonoscopy without prior gastroenterologist consultation, is becoming more common. While open access colonoscopy is undeniably a positive trend, it presents challenges for patient education.

"The concept of open-access colonoscopy has changed the way gastroenterologists practice medicine," says Michael Oblinger, MD, a gastroenterologist with Charlottesville Gastroenterology Associates in Virginia. "In the past, we talked with the patient first, and we could see if they fully understood the preparation instructions or if they were concerned or anxious. With open access, we may not see asymptomatic people before the day of the procedure."

Up to 60% of Charlottesville Gastroenterology's colonoscopy patients are scheduled through the open-access system. "Open-access patients simply obtain a referral from a primary care physician," explains Amy McDonnell, FNP, a nurse practitioner with the practice. "They speak to a coordinator, who performs an initial screening and reviews preparation instructions over the telephone. Patients then receive a printed copy of an instruction sheet with preparation steps and times."

Under this system, the role of the nurse or nurse practitioner on the telephone becomes especially important. "That contact person needs to be understanding, calm, and gentle as well as being able to clearly explain the procedure and pre-procedure preparation and adequately answer patient questions," Oblinger says. "In addition, to ensure patient compliance, the pre-procedure instructions should be in written form so that they can be mailed to the patient."

The group is interested in studying the effect of open-access colonoscopy on patient preparation. The practice plans to compare colonoscopy patients scheduled the traditional way with open access patients on measures such as bowel preparation, patient anxiety, and appointment cancellations.

—DJN

(Continued from page 3)

one of four preps for their patients, based on individual patient circumstances, although two are most commonly chosen. In addition to verbal instructions about prep solution use, medication use, and food intake, written instructions are provided in a checklist; the list includes a timetable along with information about what to expect at each step.

Procedural Issues

Oblinger is less concerned about patient anxiety at the time of the

procedure, because the gastroenterologist can help to control it. "Generally, a gastroenterologist can get a patient through this," he says. "But it is more difficult to insert the IV and more sedation is required for a patient who is extremely anxious, so it is better if the patient arrives in a good frame of mind."

Pre-procedure assessments determine any underlying conditions, including those that may be exacerbated by anxiety. "When patients come in with a serious comorbid con-

dition such as severe hypertension or cardiovascular compromise, we advise them to postpone colonoscopy and follow up with their regular doctor so that these issues can be evaluated first," McDonnell says. "Safety is always our primary concern."

Several factors can affect the procedure if instructions are not followed, McDonnell comments. "For example, we may not be able to remove a polyp from the colon if a patient has not stopped Coumadin before the procedure," she says.

For some patients, anxiety will have a physical manifestation making it more difficult to pass the scope. "Anxiety can certainly limit the gastroenterologist's ability to get a good exam," Oblinger says. For example, patients with irritable bowel syndrome have a more spastic colon, making the exam difficult.

Monitoring performed during the procedure can help identify patient anxiety. "If a patient is otherwise healthy, an elevated blood pressure or pulse is likely anxiety-related," Oblinger notes, adding that pharmacological and non-pharmacological interventions are appropriate. "The physician then must match the sedation to the anxiety level. Good nurses will also talk to patients, rub their backs, and otherwise help them feel secure during the procedure."

In Oblinger's practice, the gastroenterologists have consistently seen patients whose bowels are cleaner than they were several years ago, thanks to patient education. "We explain to patients exactly what they need to do," he says. "This has enhanced the adequacy of the preparation, which is a major factor in the adequacy of the procedure itself."

When a gastroenterologist in McDonnell's practice recommends colonoscopy to a symptomatic patient, he or she or a nurse practitioner thoroughly reviews the details of the procedure, including the pre- and post-procedure processes, risks, and alternatives, she says. "After the patient

schedules the procedure, he or she views an eight-minute video that explains colonoscopy, then meets with a nurse who reviews the procedure again and explains the necessary preparation in detail," she explains. Asymptomatic patients who have not previously seen the gastroenterologist are also given this opportunity. "In addition, we have a nurse who has actually had colon cancer that was detected on colonoscopy, and she is always willing to meet with patients who seem especially anxious or reluctant," she adds.

Important points before a colonoscopy include colon cleansing preparations; dietary instructions; medication instructions; the use of sedation; timing of the procedure and recovery; the need for a driver; typical post-procedure symptoms; and alarming symptoms that should prompt a call to the physician or an emergency room visit, McDonnell says.

Patient disinterest and excessive questioning are both markers of anxiety. "Patients who do not want to hear about the procedure are probably not paying close attention and therefore may not follow instructions properly," McDonnell says. "Patients who ask many questions, including questions that have already been answered, are probably doing so out of concern. Both types of patients need extra support."

