Are Your Physicians Crying About Your EMR?

A new report suggests that 2013 may be the year of the great electronic medical records (EMR) vendor switch given that many EMRs are falling short of providers’ expectations.

To come to that conclusion, Black Book Rankings polled roughly 17,000 active EMR adopters — and found that as many as 17 percent may switch out their first-choice EHR by the end of the year.

The reason: In light of Stage 2, provider demands are increasing, and EMR users are reporting that many EMRs aren’t living up to expectations. In fact, those polled cited numerous cases of software firms underperforming badly enough to lead them to lose market share.

As a result, 31 percent of survey respondents indicated they were “dissatisfied enough” with their EMR to consider switching. Of those users, the reasons cited for the potential switch were as follows:

- The EMR did not meet the practice’s needs (80%).
- The practice had not adequately assessed its needs
before choosing the EMR (79%).
- The EMR design did not fit the medical specialty (77%).
- The EMR vendor was unresponsive to requests (44%).

Published with permission from TechAdvisory.org and Steve Spearman’s Health Security Solutions.

Mary Pat’s Note: Lots more interesting information can be found in the original press release.

How Physicians Can Offer Direct Primary Care to Employers: An Interview with Dr. Samir Qamar of MedLion

Staying with the theme of practice models for independent physicians, here’s an interview with Samir Qamar, MD of MedLion.
Mary Pat: You are the Founder and Chief Executive Officer of MedLion, as well as a practicing Family Physician. Tell us your story.

Dr. Qamar: I grew up around the world the son of a UN diplomat, with a lot of time spent in Europe (including medical school). Growing up, I always wondered why most Europeans never needed insurance for basic medical care. I also learned a lot about the pros and cons of government-run health systems.

During my family medicine residency training at Lancaster General Hospital in Pennsylvania (one of the best programs in the nation), I took the time and effort to also understand the reimbursement system. After realizing obvious faults within it, I became obsessed with finding other models that would not necessitate daily high-volume patient traffic, which in my opinion, led to poorer quality care. “Concierge medicine” was becoming popular (2003), and I saw the advantages to both patients and doctors in this new subscription model. While still a resident, I incorporated my first concierge practice and immediately made headlines for my views on healthcare. Upon graduating from residency, I had made my decision to move to beautiful Monterey, California, where I had a dozen patients waiting for me due to marketing efforts while completing my program.

Within two months, I made local headlines again for starting the first concierge practice in central California, and soon thereafter, became the house physician for the famed Pebble Beach Resorts. In the meantime, my wife, Dr. Hisana Qamar, began her own practice that accepted traditional insurance and Medicare. Both of us grew our respective practices to great success, and were in a unique position to compare the membership model with a traditional model.

In 2009, witnessing the effects of the recession on
unemployment (and resulting lack of benefits), I created MedLion Direct Primary Care. I wanted to design an affordable membership model for those with little or no health insurance. It wasn’t long before I realized this model appealed to employers as well, and our company began to grow.

MedLion launched the first direct primary care practices in California. Today, MedLion Direct Primary Care is one of the national leaders in its industry, with practices in multiple states. Without any outside investment, MedLion's lean business tactics have enabled it to scale quickly, outshining capital-heavy competitors in half the time.

Mary Pat: I was very surprised when I Googled “MedLion” and the first entry on the page said “MedLion – Direct Primary Care – $10 a visit.” First, what is Direct Primary Care?

Dr. Qamar: “Direct Primary Care” is when individuals or employers pay “directly” for “primary care.” Because of this “direct” care, excessive overhead, such as insurance claim processing costs, prior authorizations, billing and coding, extra office space, and unnecessary staff is removed from the business equation. The savings attained are passed on to the patients in the form of lower fees. Doctors are less dependent on third party payers, and end up working in the best interests of patients, not insurance companies.

Mary Pat: How can you provide an office visit for $10?

Dr. Qamar: MedLion revenues are generated from monthly subscription fees. Among the list of services provided under the subscription are $10 office visits. MedLion believes in price transparency, and every patient knows that he or she will be charged $10 for the office visit, whether a full physical, a counseling session, or a simple blood pressure check.

Mary Pat: On your site, you state “Insurance was never meant for primary care.” Will you explain what you mean?
Dr. Qamar: Insurance is the business of risk management via coverage for rare, expensive events. Nearly every industry in this country uses insurance in this manner – except health care. In health care, in addition to covering for rare events like surgeries and accidents, insurance is also used to cover common medical events as routinely encountered in primary care. Whenever insurance is used to cover common events, premiums go up due to claims being filed more frequently. Unfortunately, routine primary care is expensive in the current state, and society is forced to seek health insurance for this as well. This drives up health care costs across the board.

Direct Primary Care is able to make primary care relatively affordable, and thus eliminate the need for costly insurance. Health insurance is reserved for rare, expensive events, like in all other industries. By removing the need for insurance from primary care, which is a significant portion of health care, costs are driven down.

5. Mary Pat: You discuss Telemedicine on your MedLion website – how do you provide care to patients without them coming to the physician’s office and what software do you use for this?

