

PHYSICIAN PRACTICE OPTIONS™

December 15, 2000

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Top Ten Trends for 2001

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

In the coming year, physicians may finally begin to find more satisfaction in practicing medicine than they have in the recent past. While managed health plans will continue to cause discontent among physicians in many markets, doctors nationwide are finding ways to practice more effectively and to use technology to their advantage to improve patient care and increase production while worrying a bit less about having utilization management teams questioning their decisions about patient care.

Based on our review of the news over the past year and our daily discussions with health care experts and physicians practicing in a wide variety of settings nationwide, we have compiled the following list of trends in 10 major areas. In addition, we invite readers to comment on these issues by visiting our Web site (www.MDoptions.com) or contacting the editor directly (see page 2). The trends are as follows:

1. Technology. Information systems and the Internet will continue to change how physicians practice medicine. Practical solutions that physicians develop will help solve complex office problems. Information systems that doctors can use at the point of care to capture data, code for billing and management systems, document care, and help reduce the number of claims that payers reject have the potential to change medicine significantly. These new information systems will use a combination of hand-held devices, desktop and laptop computers, speech recognition software, and the Internet to strengthen

medical practices by increasing revenue and reducing rework.

Physicians will rapidly gravitate to the Internet one step at a time as they gain confidence in specific applications that help them improve the quality of care they deliver and deepen their relationships with patients. As they become comfortable with these information systems, the mood of despair among American physicians will lift and begin to turn to optimism in part because doctors will regain a modicum of control over data at the point of care.

In fact, the Internet has the potential to turn health care upside-down. It is possible that some day health care will no longer be dominated by centralized institutions such as government payers, corporations, managed care organizations, academic medical centers, and hospitals. Instead, the Internet will allow patients to contract with physicians directly—although companies that will do so are just now enrolling patients. But in theory, physicians and patients could use the Internet to work together more closely than ever before.

The emphasis in medical data management will shift from comprehensive on-site mainframe systems to Internet-access devices such as palmtop computers, personal digital assistants (PDAs), and cell phones. Information systems companies will aim to provide tools to allow physicians to prescribe, code, refer patients to other physicians, and document services at the point of care. Speech-recognition systems, for example, will move to the forefront as a physician productivity tool,

READER
FEEDBACK

Visit www.MDoptions.com/toptrends
to rate and comment on the 2001 predictions.

(Continued on page 8)

Ranking Our 2000 Health Care Predictions

Since it is time to prepare our 2001 predictions, we believe it is appropriate to review the accuracy of last year's predictions, at least subjectively. On a scale of one to 10, in which 10 is the most accurate and one is the least accurate, we find we were correct in making most of our 10 predictions, but certainly not infallible. Here's what we said last year and where each prediction ranked:

1. Physicians' presence on the Internet will increase dramatically. Accuracy: eight. According to Medem Inc, a Web site (www.medem.com) for physicians that is affiliated with many of the largest medical societies, about 70% of U.S. physicians have Internet access in their offices, and 49% of these physicians use the Internet every day. Last year, we reported that 37% of physicians were using the Web.

2. Many health care transactions will be conducted on the Internet. Accuracy: five. Only 30% of physician practices have a Web site, and only about 10% use it for routine business transactions.

3. The use of hand-held computers will grow sharply. Accuracy: 3. This year, about 15% of physicians used hand-held devices for reference uses, such as storing drug information, but only 1% were using them for transactions, according to WR Hambrecht, investment bankers in San Francisco. By 2004, 20% of physicians will use them for transactions, Hambrecht says.

4. The number of procedures done in offices will continue to increase. Accuracy: 10. SMG Marketing Corp., health care consultants and researchers in Chicago, report that outpatient surgery is booming and will account for four of five surgeries performed by 2005.

5. E-mail communication with patients will become common. Accuracy: 10. A Medem survey shows e-mail use among physicians grew by 200% in the past year.

6. Pharmaceutical manufacturers will continue to contract with physicians for drug trials. Accuracy: 10. About 10% of doctors are participating in trials, and academic medical centers also are joining.

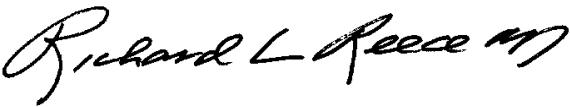
7. Some specialists will continue to do well. Accuracy: Six. The latest figures are from late last year and show that cardiologists earned \$367,000, ob-gyns \$272,000, orthopedic surgeons \$375,000, and urologists \$320,000. These figures have not changed significantly this year, experts say.

8. The Internet will let physicians outsource certain business operations. Accuracy: Three. Multiple e-health companies are saying they can help physicians cut overhead costs by 33%. We have yet to see convincing proof.

9. Physicians will become more mobile. Accuracy: unknown. We have no data to track this prediction, but recruiters tell us that business is brisk as many physicians seek better opportunities away from managed care markets.

10. Integrated delivery systems will continue to shed physician practices. Accuracy: Nine. About one-third of hospitals that have acquired practices are currently selling them, experts say.

At this time next year, we will evaluate how well we have done in making our predictions in this year. In the meantime, we invite comments from readers. If you would like to add your thoughts to ours, please feel free to call, send a fax or e-mail, or make a comment on our Web site (see page 16).



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Physicians Struggle With Pay Cuts

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

Among surgeons, complaints about managed care are quite common. Most surgeons share similar frustrations, particularly about declining reimbursement and loss of practice control. Yet until recently, the effect of managed care on the practice of orthopedic surgery had rarely been studied.

An article in *Arthroscopy* summarizes an analysis that illustrates the effect of managed care on the income of orthopedic surgeons. The analysis by Ron Clark, MD, an orthopedic surgeon in Valparaiso, Ind., and Norman Thurston, PhD, assistant professor of economics at Brigham Young University in Provo, Utah, shows that declining income due to managed care could cause the number of orthopedic surgeons to fall substantially below the number needed to meet patient demand and could limit the development of technological advances in the field. While the study analyzed the effect of managed care on orthopedic surgeons, there are lessons for physicians in all specialties.

"The most significant finding of the analysis is that despite a robust economy and an improvement in the standard of living for almost all Americans during the 1990s, orthopedic surgeons as a group have sustained an income loss of 10%," Clark says. "In select regions of the country, reductions of income have been greater than 30%. Many physicians—myself included—have responded to this problem by relocating our practices to areas of the country that are less penetrated by managed care. Some have even responded by retiring from medical practice."

Over time, the number of orthopedic surgeons will decline, Clark says. "We predict that this decline will occur as members of the baby boom generation enter their 60s and 70s, a time when the need for orthopedic services increases by as much as 600%," Clark explains. "These concurrent factors will result in a shortage of skilled

providers." What's more, a reduction in compensation could reduce the resources allocated toward innovation in orthopedics, he adds.

The impetus for the analysis came from Clark's own experience. "I practiced in Utah from 1992 through 1999, and saw my income begin to decline in 1995," he says. "In 1996 several health plans reduced payment levels by as much as 30%. Throughout the following years additional reductions were made such that overall payments were about 50% lower than pre-1995 levels."