This support can come from a primary care physician as well. Gastroenterologists can encourage their PCP colleagues to attempt to quell patient anxiety when making screening recommendations, thereby enhancing follow-through. "Our practice has an extraordinarily good relationship with most area PCPs," Oblinger notes. "They don't explain colonoscopy in detail, of course, but they do explain the value of colonoscopy and the general procedural steps involved. That kind of opening into the procedure is very helpful for gastroenterologists." The June 2001 study cited above found

that explanations from the referring physician (along with male gender and previous endoscopy) was associated with a low level of anxiety.

Issues to Consider

Good scheduling of the procedure also helps to minimize anxiety, McDonnell says. "We try to get people scheduled as quickly as possible," she notes. "We have found that the further out the procedures are scheduled, particularly for screening, the more likely the patient is to cancel."

The surrounding environment is also important. "Our endoscopy suite is a warmer, more comforting environment than that of the typical hospital," McDonnell says. "Our décor includes bright colors, and we have a fish tank in the waiting room. To reduce anxiety, we play music during

example, patients who are hungry or a little weak might appreciate a warm muffin or some crackers and juice. Make a telephone call after the procedure to see how the patient is feeling, and ask for feedback and for permission to share the feedback with the referring physician."

Success Factors

Oblinger agrees that gastroenterologists should be concerned about the patient's entire experience. "That experience will drive whether patients return to the practice, whether PCPs will continue to refer patients, and whether patients will recommend the practice to friends and family," he says. "We want the whole experience to be a good one, so that our patients will look back at their colonoscopy as a non-event."

"We have a nurse who has actually had colon cancer that was detected on colonoscopy, and she meets with patients who seem especially anxious or reluctant," says Amy McDonnell, FNP of Charlottesville Gastroenterology Associates.

the procedure and in the recovery rooms. In general, patients do seem to be less anxious about an office-based procedure than a procedure scheduled in the hospital."

Susan Keane Baker, a physician practice management consultant in New Canaan, Conn., and author of *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients*, (Josey-Bass, San Francisco, 1998) offers several other suggestions for minimizing patient anxiety and maximizing comfort. "Prior to the test, confirm the perception that care is coordinated by mentioning the referring physician by name," she says. "Once the procedure is over, continue to focus on patient comfort and satisfaction with the practice. For

McDonnell asserts that patient education and other steps to reduce patient anxiety definitely affect practice success. "Our patient satisfaction survey includes several questions that refer to the preparation process, including whether they received sufficient information and whether the provider spent enough time explaining the procedure," she says. "Patients are very grateful for the education we offer, and many report that they were referred by friends who had a good experience here and convinced them to come in."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 8).

Employment Contracts Need Scrutiny

By Andrew T. Hahn, Sr., and Rosemary Joyce

Upon graduating from medical school and completing his residency and fellowship, Richard Kildare, MD, (a fictional character) joined the Marcus Welby Medical Group of Gotham County as an otolaryngologist. As a condition to his employment, he was asked to sign an employment agreement that contained a number of restrictive covenants (see sidebar).

After working for the group for two years, Kildare wanted to start his own practice and found an office in the next town, Smallville. For the next several weeks, on his free time, he purchased equipment and furniture. The night before he submitted his resignation to the group, he gathered his patients' files and took them to his new office. He also copied a patient list containing the names, addresses, and phone numbers of all of the patients of the group. This list was locked in a cabinet in the group's office, but Kildare knew where the key was kept. After Kildare copied the patient list, he returned the original list to the cabinet and copied his appointment book of scheduled patients for the next year. The next day, he submitted his resignation and informed his colleagues to forward his mail and any phone calls from his patients to his new office. In addition, when he arrived at his new office, he mailed all of the group's patients an announcement informing them of his departure and new office.

Three days later, Kildare got a letter from the group's attorneys

demanding that he cease and desist from practicing otolaryngology in Smallville. Attached to the attorneys' letter was a copy of the employment agreement he had signed two years earlier. Kildare tossed the letter in the trash. Three days later, he received a court order temporarily restraining him from practicing otolaryngology in Smallville. At this point, Kildare called a lawyer, who said the court order was enforceable.

Limiting Factors

In the context of an employment agreement, a restrictive covenant, also known as a non-compete provision, is defined as a clause in a contract, which limits the contracting party after the termination of the contract from performing similar work for a period of time and within a specified geographical area. The laws on restrictive covenants vary by

impose strict and specific criteria for an enforceable restrictive covenant with respect to physicians. Texas, for example, requires that such a covenant must not deny the physician access to a list of his patients whom he has seen or treated within one year, must not prohibit the physician from providing continuing care to specific patients during the course of an acute illness, must provide access to certain medical records, and must contain a buy out provision for the physician. Several states, such as Colorado, have enacted statutes prohibiting restrictive covenants among physicians.

