

A Day in the Office

Chapter FastFACTS

- 1. Technology's impact on patient care and communication extends all the way from the waiting room through patient follow-up.**
- 2. E-visits can increase office revenues if they are newly billable events.**
- 3. The patient-centered medical home gets a boost from healthcare reform legislation.**
- 4. Group medical appointments are a growing trend and may become even more popular if reimbursement, regulatory, and privacy issues are resolved.**
- 5. Ethical and legal issues in 2015 will include concerns about electronic medical records, Internet usage, and information security.**

Fast-forward to the year 2015. What will be different about a day in your primary care medical office? Start in your waiting room, which has a flat-screen television—your patients will want and expect it—featuring health and wellness service announcements and videos. Patients won't have to relay information about visits to other physicians. Because the team approach to care is more common, thanks in part to more use of the patient-centered medical home (PCMH), patients' medical information from other physicians is easily accessible from their medical records. You're using e-mail and photos to communicate with your patients and using Webcams to "see" them. You

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document the visit in real time, then bill and collect while the patient is still in the exam room. You're faster, more efficient, more tech savvy, and more comfortable relying on physician extenders to see the increasing numbers of patients who now have access to primary care and are calling for appointments. Are you ready?



“There is potential for doctors to become more visible [by using online communications such as Twitter], but of course there are risks. It’s so new that there are no real guidelines about how doctors should interact with patients on Twitter.”

Kevin Pho, MD
Internist
Nashua, N.H.

Technology Leads

It’s 2015; and as soon as patients walk into your waiting room, the use of technology to streamline and enhance care and communication is apparent. Instead of filling out paper forms to update their insurance information and supply the reason for their visit, patients are given a high-tech, hand-held device to supply those details. While waiting, they may watch an instructional video on, for example, how to administer an asthma treatment to a child, says Beverly W. Macy, managing partner, Y & M Partners LLC, Beverly Hills, Calif., and CEO, Gravity Summit, a social-media marketing conference. After the visit, you follow up with the patient via e-mail. Your computer system sends reminders about annual exams that include links to set up those appointments, according to Pakhi Chaudhuri, MD, pediatrician at Pediatric Associates of Durango in Durango, Colo. For example, if a patient has a family history of diabetes or heart disease, the computer generates a reminder delivered by text, e-mail, or phone to stop in for a checkup.

People have talked about using technology like this for some time—the technology has been available—but the inspiration

and dollars to make it a reality were missing. What's going to move theory into practice over the next few years? Health reform will be a motivator along with the increasing number of physicians who like and want to use new technology. "Adoption of digital media is one of the biggest trends," Ms. Macy says. "We're seeing a new generation of doctors coming out of medical school now that is iPhone savvy—reading MRIs on iPhones, willing to download apps on iPhones—[and who] are encouraging their patients who are iPhone-literate to do the same. Doctors will be saying, 'I want you to download these coaching tips for walking, for diabetes, for lung health.'"

Technology and physicians' increasing comfort using it to communicate with patients will mean many physicians will have Facebook pages and Twitter handles, Ms. Macy predicts. Such social networks have already begun to assume importance for many physicians. For example, Kevin Pho, MD, says Twitter has greatly expanded the reach of his well-known blog. (At press time, Dr. Pho had over 25,500 followers on Twitter). The result? "More people read what I write, and are more interested in seeing me as a doctor or interested in what I have to say," says Dr. Pho, an internist in Nashua, N.H. He emphasizes that he doesn't give personal medical advice or direct messages online because of privacy concerns. "There is potential for doctors to become more visible, but of course there are risks," he cautions. "It's so new that there are no real guidelines about how doctors should interact with patients on Twitter." For now he feels comfortable using it to update his patients and readers and to guide them towards reputable sources of information.

He says more and more patients are going to look for this type of online communication with their doctors, citing a recent Pew Internet study that showed that 61% of adults in the U.S. use the

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Internet for health information and that a growing proportion is going to be found on Facebook, blogs, and Twitter. The most popular demographic on Facebook is the 18-to-35-year-old while the fastest-growing demographic is women over the age of 50, he notes.