In addition, Clark found the practice of exclusive contracting to be frustrating. "Plans favored negotiating exclusive contracts, which allowed only a few specialists in each specialty the opportunity to

as total joint replacement and arthroscopic surgery have helped to increase consumer demand for these services. Orthopedic surgeons themselves, who have invested time and money in research and development, have developed most of the innovations in orthopedic surgery in the past 20 years, Thurston says. These innovations have helped to improve outcomes and increase patient satisfaction.

Managed care has depressed income levels among orthopedic surgeons over the past decade, however. With the advent of HMOs in the 1980s, orthopedists were forced to accept discounts. "Rates were initially reasonable, reflecting the fact that HMOs were new to a market," Thurston explains. "HMOs needed

Despite a robust economy, orthopedic surgeons have sustained an income loss of 10%.

see covered patients," he explains. "Plans favored older, established physicians over younger, lesser-known physicians. By offering pricing incentives, plans enticed patients into closed-panel HMOs. The bottom line was that a number of my patients moved into the closed-panel plans and were unable to continue their care with me."

Physicians selected for the panels also lost income, however. "The bad news for the 'lucky' physicians selected for the closed panels was that they were offered very low reimbursement," Clark says.

An Economic Argument

Declines in income are particularly frustrating, given that orthopedic surgeons had seen their income grow in earlier years due to technological advances that spurred increased demand. "Between the 1970s and the early 1990s, orthopedic surgeon income was one of the fastest growing incomes of any medical specialty," Thurston explains.

Technological advances in such areas

to build physician panels, so they were willing to pay attractive prices. But once established and with a significant share of the patients, HMOs had bargaining power and negotiated rates down. Today, HMOs typically impose artificially low reimbursement rates by negotiating preset prices for orthopedic procedures."

Falling Income

Survey data show the negative effect managed care has had on the income of orthopedic surgeons. Overall, the inflation-adjusted income of orthopedic surgeons fell approximately 10% from 1991 to 1998, says the Medical Group Management Association (MGMA) in Englewood, Colo. The MGMA reports in its *Physician Compensation and Production Survey 1999* that the mean annual compensation of general orthopedic surgeons in 1998 was \$369,000 for those who did not receive capitation, and \$298,000 for those orthopedic surgeons who operated under capitated contracts for at least half of all patients under care.

(Continued on page 4)

(Continued from page 3)

A 1995 MGMA survey shows that orthopedic surgeons with more than half their patients covered by managed care contracts had median incomes that were 20% lower than those with fewer than 10% managed care patients, and 30% lower than those with no managed care patients.

When income declines, orthopedic surgeons typically respond in ways that reduce the number of surgeons in practice.

First, orthopedic surgeons may relocate their practices to areas not heavily penetrated by managed care. "Practice relocation is a natural response to low reimbursement rates in a given geographic area," Thurston says. "Orthopedic surgeons can simply

find a more lucrative location in which to practice." Migration is only a short-term solution. "As the supply of surgeons begins to increase in the non-managed care cities, competition eventually will drive incomes down," he adds.

Still, relocation is the option Clark chose. "Compensation levels in the Chicago metro area are two to three times those in Utah," he says, noting that he is not alone in his departure from Utah. "In the past three years I've met four other orthopedic surgeons who have moved out of Utah. I know of three others who retired prematurely in their 50s because of managed care." Currently, the Utah Medical Association lists 113 orthopedic surgeons as members, meaning the loss of

four would have a potentially serious effect on the market.

Seeking Options

A second response to declining income is to seek retraining to practice primary care medicine. "If orthopedic surgeon income keeps falling and primary care income keeps rising, at some point those incomes will cross," Thurston explains. "When they do, an orthopedic surgeon may choose to incur the costs of retraining into the specialty with the higher income." Regardless of income levels, however, orthopedic surgeons may be reluctant to retrain for reasons related to job satisfaction. "After all, physicians choose a specialty based on per-

Surgeon Helps Others Find New Careers

One physician who can attest to the significant negative effect of managed care on orthopedic practice is Lorne E. Weeks, MD. An orthopedic surgeon who practiced medicine for 17 years in Denver until the pressures of managed care prompted him to leave the field in November 1999, Weeks chose a new career. Coincidentally, he now helps other disaffected physicians do the same as executive-in-charge of the Physician Career Network, a division of CareerLab (www.careerlab.com), career and human resources consultants in Denver.

In addition to cutting his income, managed care caused frustration for other reasons as well, Weeks explains. First, managed care created a disquieting environment for physicians. "Under managed care, physicians have less say in treatment decisions and yet retain all the medical and legal liability and ethical responsibility for the results of that treatment plan," he says.

Second, managed care has affected physician-patient relationships negatively by imposing constraints on physicians' time. "These weakening relationships are a formula for medical-legal action should the outcome of treatment be less than optimal," Weeks says.

Third, the gatekeeper system has denied patients direct access to specialists unless the patient gets a referral from a primary care physician. This system delays the delivery of specialty care and can have a detrimental effect on patients with musculoskeletal injuries, Weeks says.

"The patient often suffers a poorer quality outcome than would have occurred if the orthopedic surgeon had been involved from the beginning," Weeks explains. "Although the gatekeeper system was developed in the interest of cost containment, the irony is that health care costs are actually increased because of the redundancy of services."

Physicians who seek the services of CareerLab express similar frustrations about managed care. "Many physicians have expressed a personal and professional need to extract themselves from patient care," Weeks says. "They want to have more personal time, be more available to their families, and pursue interests that have been on the back burner because of the fast pace of private practice."

The pursuit of a broader range of professional opportunities is excellent

protection against the vagaries of managed care. "We encourage physicians to diversify their income sources and develop a safety net of transferable skills, and practice with the knowledge that other career options are available to them," Weeks says. Physicians seeking alternatives have found professional opportunities in teaching, speaking, and consulting for medical device manufacturers, Web companies, or attorneys.

"Physicians should recognize the intrinsic stress in the environment in which they practice," Weeks says. "Our research indicates that approximately 80,000 physicians are currently pursuing alternative career paths." Several studies support these estimates. A 1998 survey of 30,000 physicians performed by The Medstat Group, consultants in Ann Arbor, Mich., showed that 36% of physicians experienced low morale and 46% of physicians said they often thought about leaving clinical practice. The general level of dissatisfaction among physicians is unrelated to the economic environment in which the physician practices, or his or her age or specialty, Weeks adds.

—DJN

“Relocation is a natural response to low reimbursement rates in a given geographic area.”

—Norman Thurston, Brigham Young University

sonal interest as well as income,” Thurston adds.

A third possibility is retirement. “At some point, the compensation is simply not worth the work,” Thurston says. “A physician can substitute leisure time for medical practice.”

A fourth option is to find a new career. If enough orthopedic surgeons choose these options, their choices could have a negative effect on the supply of orthopedic surgeons.

Declining income also could mean there will be fewer technological innovations. Since lower-income physicians must spend more time on patient care to maintain income levels, they cannot afford to dedicate significant time to research, Thurston says.