Dr. Qamar: Like most quality medical providers, MedLion has clinics where patients can be seen – but only when necessary. Because MedLion Direct Primary Care does not operate on fee-for-service incentives like most of the country, our practices do not force patients to come in unnecessarily. Most insurance-based practices are not reimbursed unless patients are seen in the office setting. This is why it’s so difficult to get on the phone with the doctor or get a routine refill on a medicine. At MedLion, we reduce unnecessary testing and clinic visits by communicating with our patients outside the practice. If an established patient can safely be treated remotely and the concerns are not serious, telemedicine is practiced. If the patient’s condition is such that the doctor (or the patient) feels it is necessary to be seen, an in-
person appointment is made. We use a variety of processes that allow us to perform telemedicine encounters, from simple phone appointments to electronic systems with texts or emails.

Mary Pat: What is the point where direct primary ends and insured care begins?

Dr. Qamar: This is an excellent question. In paying directly for care, the line is drawn when the consumer can no longer afford to pay for services, usually after basic primary care services. Direct primary care can offer affordable provider visits, labs, imaging, and medicine. Care beyond primary care is where insurance comes in handy. Examples are hospitalizations, surgical procedures, and specialist care.

Mary Pat: How does Direct Primary Care work with High Deductible Health Plans and Health Savings Accounts?

Dr. Qamar: Direct Primary Care can complement High Deductible Health Plans (HDHPs), taking care of the primary care component of health care. HDHPs, or major medical plans, can take care of catastrophes. This combination can result in significant savings overall. Health Savings Accounts (HSAs), when structured properly with Direct Primary Care plans, can also be used. The key is working with a Direct Primary Care company, like MedLion, that has unquestionable legal and insurance knowledge.

Mary Pat: I know you are focused on giving employers good value for their money. Can you tell me how Direct Primary Care works for the employer?

Dr. Qamar: MedLion’s Corporate Health Strategies division can do amazing things for employers of all sizes. MedLion’s benefits team can dismantle a company’s insurance plan, insert MedLion Direct Primary Care, and put it back together in a way that can help the company significantly lower costs. We build onsite or near-site clinics for large employers or municipalities. (Currently we are in talks with a company with
over 9,000 employees, and are discussing building a clinic for city employees in several states.) We can assist small and mid-sized businesses become self-insured despite not having large reserves, cut healthcare expenses, and circumvent many of the stringent requirements of the Affordable Care Act. MedLion can include workman comp injuries within its Direct Primary Care plans, drastically reducing costs to the employer, as well as the insurance carrier, and we are able to structure agreements with employers in such a way that monthly MedLion fees can become tax-deductible. We can also offer a minimum of affordable primary care benefits to part-time employees, dependents, opted-out full-time employees, early retirees, and independent contractors, all of which keep the entire workforce healthy. Because MedLion practices have protocols for safe and effective telemedicine, in many cases employees can be treated without them having to visit the doctor’s office – increasing productivity for the host company. We also offer wellness programs, occupational health programs, and screenings to employers of all sizes.

**Mary Pat:** I have written before about the resurgence of physicians starting new private practices – what does the MedLion model offer to physicians wanting to start their own practice?

**Dr. Qamar:** Unlike most major Direct Primary Care (DPC) companies nationwide, MedLion takes pride in teaching entrepreneurial primary care doctors how to convert, or even start, their own practices. Graduating residents desiring the DPC path are helped as well. We offer Legal Support, Membership Services, Billing and Collections, Marketing and Advertising, Referral Support, Customer Service, and Business Guidance. Several software systems have been specifically chosen for MedLion physicians. Affiliate doctors are able to practice telemedicine, import dictations, create and store electronic records, and retrieve MedLion patient records when needed from other MedLion practices. MedLion will also teach
non-EMR practices how to transfer paper charts into electronic records in the most efficient manner possible.

**Mary Pat:** Why should physicians consider MedLion as opposed to opening a Direct Primary Care practice on their own?

**Dr. Qamar:** The answer to this is simple. Most doctors have trained in medicine, not business, law, or insurance. Private practice is a business. The new industry of Direct Primary Care is unregulated and requires extensive interpretation and monitoring of continuously changing laws. Most doctors operating on a solo level cannot influence major insurance companies to cooperate, create the best self-insurance plans with Direct Primary Care, and persuade large companies to sign up its employees. Besides the knowledge and manpower required in doing all the aforementioned, it can also be extremely expensive and time-consuming. This is where MedLion can be very valuable for the solo practitioner wanting the benefits of a Direct Primary Care practice.

MedLion believes a physician should do what they do best – practicing medicine. MedLion was created by physicians, for physicians, in an effort to help resuscitate primary care private practice. Why reinvent the wheel, go through years of trial-and-error, and assume unnecessary risk? With MedLion, doctors have a nationally-reputable partner, and still retain the independence and autonomy so many physicians crave today.

*For more information, interested parties may contact MedLion.*
How One Hospital Uses Box to Mobilize Their Providers

At Wake Forest Baptist Medical Center in Winston-Salem, North Carolina, doctors are saving time and sharing ideas using Box, a file-sharing and collaboration software that lets providers browse available medical documents and communicate with each other about treatment options. We are big believers in Box at Manage My Practice – we use it, and most of our clients end up using it too. Box is the only HIPAA-compliant file storage and collaboration service, and just like the doctors at Wake Forest, it makes our lives easier countless times a day. Wake Forest uses Box to store all of their medical journals and articles, as well as commenting on each file so that physicians can discuss procedures and treatment options. The doctors can access the repository from their tablets and smartphones, so that accessing detailed disease or treatment information is always as close as their mobile device.