“EHRs are going to do away with a substantial square footage now required for paper charts. You could take that space and turn it into [an area] for group visits.”

Roland Goertz, MD
President

American Academy of Family Physicians

Dr. Pho has an active online presence and a clear message: “I say that I’m accepting new patients. People can easily e-mail me,” he says. Given the influx of patients because of healthcare reform, this type of outreach is critical, he says. “You’re going to have over 30 million patients looking for primary care. You want that type of access to be there for newly insured patients looking for doctors,” he explains. “Becoming more accessible and transparent is something I’m actively trying to do.”

The E-visit

Take that communication a step further, and you’ll find what some say will be the mainstreaming of telemedicine: the e-visit.

While today a doctor may stitch up a patient’s leg and ask him to return in two weeks so he can see that it has healed, by 2015 most doctors are going to ask this patient to take an 8-mega-pixel picture of his leg with his iPhone6 and attach it in an e-mail so he doesn’t have to trek over to the office, according to Dr. Bauer. Or, instead of saying, “Bring your toddler in to see me so I can take a look at her eyes” for a possible pinkeye diagnosis, a doctor might say, “Send me a digital photo of her eyes” so she doesn’t spread conjunctivitis around the pediatrician’s office. “The doctor will have set up a system for the patient to send in that picture and say, ‘This has healed nicely,’ or ‘I see a little red-

dening still, so I'd better have you come in,'" Dr. Bauer says.

You'll see one out of five of your patients in your "virtual" office by 2015, according to John W. Bachman, MD, a family physician and Saunders Professor of Primary Care at the Mayo Clinic. He led a pilot study in June 2010 that was the first to measure the success rate of e-visits in a primary care setting. The study, which took place over two years, recorded 2,531 visits and billed 1,159. Because 411 of those e-visits were newly billable events, revenue increased at the practice. The e-visits also proved to be a timesaver—40% of the patients who chose an e-visit did not have to make a trip to the doctor's office. Once physicians realize that many patients will even pay extra to avoid coming to the doctor's office, the frequency of e-visits will begin to rise, he says.

Aiding the trend are video chat programs like Skype, which Dr. Pho says will become more popular, especially for practices in rural areas, if insurance companies and Medicare accept those "visits" for payment. Aetna, Cigna, United, BCBS NC, and Wellpoint already cover online consults/e-visits or any other secure, structured online visit, which would likely exclude e-mail, according to Intuit Health Group. While the majority of health insurance companies don't pay for e-visits/online consults now, according to Dr. Pho, he anticipates that more will reimburse online consults in the future. "I think it is positive that large insurance companies are on board ... [but] we're still a ways from that scenario. The tipping point will be when Medicare agrees to do so," he says.

But even with the advanced technology, doctors won't be available 24/7 on a video phone. While different staffing options may stretch your resources (see "Staff Options to Consider" and "Creating a Positive Work Environment"), Ms. Macy says to

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Staff Options to Consider

To accommodate the expected surge of patients as a result of healthcare reform, many physician offices should consider new staffing options, Dr. Murphy says. Those options include the following:

- networking with other primary care practices to share calls
- extending weekend hours
- considering adding more overtime to a nurse's paycheck
- adding blocks of time during which sicker patients are delegated to one physician so that another physician can attend a patient coming in for a physical

expect more retail clinics to appear in more superstore locations. Mr. Doherty agrees that retail clinics in stores like Wal-Mart and CVS will likely feel the impact of more people being added to the pool of those with insurance coverage who need off-hours, non-acute medical treatment. “We know there’s a shortage of physicians, particularly primary care doctors. So that could create an opportunity for more of these retail clinics to pick up some of that slack,” he says.