Maintaining Income

While the lucrative payoffs that spurred research activity may be stifled, orthopedic surgeons can pursue several strategies to help them maintain their income without retiring, moving, or retraining.

One option is to form alliances with other surgeons to negotiate contracts. “HMOs can have significant market share, perhaps representing 70% of the patients in an area, but they contract with doctors on an individual basis,” Thurston notes. “If the physicians can band together to represent about a third of the physicians in a given area, then they have some power to negotiate improved contract terms. But a medical group that is getting too large eventually will arouse the suspicions of antitrust enforcers. As a result, physicians still do not have sufficient bargaining power to negotiate strongly with a large HMO.”

Physicians also can implement strategies within their practices to increase productivity or reduce expenses. “Most practice advisers are recommending that orthopedic surgeons diversify their revenue streams by offering ancillary services such as imaging or owning surgery centers,” Clark says.

Another possibility is subspecialization. “Orthopedic surgeons typically perform a lot of services,” Thurston observes. “But by subspecializing, physicians can become more efficient and lower their own costs relative to other physicians.”

Clark hopes that highlighting the income trend and its effect will help solve the problem. “Most orthopedic surgeons are very busy people who are more concerned with helping patients than with developing strategies to deal with managed care organizations. What I hope to show through this research is that, left unchecked, plans will continue to reduce payments to physicians until a surgeon shortage develops.”

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

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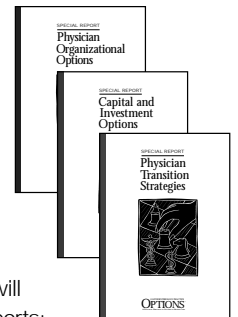
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Rebuilding a Cash-Starved Practice

By John W. McDaniel

Just about three years ago, a physician in a small Southern town began having trouble paying his bills. Previously, the physician (for this article, we'll call him John Doe, MD), had always paid his bills promptly. But starting about December 1997, Doe began falling behind on his payments.

Doe's practice had begun having trouble meeting expenses when one of his major payers suddenly stopped making payments. In Doe's town, one large employer dominates the area. To this point, Doe had run a thriving ob-gyn practice and had opened an outpatient surgery center within the office. In December 1997, the health insurer for the local company stopped paying all claims to Doe citing a lack of medical necessity and refusing to pay facility fees. If Doe wanted to continue to perform procedures on women who work for the large employer, he would need to do so at the local hospital, he was told. These patients accounted for 25% of the practice's volume.

Appeals Denied

Doe appealed the cases in which payment was denied, but the insurer turned down the appeals. Then, he arranged for another ob-gyn to review all claims in an attempt to prove medical necessity. Again, the insurer declined to pay.

Doe then contacted an attorney who specializes in employer-sponsored health care issues in an attempt to force the insurer to pay but Doe decided not to pursue this course of action, fearing he would be dropped from the company's provider panel altogether.

John W. McDaniel is the president and CEO of Physician Management Group Inc., physician practice management consultants, in New Orleans. Readers may contact McDaniel by phone at 800/764-2633 or by e-mail at pmgcode@eatel.net. More information on practice management is available on our Web site (see page 16).

Since Doe had always been a good customer at his local bank, it gave him an \$8,000 line of credit to help meet expenses and cover overdrafts. Doe believed that his financial situation was temporary and that his income would return to the level it had been before December 1997. The worst was yet to come, however.

Each day, the number of calls from creditors rose, and eventually one staff person was required to deal with creditors full time. Checks bounced frequently, and the office manager needed to beg Doe's banker to allow the payroll checks to clear each payday.

In July 1998, Doe contracted with a physician practice management consultant to review all delinquent bills and to

reduce overhead, so he had to lay off members of his office staff. This move meant he had to cut his office hours, cutting into his income still further.

Soon after it became apparent that the insurer was going to continue delaying payments, one of Doe's creditors, the IRS, filed a tax lien on his assets. At this point, PMG suggested Doe file for bankruptcy protection. For Doe, the thought of filing for protection under Chapter 13 of the U.S. Bankruptcy Code was extremely disconcerting. He deeply wanted to honor his obligations, but at this point, he simply had no other alternative.

In September 1998, Doe filed for bankruptcy protection. The filing meant he no longer needed to deal with creditors or

Checks bounced frequently, and the office manager needed to call the bank each payday and beg Doe's banker to allow the payroll checks to clear.

consider a strategy for improving cash flow. A member of the Physician Management Group (PMG) staff contacted all the creditors and explained that PMG was now managing Doe's office and was confident the financial situation would improve.

PMG attempted to negotiate with the insurer to pay some back claims. Through repeated phone calls to the facility and the insurer, PMG was assured that the claims would be examined.

When Doe's practice income began to drop, several factors compounded the problem. First, Doe had been sending all his lab tests to an outside lab, had billed the insurer, and paid the lab company for performing the tests. By billing the insurer, Doe had earned some income on each lab test. Unfortunately, Doe allowed his account to get so far behind with the lab company that the lab refused to allow Doe to bill. Therefore, the lab started billing the insurer directly and Doe lost the extra income. Second, Doe needed to

worry about assets being seized. Instead, Doe could rebuild his practice.

Restarting Cash Flow

One of the first steps taken to increase cash flow involved contacting the lab to which Doe owed several thousand dollars. Doe explained that he had filed for bankruptcy but that since Doe planned to pay all creditors in full, he wanted to return to the original agreement with the lab company. When the company refused, Doe found another lab and once again billed for procedures. This step alone increased his cash flow by approximately \$8,000 per year.

To increase ancillary revenue still further, PMG suggested that Doe install an in-office pharmacy. Doe agreed, and PMG contacted a company that provided a turnkey service. The pharmacy profiled Doe's drug prescribing patterns, installed the software, and provided staff training. Although this system is designed to fill only the initial prescrip-

tion, the office makes at least \$2.50 on each prescription.

Today, the staff is working to get Doe's office enrolled with various insurance plans so that his patients will pay only the co-payment, and the insurers will reimburse the practice the remaining cost of each prescription. Also, the staff is working to become familiar with the service. Once the process is complete, in-office pharmacy should help improve Doe's cash flow.

Adding New Patients

Many physician practices can increase cash flow simply by extending their office hours. When Doe's practice started having trouble, he was forced to reduce his hours when he let some staff members go. PMG suggested Doe extend his office hours to make them more convenient for working women. Doe is now open late two nights each week and two Saturday mornings each month. The staff had to make changes to accommodate the increased hours, but the new schedule has helped to increase Doe's patient volume.

Before the financial problems, the office had employed several nurse practitioners. Doe considered employing physician extenders again, but decided that adding highly paid workers would be premature at this time. Instead, Doe decided to allow several nurse practitioners to rent space when the office was closed. Although the rental income was nominal, the arrangement helped to boost referrals to Doe.

After Doe filed for bankruptcy protection, he continued to pursue the insurer that had precipitated the crisis and began to receive payment for some back claims, although the company continued to refuse payment for facility fees unless the procedure was performed in the hospital. Rather than continuing to fight with the insurer, PMG suggested that Doe perform all outpatient procedures for these patients at the hospital. For other patients, Doe continued to perform outpatient procedures in the office and received the facility fees for this work.