Box is a simple and secure solution for sharing content with your coworkers, customers and audience. If you have moved your organizations’s practice management, electronic health record or email service to “the cloud” then it only makes sense to move your paperwork and content out of boxes and storage and into the cloud as well. If you have are using email
attachments, a network drive, FTP server, or a non-compliant solution like Dropbox, then switching to Box can help your practice reduce your liability, stay HIPAA compliant, and store all of your digital content in a secure and accessible manner.

Box also makes mobilizing your workforce across locations easy. Box means your content is always available in a web browser, a phone or tablet, or synced on your desktop. Many of our consulting clients also use it to coordinate work and file across locations. If you have outsourced your billing or human resources, a shared folder in Box allows both locations to have the latest information and stay in touch.

Manage My Practice is a Certified Box Reseller, and would love to help you leverage Box to improve your practice’s workflow.

Cutting Waste is More Important Than Ever: An Interview with Lean Healthcare Expert Mark Graban
Many colleagues I speak with have a sense of or some experience with the tenets of “Lean.” But how does it really apply to healthcare – and is it really a way for medical practices to do more with less and maximize their resources? I recently spoke with Lean Healthcare Expert Mark Graban about where the rubber meets the road in healthcare.

Mary Pat: Most people have heard of Lean or have had some experience with it – can you explain what Lean is?

Mark: “Lean” is a process improvement methodology and a management system that’s based on the Toyota Production System, with roots and influences in the teaching of Dr. W. Edwards Deming. What was originally “Lean Production” has been embraced beyond the automotive industry into other types of manufacturing, the service sector (including healthcare and settings like Starbucks), and even government (such as the state of Washington).

Mary Pat: What is the difference between Lean, Six Sigma and Continuous Quality Improvement (CQI)?

Mark: I would associate CQI most closely with the term Total Quality Management (TQM) – a term used more in the 1990s. Arguably, Six Sigma is an evolution of TQM, with a deeper statistical focus and the added formality of “belts.”

Lean typically uses the “7 basic QI tools” that are in common with TQM and Six Sigma. While I think Lean and Six Sigma can co-exist and be complementary, I do not believe in a combined so-called “Lean Sigma” approach. Six Sigma is expert driven,
while Lean is more inclusive of the problem solving capabilities of all staff members. I also think Lean provides a more cohesive management philosophy than does Six Sigma, while Six Sigma certainly has valid methods that can be used for particularly sticky problems. One false dichotomy that’s often stated (usually from the Lean Sigma crowd) is “Lean is for speed/efficiency/flow and Six Sigma is for quality.” This is completely false. The two core pillars of the Toyota Production System are “Just in Time” (flow) AND “Jidoka” (or quality at the source).

Mary Pat: Tell us about your background and how you got involved in Lean healthcare.

Mark: My undergraduate degree is in Industrial Engineering and I have two master’s degrees, in Mechanical Engineering and an MBA, from MIT. Growing up in a GM family outside of Detroit, I saw a career for myself in progressively higher manufacturing management roles. After 10 years in industry, in 2005, I had an opportunity to take a role at Johnson & Johnson, as part of their consulting group that did Lean improvement work with medical laboratories and health systems. I was fortunate to work with some of the early adopters of Lean healthcare (those working with innovative labs in the early 2000s) and to help them extend their methodology into other parts of hospitals and primary care. When I got into healthcare, I figured it would be an interesting detour or a career shift… turned out to be a career shift as I love working in healthcare.

Mary Pat: What has been your most unusual or interesting lean project in healthcare?

Mark: Well, they are all interesting, but I think one of my favorite experiences was working with a National Health Service (NHS) hospital pathology department (lab) north of London back in 2008. Working there for about eight weeks, it really solidified my view that there’s much to learn about healthcare delivery across national boundaries. Although the
payer model is different, the way labs (and, more broadly, hospitals) work is pretty much the same in the U.S., Canada, Japan, Holland, Sweden, and other countries I’ve visited or worked with. There’s much to be learned from American hospitals (as Japanese hospitals come here to visit and learn) and there’s much to be learned from the NHS, such as their “Releasing Time to Care” (RTTC) model for improving inpatient care. The RTTC website states “Releasing Time to Care focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.”

Mary Pat: On your blog, you talk about Lean in terms of eliminating waste and creating value. Value is something we are starting to hear a lot about in healthcare – can you talk about how you use Lean to create value?

Mark: In healthcare, I think value to the patient is any activity that contributes to being comforted, diagnosed, treated, or educated. When we reduce waste, the time previously spent by doctors, nurses, or others can be rededicated to patient care – or value. If nurses get to spend more time with patients, then we have more value (better education and better emotional care) and we also reduce defects – like falls, pressure ulcers, etc. When we reduce waste and that, for example, reduces the length of stay, then we can increase throughput and see MORE patients, providing more value (and with less delay). Lean also has guiding principles that drive us to avoid providing too much care – unnecessary lab tests, etc., – since more activity doesn’t necessary mean more value.

Mary Pat: I know most of your work is focused on healthcare in hospitals, what about healthcare in physicians practices – is there any opportunity to apply Lean concepts?