Your Medical Home

A day in your office in 2015 is likely to reflect the PCMH, in part thanks to health reform’s emphasis on a team-based approach to medicine that prioritizes preventive care. “Right now healthcare is episodic—you wait until you get symptoms to go to the doctor. The problem is that too often the symptoms or the illness comes on and is preventable,” Dr. Cutler says.

Mr. Doherty notes that references to the PCMH are sprinkled throughout the reform package. For example, Medicaid will have a new option: to offer medical homes as a source of care for

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Creating a Positive Work Environment

As your practice prepares for the future, it's more important than ever to create a positive work environment. Here are tips from Dr. Murphy on how to do so:

Align team member performance with your organizational goals.

Team members want to know what you expect of them. As a leader, don't assume that your team knows your mission and goals, no matter how experienced they may be. Create "SMART" goals: specific, measurable, achievable, results-oriented, and time-bound. For example, receptionists will make a pre-visit telephone call 24 hours before the appointment to verify that the patient remembers the appointment and plans to keep it.

Provide positive reinforcement to colleagues when you see your team achieving goals and doing things right. Did you witness a nurse handling a defiant two-year-old with finesse? If so, compliment her on the spot. Provide "FAST" feedback to your team members—frequent, accurate, specific, and timely. When you, as a leader, give this type of positive reinforcement and encouragement, you are showing everyone which behaviors you want in the workplace.

Think about what kind of leader you are. Have you created positive, coaching relationships with each member of your team? Do you meet with your team members individually, getting to know their goals, ideas, and obstacles? Are you upbeat, positive, and energized with a clear vision of where you're going? Would you want to follow you? When the leader is positive and energetic, the office climate feels optimistic and energized. When the leader is upset, frustrated, and negative, these emotions permeate the culture.

Talk with your team about the culture you want, and ask for their ideas. How do they visualize an ideal office setting? How do they want patients to describe a visit to your office? How do they want to treat each other? What kinds of professionals do they want to work with every day? Now, more than ever before, leaders of medical practices must take initiative to build an engaging culture where team members are encouraged and rewarded for providing patient-centered, high-quality, and cost-effective care.

Medicaid enrollees. "This is very important because ... about 15 to 16 million more people will end up being covered by Medicaid under the new legislation. So creating options for those people to get care through a qualified medical home would be a major

change,” he says. In addition, the Center for Medicare and Medicaid Innovation, under the legislation, would specifically consider ways to accelerate the implementation of medical homes for the Medicare population. Other provisions in the PPACA would provide help to practices that want to become a medical home, he says. He is also encouraged by legislation in the PPACA that will require the U.S. Dept. of Health and Human Services to implement a grant program that would fund health teams of nurse educators, dietitians, and others that could provide support to small practices that want to become medical homes but may lack the resources to hire those people themselves.

Fred Ralston, MD, FACP, ACP president, and a practicing physician in Fayetteville, Tenn., says he hopes—and anticipates—that patient care will be delivered through PCMHs by 2015. “[These will be] the focal point of many aspects of practice transformation, allowing new ideas to be tested and best practices to be disseminated widely,” he says. (See “One Internist’s Typical Day.”)

Group Medical Appointments

Another option for additional revenue that will be more common by 2015 is the group medical appointment, which is centered on a chronic condition like diabetes, chronic lung disease, blood pressure, or obesity. It’s already gained in popularity: An AAFP survey in 2009 found that twice as many family physicians held group visits as did so in 2005. Part of the growth may be due to having more physical space available in the office because of new technology, according to Dr. Goertz, who recently began offering these appointments to his diabetic patients. “EHRs are going to do away with a substantial square footage now required for paper charts. You could take that space and turn it into [an area] for group visits,” he says.

In addition, the emphasis on population-based care coordination and more efficient ways of delivering services will encourage more physicians and patients to try group visit arrangements, Mr. Doherty says. “For them to be successful, though, reimbursement, privacy, and regulatory barriers would need to be overcome,” he notes.