One of the most important lessons for Doe (and any physician) is that having one payer account for so much revenue is dangerous. Since the insurer that worked

with the one large employer in town accounted for 25% of Doe's practice income, PMG suggested that Doe attempt to change the payer mix. By extending his office hours, by getting his name out into the community by speaking at a local forum on health care, and by sending out a newsletter to current and former patients and to women in a desirable income bracket, Doe increased his patient volume. Today, Doe has a wider mix of insurers and the one most troublesome company accounts for only about 10% of his total income.

Whenever a practice struggles financially, it is appropriate to conduct a chart audit to ensure that the physician is coding appropriately and to seek an opportunity for fee increases if appropriate. An audit showed that Doe had been coding well but that his fees could be raised slightly.

Cost Cutting

Raising fees and adding patients are important for any practice seeking to increase income, but consultants also believe strongly in the value of cost cutting. Since dictation was costing Doe \$600 and \$800 per month, PMG suggested a voice recognition system. While the system proved inadequate for medical dictation, it was useful for the office reports and staff meeting minutes and helped cut dictation costs to \$300 to \$600 per month.

Another area ripe for cutting was the money spent on Yellow Page ads, for which the practice was spending about \$1,800 per month. Since some of the phone books covered the same areas, the practice saved \$900 per month by cutting redundant ads.

An audit of Doe's insurance coverage showed that he could save about \$8,000 annually by changing malpractice insurers. The change also resulted in increased coverage limits.

Lessons Learned

Today, the practice has seen improvements in a variety of areas. Patient visits increased 76%, gross charges increased 20%, net collections increased 32%, and the net profit per visit increased 86%. Overhead was cut by 25%, and accounts receivable decreased by \$219,000.

Steps Taken to Rebuild Practice

Here are some of the steps that consultants took on behalf of John Doe, MD, to help him rebuild his practice.

- Audited the use of evaluation and management codes to assess reimbursement potential
- Audited charts to ensure appropriate utilization of codes and documentation
- Followed up with insurers to review outstanding claims and attempt to work out new arrangements for facility and professional fees
- Analyzed practice fee schedule
- Conducted a charge and collection analysis by payer
- Developed a coding policy and procedure manual
- Monitored payment of outstanding claims, including reasons for denials and frequency of claims submission
- Developed system to follow-up on unpaid claims
- Reviewed performance of collection agency
- Implemented electronic claims submission
- Established collections policies
- Established targets for over-the-counter collections.

Source: Physician Management Group Inc., New Orleans.

While not all of the changes have gone smoothly, Doe and his staff are continuing to rebuild the practice. The lessons Doe learned, however, are applicable to many physician practices. When trouble strikes, it may take a combination of drastic steps, such as filing for bankruptcy, and a number of small steps, such as seeking a wide variety of ways to increase revenue and decrease expenses. It is possible to turn around most struggling practices. Doing so takes time, effort, and a willingness to change the way things have been done in the past. ■

(Continued from page 1)

when it becomes apparent that speech recognition software can facilitate workflow and patient care.

Physician entrepreneurs will develop and market information systems for other physicians. These so-called early adopters will help to make mainstream believers out of physicians who have so far been reluctant to use the Internet or information technology to empower themselves. At the same time, physician executives will stop working for traditional managed care organizations and will seek employment in other, related fields, such as biotechnology research, medical device manufacturing, health-related Internet sites, and medical information companies.

The downside of the technology revolution in medicine is that those health-related Internet companies that offer information only but no revenue-producing products or services will fail in increasing numbers because con-

less than they could for many services they deliver to patients. Yet, when focusing on patient care, they also do not document well all the work they do for patients. Now that physicians have begun to realize that proper documentation will save them from an expensive audit and help increase revenue, they will begin to use information systems to increase the accuracy of their records and to bill for all services they deliver.

In the meantime, health plans and government payers will increase efforts to eliminate fraud and abuse and will target innocent practitioners in their efforts to find the few who are committing fraud. The Office of Inspector General (OIG) of the federal Department of Health and Human Services, for example, has said that in the coming year it will investigate the services provided by nonphysician practitioners, nurse practitioners, physician assistants, and clinical nurse special-

cians. The number of physician-owned surgical outpatient and surgical hospitals will grow significantly. Currently, there are only about two dozen acute-care surgical hospitals in the United States. But some physicians foresee a trend toward physician-owned facilities and are working to ensure that their unique needs are represented by a national organization. Take Oklahoma City, Okla., for example. This city of 475,000 people, located in a metropolitan area of one million, supports four specialty owned facilities—a spine hospital, a heart hospital, an orthopedic hospital, and an ob-gyn hospital. Medcath, a company in Charlotte, N.C., that specializes in developing heart hospitals, operates eight such facilities nationwide. Two more are under construction, and Medcath has plans for 12 others. Physicians own and operate these specialty facilities, so they will be criticized by those administrators and organizations that own full-service hospitals. But these facilities focus on patient care and can be profitable for physicians. Therefore, they have a reasonably good chance to succeed.

5. The doctor-patient relationship. The era of alienation and distrust between patients and physicians is ending. Physicians have long been patient advocates while patients have found that many managed care plans have abandoned them. Communication via e-mail and the Internet will enrich the relationship between patients and physicians. Physicians will discover that one effective way to boost productivity is to empower patients by having them complete medical histories and health evaluations online. Or, physicians can ask patients to download forms from the Internet, fill them out, and bring them to the office. In this way, physicians can focus more efficiently on patients' problems, increase practice productivity, and raise patient satisfaction levels as well.

6. Consumer empowerment. The consumer-led revolution in health care will gain strength as employers introduce defined benefit plans and medical savings and flexible spending accounts, and as members abandon HMOs for PPOs.

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As physicians become comfortable with new information systems, the mood of despair among them will begin to turn to optimism in part because doctors will regain a modicum of control over data at the point of care.

sumers and physicians are unwilling to pay for information.

One of the most significant ways that technology will be put to use is in reducing medical errors. A report last year by the Institute of Medicine said that as many as 98,000 patients die in hospitals each year because of medical errors. Many experts believe technology will be used in a wide variety of settings to help reduce errors. Soon, all prescriptions, for example, will be written on a computer, or ordered electronically.

2. Compliance. Efforts by the federal government and HMOs to blame increased costs on what they call "fraud and abuse" by physicians and to prosecute physicians for upcoding will backfire. Fearing prosecution from the government and audits from payers of all types, 80% of physicians undercode, meaning they bill

ists to Medicare beneficiaries. The OIG is particularly interested in these providers because Medicare recently changed the way they are paid and because these practitioners provide complex services to patients. Also, the OIG said it will investigate the work physicians do in approving and monitoring home care for Medicare patients.

3. Group practice failures. The rate of insolvency among physicians in California and other regions where managed care has a significant presence will grow until consumers and health policy experts realize that consumers must become responsible and accountable for their own health care to help control health care costs. Physicians alone should not be at risk for the irresponsible behavior of health plan members.