Mark: With Lean, we should always start by defining the problem – what do we want to improve? What are some of the problems in physician practices? If patients are waiting a
long time for appointments, the clinic should work on increasing patient throughput – which is done by reducing waste, not shortening appointment times. Clinics can make other improvements that increase patient satisfaction, such as improving communication with patients, reducing delays in getting lab results or prescription refill orders out, etc. There are fewer examples of Lean in outpatient clinic settings, compared to hospitals, but the results can be impressive. Sami Bahri, DDS, “the world’s first Lean dentist” in Jacksonville, Florida has reduced waiting times for patients (eliminating the use of his waiting room and taking care of follow up care in the same visit instead of a separate visit), while dramatically improving his dental group’s financial performance (as outlined in his book Follow the Learner).

Mary Pat: Short of attending a Lean workshop, which many healthcare managers may not be able to do, how do you suggest they introduce themselves to lean and consider how they can apply it to their organization?

Mark: At the risk of being self-serving, my books Lean Hospitals and Healthcare Kaizen are a relatively inexpensive start. There are also some fantastic books that have been published about the Lean work done at three leading organizations: On the Mend (about ThedaCare), Transforming Health Care: Virginia Mason Medical Center’s Pursuit of the Perfect Patient Experience, and Leading the Lean Healthcare Journey: Driving Culture Change to Increase Value (Seattle Children’s Hospital). Books and blogs are inexpensive (or free) ways to learn Lean lessons and case studies.

Mary Pat: You have a lot of interesting resources on your blog, www.leanblog.org, among them 168 podcasts! What one podcast that you’ve recorded should everyone reading this interview listen to and why?

Mark: I’ve managed to have some really great guests on the
podcast to talk about Lean, including former ThedaCare CEO John Toussaint MD. I think the most powerful podcast is my discussion with Paul O’Neill about leadership and patient safety (http://www.leanblog.org/124). O’Neill made huge improvements to employee safety while CEO of the aluminum maker Alcoa and brought his leadership lessons into healthcare through the Pittsburgh Regional Health Initiative, inspiring the work of Richard Shannon, MD and others who have reduced hospital acquired infection rates through Lean methods.

**Mary Pat:** You are also Chief Improvement Officer for KaiNexus. What is KaiNexus and what does a Chief Improvement Officer do?

**Mark:** KaiNexus is a software and technology company that makes improvement easier for organizations, including those in healthcare. We were founded by an Emergency Room doc who learned about and used the “kaizen” method of improvement as a resident at Vanderbilt, developing technology that was later spun out as KaiNexus. We have a web-based platform that allows organizations to solicit, capture, and track improvement ideas, resulting in employee recognition and a searchable and sharable history of improvements that can be easily accessed. The software leads to more improvements being implemented more quickly, based on our customers’ experience. In the role of chief improvement officer, I am the primary educator and advocate for Kaizen-style improvement, working with current customers and assisting in the sales and marketing processes. We’re a small company, so everybody gets to do a little bit of everything. It’s a lot of fun.

**Mary Pat:** Is Lean Mean?

**Mark:** The word “Lean” as a description of the Toyota Production System was supposed to be a positive – in that they had significantly fewer defects, lower costs, and faster time to market with new products as compared to their competitors. But, in everyday parlance, “Lean” has connotations of not having enough resources or cutting to the bone. The Lean
methodology is very positive for healthcare if people can get past the word. **Lean is a methodology that solves problems like understaffing, long waiting times, and poor quality.** If the MIT researchers had described Toyota as “effective production” or “happy production,” instead of “lean production,” this methodology might be more warmly received when people first hear the word.

Mark Graban is an internationally-recognized author, consultant, and speaker who can be contacted through [www.MarkGraban.com](http://www.MarkGraban.com) or his blog at [www.LeanBlog.org](http://www.LeanBlog.org)

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**Before and After: How the Sequester's Cut will Change Your Medicare Reimbursement**

This is no April Fool’s Joke for medical practices and providers: starting Monday, April 1st, we will face a 2% cut in reimbursement for services due to the “sequester.” The sequester is the other half of the “fiscal cliff” that we
Although not too long ago, all the conventional wisdom was dead set against the government “going over the cliff,” and here we are with both automatic tax hikes and spending cuts now a reality.

Managers might find themselves giving the same explanations about gridlock to the doctors that you gave your employees when their first paycheck of 2013 was lower than usual.

Although the cut is only 2%, it comes entirely from the 80% of the allowable that the government reimburses, as opposed to the 20% patient responsibility. The cut does not affect the Medicare patient’s co-insurance, not does it affect the 2013 Medicare Part B deductible.

To give medical practice managers an idea of what that cut will look like, here are some sample numbers.

Let’s Assume: a solo primary care physician sees roughly 500 patients a month, 30% of whom are Medicare-enrolled. Of the 150 Medicare patients seen per month, a quarter of them are new patient visits. Let’s also assume that about 40% of your Medicare visits are coded as level 3 office visit, with the remaining 60% coded as a level 4 visit. If these numbers seem oversimplified – they are, but I’m hoping to keep the math a little under control. Using the unadjusted, national reimbursement of these four basic CPT codes from the AMA, here’s how the sequester would affect a practice.