Edward J. Shahady, MD, FAAFP, a family physician in Fer-

One Internist's Typical Day

Dr. Ralston, who has been in practice since 1983, outlines how he envisions a typical day as an internist in 2015:

From Home:

From home enter a secure link to the electronic record, and review scheduled appointments for the day. Review e-mail requests from patients and respond as appropriate—sometimes scheduling an appointment and in other cases calling the patient or referring to an appropriate staff member. Review reports from the evening walk-in clinic, and see what follow-up might be required. Check on the patient recently discharged from a referral hospital, and send an e-mail requesting a discharge summary and medication reconciliation.

In Office:

See a patient with back pain; share appropriate guidelines with him, talking him out of an immediate referral or an MRI. With another patient find that there is a need for a branded medication. Query the electronic record and find which medication is covered and whether prior approval is needed; this information is immediately populated through an online form. (I will only have to enter some clinical data and get either immediate or prompt approval with minimal expenditure of time.) With partners and other members of the healthcare team, see walk-in patients who are able to come for visits that work with their schedules.

During breaks in the work day send e-mails giving routine test results. Review and act on incoming specialty evaluations. Respond to routine e-mail requests from other specialists for information that helps them avoid duplicated tests and provide better care.

Such a system provides better value, measures quality, and provides a process for continuous quality improvement.

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nandina Beach, Fla., has been conducting group medical appointments for ten years and says patients thrive on the support. But he notes that physicians need different skills to lead a group visit as opposed to a one-on-one visit. “It’s a facilitated skill. You have to encourage [patients] to ask questions and then resist the urge to answer a question. Sometimes you make more of an impact when another patient says, ‘Yep, I had that same problem, and this is what I ended up doing,’ and then you can reinforce good advice and ask if anybody else has tried anything,” Dr. Shahady suggests.

Escalating Risk?

The changing environment in your office brings with it ethical and legal concerns, especially given the likelihood of bringing in physician extenders to meet increasing patient demand. “With regard to the increase in patient volume, I think that physicians would need to avoid the temptation to delegate tasks to professionals without appropriate training. As long as they do so and provide appropriate supervision, they are protected,” says Michael K. Gusmano, PhD, research scholar at The Hastings Center, Garrison, N.Y. He says that while supervising physician extenders will not be radically different in 2015 from what it is today—the individual state will continue to govern who is allowed to perform certain tasks—it could create a greater supervisory burden on the physician. “This will need to be balanced against the benefits of freeing up physician time for other activities,” he says.

One way to minimize supervision time is to hire well and do thorough background checks, says Thomas P. Cox, president and managing member of Bluewater Solutions LLC, a risk and insurance management firm in Richmond, Va. “Develop strict protocols based on state laws, standards of care, and common sense; then put in place processes to ensure the protocols are followed,” he advises.

Ethical and legal worries in 2015 will include increased concerns about electronic medical records, Internet usage, Internet and electronic information security, and related issues. Privacy regarding patient records will be “a real hot issue,” says Dr. Murphy. In addition, “Physicians will have an increased strug-

gle with others telling them what to do, i.e., health systems, insurance companies, and the government ... but with the physician ultimately responsible for the outcome,” Mr. Cox says.

Doctors like Dr. Martin expect more legal issues to arise, given Stark and Medicare anti-kickback statutes that will make it difficult for independent practices to engage in joint-venture activities such as clinical lab and imaging for their patients. “Stark anti-kickback statutes are currently in place, will be updated in the future, and will most likely become more onerous in the future,” Dr. Martin says. “Many of these laws, however, have provisional carve-outs for group practices to develop broad ancillary services in the group setting.” He also notes that ever-changing medical business regulations such as HIPAA, OSHA, CLIA, and labor law statutes will continue to be burdensome for physicians.

Medicare reimbursement, based on the sustainable growth-rate formula, as well as future payments for reporting or performance, electronic prescribing, and EHRs will be more challenging in the future, he says. He advises paying particular attention to future contracts to the legal structure, compensation, severance policies, chart and patient-list ownership limitations, malpractice tail coverage, and restrictive non-compete covenants.

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