4. Organizational strategies for physi-

(Continued from page 8)

Those companies that will allow physicians to contract with patients directly will assist this revolution. Consumers will soon realize that the Internet gives them information they can use in negotiating with HMOs and physicians. More than 20 new companies are currently working to develop a new health care marketplace that has the potential to replace managed care. These new companies are building the foundation for what employers and health care experts believe will be a health care market that is focused more closely on serving the needs of consumers.

These new companies aim to give consumers responsibility for health care decisions by allowing them to select their own physicians and other providers and purchase health care services directly without going through a managed care middleman. When working with these new companies, physicians will be allowed to set their own prices and manage patient care without having to answer to the utilization controls that managed care organizations have used traditionally to control costs. Physicians also will be empowered to choose how they will measure and manage quality, and they will compete with one another for patients.

Using the Internet to present information to consumers about the prices, practices, credentials, and quality that physicians offers, these new companies include Ehancedbenefits.com (in Elk Grove Village, Ill.), doctorandpatient.com (in Sacramento, Calif.), and HealthAllies.com (in Glendale, Calif.). Currently, they let physicians submit prices for various medical procedures and services and consumers who lack health insurance can compare and select providers by shopping online. These sites also may attract some consumers who have health insurance but who are seeking to save money on procedures that are not covered by their health plans.

Other new companies are taking the idea of linking consumers and physicians over the Internet a step further. Some companies are planning to compete with more traditional managed care plans by offering an alternative to employer-sponsored health insurance. Among the com-

Reader Participation Invited

Each year, the editors of *Practice Options* meet to discuss the issues we have covered over the previous year and plan our coverage for the coming year. As part of this discussion, we identify the trends we believe will have a significant effect on the practice of medicine. Our analysis involves speaking with health care experts and reviewing news articles and other sources of information on the practice of medicine.

Since we have found in the past five years that no system for evaluating trends is perfect, we invite our readers and visitors to our Web site (www.MDOptions.com) to rank our predictions on a scale of 1 to 5 in which a five means you completely agree and one means you completely disagree. We believe practicing physicians may be the best judge of what is likely to transpire in the year ahead. We will average your ratings and then identify the top trends from your selections. —RLR

panies that are linking patients and physicians are Vivius and Definity Health (formerly, HealtheCare), both in Minneapolis, and HealthMarket, in Wilton, Conn. Each of these companies plans to reduce the role of the middleman while giving consumers more control and responsibility for choosing physicians. Those physicians who participate in these plans will be able to set their own prices, and market their services based on the quality of care they deliver.

7. Managed care. HMOs will raise premium rates by 10% for large groups of employed members and by as much as 20% for self-employed individuals. These organizations have struggled financially over the past two years, and rate increases will help them return to profitability. Their stock values will rise temporarily following the premiums increases, but then membership will begin to fall relentlessly as members abandon HMOs in favor of other forms of insurance. Higher premiums will cause many members either to drop health insurance altogether or to seek lower-cost forms of insurance such as coverage for catastrophic care only.

8. Academic medical centers. Academic medical centers will begin to adapt to the realities of competition by striking deals with pharmaceutical companies to conduct clinical trials. The number of clinical trials will surge and become a major source of income for academic medical centers (and for those physicians who want to participate in this

potentially rewarding business).

9. Hospitals. Administrators will recognize that the salvation of hospitals lies in working closely with strong, independent group practices managed by physicians but supported by the hospitals. The key to success in physician-hospital organizations will be allowing physicians to practice medicine without interference from administrators. One major crisis of the coming year, however, will be the growing shortage of nurses in hospitals and nursing homes.

Many hospitals have divested the physician practices they purchased earlier because they have found that owning physician groups gave them no greater control than having independent contracts. In addition, hospitals found that physicians are more productive in independent practice, where they can see the economic advantage of working 10-hour days and keeping costs down, experts say.

10. Genetic research and biotechnology. Genetic research and technological innovations—gene identification, inhaled insulin, transplanted cells, and wristbands that can monitor glucose levels—will transform the care of diabetes patients. Biotechnology and its applications will be spurred by the mapping of the human genome and will continue to blossom into a major industry in such cities as Austin, Texas; Boston; New Haven, Conn.; Raleigh-Durham, N.C.; and San Francisco. This industry will become a major employer of research-oriented physicians. ■

Choosing a Suitable Legal Structure

By Thomas M. Gorey, JD

Responding to the challenges of practicing in managed care markets, physicians are continuing to form various legal entities designed to enhance their competitiveness and increase their patient base. In addition to aligning their interests with other physicians, doctors are entering into joint venture arrangements with hospitals and other nonphysician entities. If based on a well designed strategic plan and if executed properly, such strategies can improve a group's competitive position and can increase practice efficiency.

A number of legal structures can be used when establishing physician organizations and in implementing joint venture strategies, including corporations, partnerships, limited liability companies, and contractual arrangements. The legal structure that is most appropriate or advantageous in any given case will depend on the specific facts and circumstances involved. Therefore, most experts recommend a consultation with a qualified attorney who has demonstrated expertise providing legal advice to physicians on business issues.

Corporations

A corporation is a separate legal entity that is formed by filing articles of incorporation with the secretary of state for the state in which the business is being incorporated. A board of directors governs corporations in accordance with the articles and bylaws of the corporation. Officers elected by the board manage the day-to-day affairs of the corporation. One

of the most significant advantages of the corporate form is limited liability, meaning owners are responsible for business liabilities only up to the extent of their capital investment.

Physicians should remember two points about the limited liability feature of corporations, however. First, physicians will remain liable for any negligent or wrongful acts even if they are practicing as part of a corporation. Second, and perhaps more important, physician shareholders of a medical practice or other form of physician organization (particularly one that is newly created) may be required to guarantee

decides to discontinue participating in the practice or business venture.

A significant disadvantage of the for-profit form is that it can involve double taxation, in which profits are taxed once at the corporate level and again at the individual physician shareholder level. With careful planning and good professional advice, however, there are ways to minimize and possibly avoid the effect of double taxation.

Subchapter S corporations. Under the Internal Revenue Code, some corporations can qualify as S corporations, which provide most of the advantages of doing business as a corporation—including lim-

Among the advantages of for-profit corporations are ease of transferability of ownership through shares of stock and the ability to raise capital.

loans to the corporation personally, a move that could expose personal assets to creditors' claims.

Physicians commonly use several types of corporate forms: for-profit, subchapter S, professional, corporate practice of medicine, and nonprofit corporations.