<table>
<thead>
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<th>Medicare Reimbursement</th>
<th>Patient Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-Sequester</td>
<td>Post-Sequester</td>
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<tr>
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<td>$108.19</td>
<td>$99.55</td>
</tr>
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<table>
<thead>
<tr>
<th>Medicare Reimbursement</th>
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<td>Post-Sequester</td>
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</table>

In this scenario then, pre-sequester, the physician would be reimbursed a
total of $12,629.18 for the month. With the 2% cut taken on the federal government’s portion starting April 1st, 2013 that number would shrink to $12,376.60 – a difference of $252.58 a month.

The beginning of the calendar year is already tough on many practice’s cash flow because of deductibles restarting. A 2% cut in Medicare reimbursements from Uncle Sam is not going to help. As for the future outlook of the sequester cuts, there has been no real movement on the part of the Democrats or the Republicans to replace the cuts now that they have happened. For the time being, they seem here to stay.

We are advising our clients to take a look at their financial policies and collection procedures in the wake of these changes. Collecting patient-responsible co-pays, co-insurance and deductibles on the front end is more important than ever. One idea that we recommend every practice take a look at is starting a credit card on file program in your practice to cut collection costs, increase front-end collections, and reduce days in accounts receivable (A/R.)

Our next webinar – “Starting a Credit Card on File Program in Your Practice” will be Tuesday, April 2nd, 2013, and is a 60-minute program designed to give you all the tools you need to start a program in your practice. We’ll hope you’ll join us. Register Today!

[Slide Deck] How Doctors Are Paid Today: Understanding
RVUs

There’s a lot of talk today about how physicians (and other care entities) are paid. This slide deck discusses how the system used predominantly today (RBRVS) to pay physicians came to be and how Medicare and other payers calculate a payment. Download this Slide Deck and learn about Relative Value Units.

Understand RVUs from ManageMyPractice
Click Here to Download.

The Single Most Important Thing You Will Do to Improve Your Accounts Receivable in 2013

If you could improve your patient collections from $600 a week to $6000 a week, would you do it? Of course you would! These numbers are from a Manage My Practice client who is collecting between $2500 – $3000 per day in a solo primary care physician practice with the Credit Card on File program.

Establishing a Credit Card on File program in your practice will significantly increase your practice’s cash flow, significantly decrease your accounts receivable, and reduce your patient collection expense immediately!

Register now for just $59.95 and learn why it works and how it works, and get all the templates and forms you need to start the program in your office. Most practices can implement a
Credit Card on File program in as little as 5 or 6 weeks.

Please join us on Tuesday April 2nd, 2013 at 1 p.m. EST for a 60-minute session that will prepare you to plan, prepare, negotiate, and execute your Credit Card on File Program. Your patients and your staff will be happier – and so will you!

Register here for Tuesday’s Webinar.

Also, special thanks to Brandon Betancourt of Pediatric Inc for his very kind words about our webinar. Check out his blog!

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The Direct Pay Physician Practice Model: An Interview With Scott Borden

Most readers know that I have a special interest in helping physician practices survive and thrive, and have been writing recently about different models of care that physicians are adopting to make private practice financially viable.
Here’s an interview with Scott Borden of Direct Pay Consulting, who helps practices convert to a Direct Pay Model. ~ Mary Pat Whaley

Mary Pat: What is your background, Scott?

Scott: I am a passionate Health Savings Account (HSA) expert. My background has been in health insurance marketing and management for 23 years. I have been heavily involved with Consumer Driven Healthcare for the past 15 years. I have been both a talk radio show host and guest on hundreds of shows over the past 8 years. I have also been featured on several television broadcasts and been a guest speaker for dozens of organizations.

Mary Pat: Your company is called Direct Pay Consulting and you help primary care practices transition to a Direct Payment Care (DPC) model – will you explain what that model is?

Scott: DPC is where the patient pays the physician directly without any third-party insurance company or government program being involved with the payment or treatment plan. It is also known as Direct Primary Care or simply Direct Pay. This usually involves an annual membership fee and sometimes a per visit fee. There are hybrid versions available where insurance is billed above the annual membership fee, but we know any payment from an insurance company or government entity will include intrusive control over how the physician practices medicine. And it significantly increases paperwork.

The original version known as “Concierge Medicine” started in the late 1990’s in Seattle and has been slowly picking up steam. Both Concierge and DPC allow physicians the time necessary to treat the root cause instead of simply medicating symptoms. Additional benefits include same or next day appointments, less (or no) waiting times, cell phone / email / Skype access, coordination of care with specialists and even house calls. Concierge physicians may charge $1,500 – $20,000
or more per year so it may be cost-prohibitive for many Americans. DPC offers nearly the same benefits as a Concierge Physician at an affordable rate almost anyone can afford.

Mary Pat: Why do you think now is the right time for this model?

Scott: There are many things currently happening that each point towards DPC as the solution. Together they are turning what would have been a gradual movement into a potential mass exodus.

The first issue frustrating all physicians is decreasing reimbursements. The “Doc Fix” is unlikely this year as Medicaid payments will match Medicare in 2014 meaning the fix would be much more expensive this time. The odds are further reduced by the lack of an election this fall pressuring congress to delay the planned cuts again. Many independent physician practices are being bought by larger hospital groups. Since reimbursements are not tied to the amount of time spent per patient, these groups typically pressure physicians to see more patients per day. They have been known to require treatment plans based on maximizing reimbursements instead of better patient outcomes. So unfortunately many doctors today feel like they’re working for insurance companies and hospitals instead of their patients.