Most states, however, have declined to find restrictive covenants among physicians to be unenforceable, and the overwhelming majority of states have ruled that restrictive covenants among physicians are enforceable if found to be reasonable. In certain jurisdictions, such as New York, where

Courts will consider four factors regarding the enforceability of restrictive covenants.

state. While restrictive covenants tending to prevent a person from pursuing his or her vocation after the termination of an employment relationship are disfavored, they will generally be enforced if they are:

1. Reasonable,
2. Necessary,
3. Not harmful to the public,
4. Not unduly burdensome.

Covenants restricting physicians from competing with a former employer are common and generally acceptable in many states, so long as certain requirements are met. Many states recognize the different considerations affecting the enforceability of non-compete provisions in the medical profession. Indeed, some states

the restrictive covenant is included in an agreement between doctors, the interests of the employer have enjoyed careful consideration. The courts have enforced restrictive covenants against the departing doctors if the four-prong analysis has been satisfied.

Reasonable Protection

The more restricted the time and geography, the more likely that the courts will enforce the restrictive covenant. A six-month time restriction has better chances of enforceability than a five-year restriction. Likewise, a 15-mile radius restriction has better chances of enforceability than a statewide geographic restriction. The restrictions should be care-

Andrew Hahn is a partner in the litigation practice group and Rosemary Joyce is an associate in the labor and employment practice group in the New York office of Seyfarth Shaw LLP, a national law firm with more than 625 lawyers in 10 offices in the United States and Europe.

Flexibility Restricted

Here's the restrictive covenant that Richard Kildare, MD, signed when he joined the Marcus Welby Medical Group in Gotham County.

"The physician acknowledges that, as of the date of this agreement, he has no substantial sources of patients or referral sources. Physician further acknowledges that the medical group has been materially induced to enter this agreement in reliance upon the physician's express agreement to be bound by the restrictive covenant as set forth below. The physician also agrees that under the circumstances of this transaction, the following restrictive covenants are reasonable in extent, duration, and geographical scope. Accordingly, the physician agrees that in the event of the termination of the physician's employment with the medical group for any reason, the physician shall not, for a period of two years following the termination of his employment, without the written consent of the medical group, engage directly or indirectly, as principal, agent, or employee, in the practice of otolaryngology within Gotham County."

fully and specifically defined. Phrases such as, "the Smallville metropolitan area," as the geographic restriction can lead to unnecessary disputes as to whether a town falls within the scope of that location.

Assuming the covenant is reasonable in time and geographic scope, a court must further consider whether the covenant is necessary to protect the employer's trade secrets or confidential information including patient information and protect the employer's relationships with its patients that was developed over time and with expense.

A New Jersey court found that the employer had a legitimate interest in protecting himself "from erosion of his patient base resulting from the departing physician's practice at hospitals located in the restricted area." A recent decision from New Jersey's Supreme Court reaffirmed the hospital's legitimate interests including the protection of patient lists, patient base, referral base, and investment in the doctor's medical training while working at the hospital.

In Kildare's case, Kildare took patients' files to his new office. Because doctors, medical groups, and hospitals generally maintain such files with a

high level of confidentiality, courts do not challenge the employer's interest in this regard. With respect to patient relationships, courts are divided. On the one hand, the employer devoted substantial time and resources to develop its patient base. Moreover, as in the case of Kildare, some doctors did not bring any patients with them. If a doctor did bring a group of patients, he or she would most likely be allowed to take such patients to the next practice. This is informally referred to as the "What's mine is mine" rule. On the other hand, the patient should be able to select the doctor that he or she prefers. In other words, the patient cannot be forced to stay with a particular doctor. If the patient preferred to stay with the Gotham Medical Group, Kildare should accommodate the patient's wishes.

Courts will not enforce a restrictive covenant if some harm to the public results. In the context of medical professionals, the argument has been made that enforcement of the restrictive covenant would limit patients' choice of a physician, especially in a medical area that is deficient of physicians generally or includes physicians specialized in a particular field. The federal government can designate cer-

tain areas as a Medically Underserved Area (MUA) or as a Health Professional Shortage Area (HPSA). Such designations can be evidence of public harm if a physician could not practice in an area where he or she is the only specialist. However, the availability of nearby specialists can be sufficient to alleviate any possible public harm that could be caused by the enforcement of the restrictive covenant, even in some cases where patients would be required to cross state lines for treatment.

In the recent New Jersey Supreme Court case, the court considered carefully the public interest, specifically the negative effect of the 30-mile restriction that would preclude the restricted doctor from becoming one of two neurosurgeons available to provide emergency coverage at the new hospital, hereby "dangerously compromising" neurological treatment and evaluation in the emergency room there."

Undue Burden

The final prong of the analysis involves whether the enforcement of the restrictive covenant would be unduly burdensome to Kildare. The restrictive covenant prohibits him from practicing otolaryngology within Gotham County. Courts would not likely find undue burden if he had to move his practice to another county.

A medical practice is a business, and one of its most important assets is the goodwill that it enjoys with its patients. Such goodwill must be protected, and a detailed agreement with in-coming physicians can offer enormous protection. Conversely, if a doctor is required to sign an employment agreement he or she should review the restrictions carefully, and, if necessary, consult with an attorney familiar with the law of the relevant jurisdiction.

—More information on physician practice strategies is available on our Web site (see page 8).

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