For-profit corporations. For-profit corporations, which are also referred to as business corporations, stock corporations, or taxable corporations, are organized and operated for the purpose of generating a profit for the entity's shareholders. The investors in a for-profit corporation are issued shares of stock in exchange for their investment and they share in the profits of the business through the receipt of dividends. For-profit corporations are governed by a board of directors, which is elected by and accountable to the corporation's shareholders. Among the advantages of for-profit corporations are ease of transferability of ownership through shares of stock and the ability to raise capital by offering stock to outside investors. Another advantage is continuity of the corporation as a distinct entity if a physician shareholder dies, retires, or

ited liability—with some of the advantages associated with partnerships (such as avoidance of double taxation). To qualify as an S corporation, the entity must have one class of stock only and no more than 35 shareholders. A corporation that qualifies for and elects to be treated as an S corporation is not subject to federal taxation. Instead, like a partnership, income and losses are allocated on a pro-rata basis among the shareholders. An important consideration in determining if an S corporation would be advantageous is whether current corporate earnings are likely to be distributed to shareholders in the form of dividends. If they are, an S corporation can offer the advantage of avoiding the double taxation problem that for-profits face when distributing earnings.

Professional corporations. A professional corporation is a special form of corporation, the characteristics of which are specified in pertinent state statutes. In some states there are different types of professional corporations, including, for example, medical corporations, which can be formed by physi-

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cians only, and professional service corporations, which can be formed by related professionals, such as physicians, dentists, and podiatrists. Professional corporations may facilitate contracting and reduce personal liability for the physician owners. Certain employment benefits may be available on a nonprofit basis to the physicians and employees of a professional corporation.

Corporate practice of medicine. Although considered arcane in some parts of the country, there have been certain statutory provisions or court decisions in some states that provide that only licensed professionals—including individual physicians and professional corporations—are entitled to practice medicine. Such laws prohibit laypersons and corporations, including hospitals, from hiring physicians or controlling the professional aspects of a physician practice. Despite the broad nature of these prohibitions, many states that still have corporate practice prohibitions have chosen not to enforce such laws. Nevertheless, in states in which such prohibitions remain, hospitals and other entities seeking to employ physicians have found creative ways to circumvent such prohibitions, including the use of medical foundations.

Nonprofit corporations. Although nonprofit corporations can be taxable or tax exempt, most of the ones established by physicians to enhance their competitive position are taxable because they do not meet the charitable purpose requirements for tax-exempt nonprofit organizations. The nonprofit structure, which is based on the concept of members rather than shareholders, offers considerably more flexibility in governance than does a for-profit corporation. Unlike shareholders in a for-profit corporation, however, members of a nonprofit corporation generally are not considered to have an ownership interest in the corporation and their voting rights are not necessarily related to their investment in the business. In fact, the right of members to vote may be limited or denied if so specified in the articles of incorporation or bylaws of the corporation.

Partnerships

There are two broad categories of partnerships: general partnerships and limited partnerships. The Uniform Partnership Act defines a partnership as “an association of two or more persons to carry on as co-owners of a business for profit.” The key components of this arrangement are a sharing of control and a sharing of profits—and losses. Compared with corporations, partnerships are relatively easy to establish and there are fewer formalities with which to comply.

Technically, a partnership can be formed without any written agreement, but as a practical matter it is essential that physicians entering into a partnership execute a written agreement outlining the specific rights and responsibilities

Unlike corporations, partnerships do not limit the liability of physician partners to the extent of their capital investment.

of the parties. Although, unlike corporations, partnerships do not require articles of incorporation, bylaws, and shareholder agreements, many of the issues addressed in such documents nevertheless need to be covered in a partnership agreement. Such issues include capital contributions, distributions of profits and losses, powers and responsibilities of the partners, removal of a partner, and partnership decisionmaking.

In addition to involving fewer formalities than a corporation, partnerships avoid double taxation of earnings. A major drawback of general partnerships is that, unlike corporations, partnerships do not limit the liability of physician partners to the extent of their capital investment. As such, each partner is personally responsible for business liabilities of the partnership.

Limited partnerships. Limited partnerships are a particular type of partnership that meet certain state statutory requirements. Such partnerships have both general and limited partners. General partners, who participate in the management and control of the

business, have unlimited liability—similar to that of any partner in a general partnership. Limited partners have limited liability—similar to that of shareholders in a corporation. Limited partners, however, are precluded from participating in the management or control of the business.

Limited Liability Company

A limited liability company is a relatively new legal structure available in many states. A limited liability company offers some of the characteristics and advantages of corporations and partnerships. Like a corporation, a limited liability company limits the legal liability of its physician owners. The extent of their responsibility for business debts is limited to their capital investment in the compa-

ny. Like a partnership, however, a limited liability company avoids the double taxation inherent in the corporate form.

Contractual Arrangements

Depending on the nature of the arrangement between the participating physicians—and, in some cases the nonphysicians—an alternative to establishing a formal business entity is simply to enter into a contractual arrangement. This approach is quick and easy to implement. Also, contractual arrangements tend to be more flexible than forming a business entity and usually permit the parties to retain maximum autonomy. Contractual arrangements of this type, however, tend to lack the permanency associated with formal business entities.

Regardless of the organizational or contractual approach that physicians choose, those entering into collaborative arrangements—whether with other physicians or with physicians and nonphysician partners—need to ensure that there is a comprehensive, clearly written legal document outlining the terms of the venture. ■

Web Site Helps Group Compete Against Larger Practices for Patients and Staff



Victor Gong, MD, practices in Ocean City, Md., as an internist and emergency room specialist. He is the owner, administrator, and medical director of the 75th

Street Medical Center and the 126th Street Medical Center, and Doctors Weight Control and Wellness Centers, all located in Ocean City. He attended medical school at the State University of New York at Downstate Medical Center. He completed his internship and residency in internal medicine at Robert Wood Johnson Hospital in New Brunswick, N.J., and completed an emergency medicine fellowship at Johns Hopkins University Hospital in Baltimore. He has written two books on AIDS: *Understanding AIDS: A Comprehensive Guide* (New Brunswick, N.J.: Rutgers University Press, 1985) and *AIDS: Facts and Issues* (New Brunswick, N.J.: Rutgers University Press, 1986). Gong has been practicing family and emergency medicine for 15 years. Readers can reach Gong by phone at 410/524-0075 or e-mail at cellulite@compuserve.com. Richard L. Reece, MD, editor-in-chief, conducted this interview. More information on using the Internet is available on our Web site (see page 16).

Q. Why have you been developing a Web site?

A. More than half of all Americans—some 100 million people—use the Internet. According to a study by CyberDialogue, researchers in New York, 50% of respondents say that they would use physician Web sites if their doctors had them. But only about 30% of physician groups have Web sites. Physicians without sites are missing an opportunity to publicize their practices, enhance their efficiency, and reach out to patients.

I view Web site development as a tremendous opportunity for my practice

because most physicians still do not have a Web site. As a group, physicians are still not as technologically savvy as the general population. I knew I would be able to leverage opportunities for my practice by becoming one of the first physicians to develop a site in my area. Our Web site (at www.75thstmedical.com) has been up since March.

Q. Do you believe that physician Web sites will soon be universal?

A. Yes, eventually, patients will expect every doctor to have a Web site.

Q. Why do physicians need a Web site to practice medicine?

A. Physicians need a Web site for several reasons. First, physicians need a Web site because their competitors—other physicians, large medical groups, hospitals, and other health care providers—will have one. Any physician who does not have a Web site will soon be behind the times.