Second is the shortage of physicians. Nearly 50% of a primary care physician’s time is spent writing letters and filing claims in order to receive payments from insurance companies. And whatever payments they actually do receive seem to arrive late. Forecasts show that physician access will be significantly worse once the Affordable Care Act (Obamacare) subsidizes health insurance for 30 million people that will be searching for a primary care physician instead of using the Emergency Room for minor medical needs. This will even further reduce the amount of time available with each patient.
And the most important driver is the pent-up demand from patients. People are afraid Obamacare will take their doctor away. They already hate being herded through a system of long waits and limited access, and they know it’s not going to get any better. Many middle class Americans are willing to pay a little more to receive excellent medical care from a doctor they have chosen.

Mary Pat: How can physicians evaluate whether DPC is a good fit for them?

Scott: Although every physician should consider DPC, very few will be able to transition without the typical “income dip” that occurs when all insurance and Medicare reimbursements stop.

We have developed tools to help determine whether a physician should go full DPC or start out with a hybrid version while the DPC side builds along with potential revenue projections. These tools don’t account for every situation such as those physicians that are wanting to semi-retire without reducing income. Every situation is different.

Mary Pat: What is the scope of services you provide?

Direct Pay Consulting provides all of the services a physician needs to convert his/her practice:

- Conversion planning and execution
- Patient insurance education and guidance
- All announcements and ongoing communication
- Patient sign-up management
- Patient agreements
- Online tools and calculators for patients
- Custom web pages for the doctor
- Management of the wait-listed patients

The idea is for the doctor to continue to do what they do best while we manage the conversion and ongoing patient
participation. We have partners that can provide services from setting up an office to management of day-to-day operations for those doctors who are breaking away from a group. All of this is completed at fair and reasonable costs.

Mary Pat: Is it scary for physicians to take the “leap of faith” necessary to make the switch over from fee-for-service to DPC?

Scott: Actually I think the scary option would be to remain in the current system allowing insurance companies and government bureaucrats to take over virtually every business and patient decision! Many doctors who take on the conversion as a lone wolf find that it takes much more time than expected. They experience many pitfalls and delays. Many times they are forced to completely stop their practice to allocate the time needed which is very costly. If they don’t have enough patients sign up then physicians are forced to begin the even more difficult process of finding new patients. The idea behind Direct Care Consulting is to have the doctor continue to file insurance until a predetermined number of patients sign up thus limiting the risk.

Mary Pat: What expenses are eliminated when DPC is adopted? What new expenses, if any, arise? Are any staff positions eliminated?

Scott: Each conversion is vastly different. The primary expenses that go away are those related to coding and filing for payment from insurance providers and government agencies. Rarely are there any new expenses. For many practices this can eliminate one or two clerical positions.

Mary Pat: How does it work if physicians want to continue to see Medicare patients? Does the physician have to opt out of Medicare?

Scott: No physician would be forced to opt out, however most DPC physicians will choose to stop taking Medicare. They don’t
want anyone (let alone a government agency) dictating how they are to treat patients. Accessing some benefits outside the DPC practice for Medicare patients such as durable medical equipment might be more complicated, but not impossible. Medicare patients may find it more difficult to find physicians willing to accept them in the near future, so Medicare patients could very well become the fastest growing adopters of DPC.

Mary Pat: I’ve heard you are called the “HSA Guy.” What do HSAs have to do with DPC?

Scott: HSA-qualified High Deductible Health Plans (HDHP) offer the catastrophic protection everyone needs at a significantly lower cost than low deductible co-pay health insurance plans. I call HSA-qualified plans “DPC friendly” since they are not allowed to have office visit co-pays which wouldn’t be accepted by a DPC physician anyway. This insurance premium & tax saving tool allows many middle income patients to transition to a DPC practice without breaking their budget. HSAs make DPC affordable for (almost) anyone.

Mary Pat: Why did you transition from 20+ years of health insurance consulting into Direct Pay Consulting?

Scott: Last year I had no idea how much pent-up demand there was from both physicians and patients for DPC. Then I was approached by Dr. Douglas Brooks who has been a long time talk radio show listener that was ready to go Direct Pay.

But Dr. Brooks’ wife wasn’t convinced. She was concerned about the dreaded income dip that normally accompanies quitting insurance and Medicare cold-turkey. She was especially concerned since Dr. Brooks was already one of the top 1% compensated primary care physicians in the country. But Dr. Brooks was so fed up with the various hospital groups he had worked for that he was willing to go for it. He asked me for my help and we put together a business and marketing plan.
I felt we needed 1,000 patients to sign up in order to replace his salary. He reached that level in three months. Let’s just say Mrs. Brooks is no longer concerned. I now know this level of success is extremely rare. I’m not sure it has ever been done before. Ignorance is bliss. The biggest reason he was able to transition so quickly is because he is a very popular physician with a large number of loyal patients. Many of them attended one (or both) of our seminars. Our insurance office fielded hundreds of phone calls from his patients along with dozens of appointments, helping them understand why they should switch to HSA-qualified plans. Dr. Brooks estimates 40% of his DPC patients are now paying his fees with tax-deductible HSA dollars. HSA participation is around 5% nationally.

We know the direct patient contact necessary for a successful transition will limit the number of physicians we are able to work with to a maximum of 20 this year. There are currently less than 5000 DPC physicians. Yet there are over 300 million Americans that want more access to their physician. HSAs and DPC make it affordable for almost everyone.

Scott Borden is the founder of Direct Pay Consulting and can be reached at 913-980-4694 (mobile) or at SBorden@DirectPayConsulting.com.
The HIMSS13 Conference in New Orleans, one of the biggest gatherings of Health Information Technology professionals of the year, was host to speakers, panel discussions, and one pretty large announcement from some of the big names in the electronic health record industry.

Allscripts, AthenaHealth, Cerner, Greenway, and McKesson have announced the founding of the CommonWell Health Alliance, a non-profit trade group designed to implement standards around some of the most difficult problems with interoperability between systems. CommonWell will focus on working to standardize three areas: patient matching, patient access consent, and record location. Once standards are set for these areas, they can be made public and licensed at a “reasonable cost”. The Alliance’s formation was inspired in part by a Bipartisan Coalition meeting, and especially a comment from National Coordinator for HIT Farzad Mostashari. The conversation was recalled by David McCallie, vice president of informatics at Cerner, in an interview with HealthcareITNews:

“...everyone was sort of complaining to Farzad: “You’ve got to
go solve this identifier problem, it’s killing us.” And Farzad said, “Look, it’s against the law! I can’t do it. You guys have to solve it.” I came back and literally quoted that – “you guys have to solve it” – I sent an email to Arien and he said, “We think the same thing. Let’s talk about it.” And within a week, we knew this was what to do.”

Interoperability is the principle that patient information that is shared between two different software packages should work seamlessly. Think about the interoperability of the Internet. A web page can be read on any brand of computer, any browser, and with any internet service provider. It just works. Interoperability between EHR software would look very similar. Anywhere a patient needs care, their records could be transferred and read electronically, without having to worry about the different software formats. It’s important to distinguish between interoperability, which allows different software packages to understand each other, and Health Information Exchange, which is simply a means of communication between locations and providers. To extend the analogy, a telephone can connect two people, but if they speak two different languages, you will need a translator between them.

The founders of the CHA have extended an open invitation for other vendors to join the alliance, but one big name was conspicuously absent from the list of participants: Madison, Wisconsin’s Epic Systems, who serves almost half of the US market. Epic founder and CEO Judith Faulkner was dismissive of the announcement:

“We did not know about it. We were not invited,” Faulkner said. “It appears on the surface to be used as a competitive weapon and that’s just wrong. It’s wrong for the country.”

Epic COO Carl Dvorak was even more to the point, calling CommonWell a “marketing opportunity.” Epic System made a collaborative announcement of their own during HIMSS,
introducing the DRIVE program to test Epic software in virtualized environments with the help of Dell, Red Hat, Intel and VMWare. The program would be especially useful to facilities looking to bridge older, closed software installations, with more modern and open systems.

Whether or not CommonWell will be a net win for patients or just an opportunity for vendors to make up ground with Epic remains to be seen. Proponents argue that CHA is a step in the right direction for the industry to achieve real interoperability, even if the gains are only modest. The skeptical take, articulated very well by Adrian Grooper, MD at TheHealthcareBlog says there is no real difference between giants like Epic and coalitions like CommonWell.

“The shame is that another program with opaque governance by the largest incumbents in health IT is being passed off as progress. The missed opportunity is to answer the call for patient engagement and the frustrations of physicians with EHRs and reverse the institutional control over the physician-patient relationship. Physicians take an oath to put their patient’s interest above all others while in reality we are manipulated to participate in massive amounts of unwarranted care.”

So what do you think? Is CommonWell a good step for interoperability, or just another excuse for big software players to control the marketplace? Let us know in the comments!
Meaningful Use (MU)

Meaningful Use is the phrase used in the 2009 HITECH Act to describe the standard providers must achieve to receive incentive payments for purchasing and implementing an EHR system. The term meaningful use combines clinical use of the EHR (i.e. ePrescribing), health information exchange, and reporting of clinical quality measures. Achieving meaningful use also requires the use of an EHR that has been certified by a body such as CCHIT, Drummond Group, ICSA Laboratories, Inc. or InfoGuard Laboratories, Inc. The term can also apply informally to the process of achieving the standard, for example “How is our practice doing with meaningful use?”

mHealth

An abbreviation for Mobile Health, mHealth is a blanket label for transmitting health services, and indeed practicing medicine, using mobile devices such as cell phones and tablets. mHealth has large implications not only for newer
devices like smartphones and high-end tablets, but also for feature phones and low-cost tablets in developing nations. Many different software and hardware applications fit under the umbrella of mHealth so the term is used conceptually to talk about future innovations and delivery systems.

**NLP**

An acronym for Natural Language Processing, NLP is a field of study and technology that seeks to develop software that can “understand” human speech — not just what words are being said, but what is meant by those words. By “processing” text input into an NLP program, large strings of text can be parsed into more traditionally meaningful data. For example, narrative from a doctor in a medical record could be transferred into data for research and statistical analysis. If we had every medical record and narrative in history, we could search it and look for trends — and possible new cures and symptoms. IBM’s famous Watson machine that could “listen” to Jeopardy! clues and answer is an advanced example of NLP.