Second, any physician who has a Web site will draw many more patients, especially from those segments of the population that are Internet savvy, to their practices, than those physicians who do not have a presence on the Internet. The people who use the Internet are usually more affluent, more educated, and have higher discretionary income to spend than those who do not. These are desirable qualities in a patient base.

Third, a Web site can make patients' and physicians' lives more convenient and productive. For example, our site includes online registration so that patients can complete forms before they get to the office, saving time for both our patients and our office staff. We have online patient scheduling as well, so that patients can make appointments online.

Fourth, increasingly physicians will need Web sites to communicate with colleagues, especially to refer patients, and to receive referrals. Web sites can streamline and expedite the referral process.

Finally, simply having a Web site communicates something positive about a practice. A Web site is open 365 days a year, 24 hours a day, seven days a week. This type of instant accessibility is great for a physician's image. Having a Web site also conveys the message that a physician has a cutting-edge practice and is technologically savvy. If a physician maintains a well crafted Web site, he or she will be regarded as user friendly, warm, accessible—traits patients want from their physicians.

Q. How did you go about constructing your Web site?

A. I surfed the Internet first. I wanted to see what types of sites my competitors had, as well as the sites of other local businesses. Then I looked at some of the Web sites run by very large medical groups. After reviewing these other sites, I was better equipped to define what I wanted to accomplish with my site. Would I use my site for patient education? Would I use it for e-commerce? Would I use it to market my practice? Would I employ it for managing risk? Ultimately, I decided that rather than build an all-purpose site at one time, which would have required a substantial amount of money, I would build the site in segments.

I used a loose-leaf book to help me design the site in segments. I recorded what I wanted the front page to look like and what kind of graphics I thought would be effective. Then I composed the rest of the site, page by page. This allowed me to organize the site appropriately and visualize how the site would look.

Q. What is the primary purpose of the site?

A. I wanted to use the site as part of a strategy of "guerrilla marketing." Guerrilla marketing entails low-cost strategies that enhance the reputation of a business and make it more profitable. It's a great strategy for small businesses that don't have significant marketing and

“Having a Web site conveys the message that a physician has a cutting-edge practice and is technologically savvy. If a physician maintains a well-crafted Web site, he or she will be regarded as user friendly, warm, accessible—traits patients want from their physicians.”

advertising budgets, unlike their larger competitors.

The strategy is discussed in *The Guerrilla Marketing Handbook*, by Jay Conrad Levinson (New York: Houghton Mifflin Co., 1995). The guerrilla marketing strategy impressed me because it is geared toward small businesses and how they can compete with bigger competitors that might spend millions of dollars on marketing. Guerrilla marketing is especially relevant to physicians in private practice, who may feel they are not big enough to compete with integrated delivery systems.

Like most independent physicians, I am a “David” against many “Goliaths.” Although our practice has 20,000 patient visits per year, we still compete with larger medical entities. I wanted to look as big and impressive as the large group practices and large hospitals in my area. The Web levels the playing field, and can fill an important role in a guerrilla marketing strategy. Physicians can project themselves to be as good as the big guys if they are clever in how they design and present information on their Web sites. In this way, the Web site helps my practice become more successful.

Q: *What do you try to achieve on your home page?*

A: The home page outlines the nature of our practice, where we are, and our mission statement. It is a road map that guides the patient to our various services, demonstrates what’s new in our practice, highlights employment opportunities, offers educational points of interest, and provides links to other interesting sites. Our home page also stresses our special programs, such as wellness, weight reduction, and occupational medicine. These are the programs we want to market. We try, for example, to direct new employers to go to our page on occupational medicine. The same goes for

consumers who are into health maintenance, wellness, and weight control.

In addition, we offer employment opportunities for other health professionals. We discuss our practice in a friendly way, describe our office and our corporate cultural beliefs, and state why it would be enjoyable and exciting to work with us. Since we are located in a resort town and require extra help in the summer, we hire a lot of staff who reside outside our area.

We offer free use of condominiums for summertime doctors, x-ray technicians, and physician assistants, for example. To entice summer help, the Web site shows pictures of our condos and of Ocean City. We also provide links to the Ocean City Visitors Bureau and the Chamber of Commerce. Using the site as a recruiting vehicle adds to its utility.

Q: *In your opinion, what makes a good Web site?*

A: The best sites reflect the attempt of the designers to think as a patient thinks. The site’s purpose should be apparent to the viewer when he or she sees the first page. The practice name, address, e-mail address, and phone and fax numbers need to be clear and easy to find. The site also must be easy to navigate. Good color and graphics also are important, and the design should be visually appealing.

Furthermore, it is important for a site to be reader-friendly, like a storybook that can be read in brief sections. Large blocks of text can be a deterrent. It’s preferable to have small referral text that provides links to other text so that readers can delve deeper into more detailed information if they wish.

Finally, physicians should avoid loading up too many images on one page, because this will extend the time the viewer’s computer takes to load the Web site.

Generally, the site should give the impression that the physician’s practice is

the type of organization that the viewer would want to visit. The site’s content should be nontechnical. The site should have a warm and friendly feel and a professional look.

Q: *Is it a mistake to include a lot of prose?*

A: Yes. Excess prose detracts from a friendly image. Initially, many physicians produce an electronic brochure on the Web. That strategy is fine if the physician does not have anything else he or she can do. The trend, however, will be to make Web sites much more interactive.

Q: *Are there malpractice risks due to having something printed on a physician’s Web site?*

A: The physician group is responsible for any information posted on its Web site as well as information that is on linked sites. There are ways around the malpractice problem, however. Physicians should carefully label their sites with disclaimers about the appropriateness and completeness of the information, for example. In addition, the site should clearly state that it is for informational purposes only and that it is best to visit the office so that a physician can assess any health concerns. Any information on the Web site should be thoroughly screened by physicians in the group for accuracy and clarity, and links to other Web sites should follow the same level of scrutiny. Also, physicians can reduce their malpractice risk by quoting the original source of information.

Q: *What methods do you use to promote your site?*

A: We tell everybody and anybody about our site. We put the Web site name on all our stationery and our business cards. We also include it in all of our advertising on TV, radio, newspapers, and the Yellow Pages.

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“The Web levels the playing field and can fill an important role in a guerrilla marketing strategy. Physicians can project themselves to be as good as the big guys if they are clever in how they design and present information on their Web sites.”

(Continued from page 13)

Ideally, once people sign on, Web sites should promote themselves by having useful and accurate content, and by being appealing to the user. Educational materials and content are a big draw, as are links to other reputable medical Web sites. Physicians should update their Web sites frequently—at least monthly, but preferably weekly—so that patients and others will return regularly. Then, the message about the quality of the site will spread by word of mouth. As we increase our awareness among the community and create an image, we will come to be known as the community Internet health provider.

Q: *What do you do to help your site stay current?*

A: We include the monthly columns that we write for the newspapers. We have online surveys that allow us to get feedback right away. We offer health tips on an ongoing basis.