**ONCHIT**

An acronym for “Office of the National Coordinator for Healthcare Information Technology,” the ONCHIT is a division of the Federal Government’s Department of Health and Human Services. The Office oversees the nation’s efforts to advance health information technology and build a secure, private, nationwide health network to exchange information. Although the National Coordinator position was created by executive order in 2004, the Office and its mission were officially mandated in the 2009 HITECH Act as a part of the stimulus package.

**Patient Engagement**

Patient Engagement is a broad term that describes the process of changing patient behaviors to promote wellness and a focus
on preventative care. “Engagement” can roughly be read to describe the patient’s willingness to be an active participant in their own care and to take responsibility for their lifestyle choices. Patient Engagement efforts can be as simple as marketing campaigns for public health and appointment reminders, and as advanced as wearable monitors that can transmit activity and exercise information so patients can track their fitness. Improving the health system’s ability to engage patients is considered key to lowering healthcare spending and attacking epidemics like obesity and heart disease.

**Patient Portal**

A patient portal is software that allows patients to interact, generally through an internet application, with their healthcare providers. Portals enable communication between providers and patients in a secure environment with no fear of inappropriate disclosure of the patient’s private healthcare information. Patients can get lab results, request appointments and review their own records without calling the provider. Patient portals can be sold as a standalone software module or as part of a comprehensive Practice Management/EHR package.

**Patient-centered Care**

Patient-centered care is a healthcare delivery concept that seeks to use the values and choices of the patient to drive all the care the patient receives. As elementary as it sounds, developing a culture that places the needs and concerns of the patient – the whole patient – at the center of the decision-making process is a new development in the healthcare system. Patient engagement is at the core of patient-centered care, because the patient is the central driver of the decisions – as is only right!
PCMH

An acronym for Patient Centered Medical Home, a PCMH is a model for healthcare delivery where most or all of a patient’s services for preventative, acute and chronic primary care are delivered in a single place by a single team to improve patient outcomes and satisfaction as well as lower costs. PCMHs may also operate under a different reimbursement structure, as they can be paid on an outcome basis or on a capitation model as opposed to fee-for-service.

PHR

An acronym for a “Personal Health Record,” a PHR is a collection of health data that is personally maintained by the patient for access by caregivers, relatives, and other stakeholders. As opposed to the EHR model, in which a single hospital or system collects all the health information generated in the facility for storage and exchange with other providers, the PHR is maintained, actively or passively with mobile data capture or sensor devices, by the patient. The PHR can supplement or supplant other health records depending on the way it is used.

PPACA

An acronym for the “Patient Protection and Affordable Care Act,” the PPACA was a federal law passed in 2010 to reform the United States healthcare system by lowering costs and improving access to health insurance and healthcare. The PPACA uses a variety of methods – market reforms to outlaw discrimination based on gender or pre-existing condition, subsidies and tax credits for individuals, families and employers, and an individual mandate forcing the uninsured to pay penalties – to increase access to insurance and lower healthcare costs.
PQRS

An acronym for the “Patient Quality Reporting System,” PQRS is a mechanism by which Medicare providers submit clinical quality and safety information in exchange for incentive payments. Physicians who elect not to participate or are found unsuccessful during the 2013 program year, will receive a 1.5 percent Medicare payment penalty in 2015, and 2 percent Medicare payment penalty every year thereafter.

RAC

An acronym for “Recovery Audit Contractor,” a RAC is a private company that has been contracted by the Centers for Medicare and Medicaid Services to identify and recover fraudulent or mistaken reimbursements to providers. There are four regions of the United States, each with its own RAC which is authorized to recover money on behalf of the Federal Government. A pilot program between 2005 to 2007 netted nearly $700 million dollars in repayments and the program was made permanent nationwide in 2010.

REC

An acronym for “Regional Extension Center,” a REC is an organization or facility funded by a federal grant from the Office of the National Coordinator for Health Information Technology to provide assistance and resources to providers who want to adopt an EHR and achieve meaningful use but need technical or deployment support to get their system up and running. There are currently 62 RECs in the United States who focus primarily on small and individual practices, practices without sufficient resources, or critical access and public hospitals that serve those without coverage.
Registry

A Registry is a database of clinical data about medical conditions and outcomes that is organized to track a specific subset of the population. Registries are important to track the efficacy of drugs and treatment, as well as to analyze and identify possible treatment and policy opportunities to improve care. A registry can also be used to report PQRS.

Telehealth

Telehealth is a broad term that describes delivering healthcare and healthcare services through telecommunication technology. Although the terms telehealth and mhealth can be used somewhat interchangeably, “telehealth” tends to focus more on leveraging existing technologies – phone, fax and video conferencing to deliver services over a long distance, or to facilitate communication between providers. Remote evaluation and management and robotics are both examples of care innovations that would fall under the telehealth umbrella.

Value-based Purchasing

Value-based purchasing is a reimbursement model for health care providers that rewards outcomes for patients as opposed to the volume of services provided. Both through increased payments for positive outcomes, and decreased payments for negative ones, value-based purchasing seeks to lower costs by focusing on increasing quality and patient-focus. Accountable Care Organizations and Patient Centered Medical Homes are both examples of delivery systems that rely on value-based purchasing.