We also have a section called “What’s New.” It’s a friendly summary of what’s happening in our practice. We write about the employees and include news about the practice. We created a link to a Web site about our dog, Abbey, the office mascot. Children and adults alike love to read about dogs. It may sound hokey, but for patients, it’s memorable and sets a friendly tone.

Q: *What are the resources required to develop a Web site?*

A: The site is a growing part of my budget. Physicians can do it for free, or they can spend several thousand dollars. In addition, there is time required for getting the pieces of content together for inclusion in the site.

Q: *Physicians have several options when building a site. They can create their own Web site or they can get a free site from www.medscape.com, www.medem.com, www.salu.net, and others. Why not just get a free site?*

A: Right now anybody can create a free personal Web site on some of the major Internet service providers or doctors might use one of the medical Web sites. The medical sites offer free Web site template designs for physicians. Designing a site this way requires little more than 30 minutes. If a physician wants to get started with a Web site, it’s a good way to try one out, and it doesn’t cost anything.

Free Web site services are a useful option, but may not be the best option. An amateur can easily create a Web site, but the site may not be attractive to experienced Internet users. In addition, the companies own the Web site name, or domain name, so the doctor has no control over the use of that name. Furthermore, companies offering free Web sites usually attach their own name to a site, making the whole site name overly long and difficult for patients to remember. Finally, the companies allow each site only limited space, making it hard for physicians to develop a mature, growing, in-depth, and versatile site.

Q: *An independent Web design company designed your Web site. How did that arrangement work out for you?*

A: The company offered to design a seven-page site for free if I used their site and paid a hosting fee. This type of arrangement is relatively common. I investigated the company and its references, including five or six hospitals and physician groups. Their sites were nicely done. I designed the site using the loose-leaf notebook, and then wrote the content using Microsoft Word. The Web designers then converted everything to HTML format, scanned the images, and did the programming.

Physicians have to be careful when working with a Web site design company. For example, as it turns out, seven pages were not sufficient for a physician

Web site. Accordingly, when I want to add additional pages to my site, I must pay a substantial cost. Currently, my site contains 15 or 20 pages, and it keeps growing. Unfortunately, despite our extensive reference checking, we still had other unexpected problems develop with the company.

I suggest that if physicians want to outsource their Web design, they should work with a local company, check the company’s references and visit its sites. They should look for a company that will design a site with interactive capabilities and the ability to link with other sites. Sometimes, physicians can find a student to help. They can contact their local business school, ask for the internship director, and tell him or her that they are interested in developing a Web site. The internship director may be able to find a student who can work on the project.

Q: *Do you have any other advice for physicians interested in developing their own sites?*

A: Physicians should remember that the best sites are dynamic, growing, flexible, versatile. Each one should be a work in progress. Therefore, physicians need to work at making their site useful, and need to budget time and financial resources to make it successful. In addition, the physician needs to take the lead. This would be true for any new initiative, whether it is a clinical or marketing program, regardless of whether it is big or small.

Also, a physician Web site should create a sense of fun for the community. For example, an ob-gyn can post pictures of babies. Contests and community events can be promoted as well. A site can be fun and exciting but still have a professional image. Make it professional, informative, lively, warm, interactive, useful, and make it a place where patients like to come to see what’s new in the practice of medicine. ■

Vendors May Ease HIPAA Compliance

By Jon Zimmerman

Whether hiring a consultant, a clearinghouse, or having your internal staff implement the new HIPAA transaction rules, physician groups should start now. HIPAA (the Health Insurance Portability and Accountability Act of 1996) requires physician groups to be compliant by Oct. 16, 2002. By now, your HIPAA team should be in place, working on assessment and implementation strategies. Keep in mind that no vendor or consultant alone will be able to make you HIPAA-compliant. That is ultimately the physician group's responsibility. The best way to ensure HIPAA compliance is to make HIPAA part of every project currently underway, and incorporate it into any e-business strategies you have.

HIPAA does not mandate electronic data interchange (EDI), but requires the use of specific standards if EDI is used for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, eligibility for a health plan, health care payment and remittance advice, health plan premium payments, health claim status, and referral certification and authorization.

When preparing to comply with HIPAA, two important steps involve getting senior managers engaged from the start and appointing a multidisciplinary HIPAA team. This cross-functional team should perform a HIPAA analysis for technical, educational, personnel, and managerial readiness and gaps, develop a

plan to address these gaps, and work on implementation planning.

In assessing where you are, and where your gaps in compliance may be, the team will want to determine if your organization has the proper translation capabilities to upgrade to the HIPAA mandated standards and code sets, for example. If not, what are your options? Some

- How will the vendor handle issues related to conflicts in X12 versions?

Clearinghouses

Since clearinghouses must be HIPAA-compliant, they can act as payer aggregators and provide one-stop shopping for all business partners, meaning both payers and providers can use them to transmit

Depending upon your expertise, it may be best to outsource some or all of your HIPAA assessment, planning, implementation, and maintenance.

questions to ask include:

- Do you want to hire staff, outsource the work, or hire a clearinghouse?
- Who will monitor and report on the progress of the translation and transition to the mandated standards?
- Are your trading partners HIPAA-compliant? How will you know for sure?
- Do you know what questions you should ask your existing and potential consultants and vendors?

Outsourcing

Depending on your in-house expertise, it may be best to outsource some or all of your HIPAA assessment, planning, implementation, and maintenance. Questions to ask prospective vendors or consultants include the following:

- What processes are in place for the vendor to be HIPAA-complaint?
- What HIPAA policies and procedures is the vendor following?
- What security measures does it use?
- Does the vendor have a team of professionals learning about the legislation?
- Who are the experts on the team?
- What services does the vendor offer?
- What industry organizations does the vendor participate in?
- Is the vendor currently using X12 (the standards the government has adopted for HIPAA) for transactions?
- What version of X12 is it using?

health care data effectively. Also, they can integrate the HIPAA transactions into your workflow and support all future standards. Clearinghouses that specialize in health care transactions interact with other clearinghouses and keep up on all versions of the X12 standard and all the mandated code sets, allowing physician groups and payers to send one version of their data to the clearinghouse. Because the clearinghouse will know what version to use, it will handle any necessary data conversion.

Some clearinghouses offer integration into the vendor systems that create the underlying transactions. Some effective examples of workflow integration include eligibility, authorizations, referrals, claims status, and remittance processing. Integration improves business processes for physicians and for payers and consumers as well. With integration, your data will be processed faster and be more accurate without the need for human intervention or rekeying. Also, the data will be available for reuse with subsequent transactions, such as certifying eligibility when submitting the claim.

While you may not yet know how you will achieve HIPAA compliance, the most important issue to focus on now is getting started. With less than two years to go, the clock is ticking. ■

Jon Zimmerman is the senior manager, HIPAA Initiatives, for Shared Medical Systems Corp., a Siemens Co., in Malvern, Pa., that specializes in health care information systems. He also is the general manager of Healthcare Data Exchange Corp. (HDX), a subsidiary of SMS that provides electronic transaction services for the health industry. More information on HIPAA is available from SMS at 610/219-2000 and on our Web site (see page 16).

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