



# Prescriptions *Medical Alert*

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*Many doctors often report a great sense of satisfaction in building better relationships with patients and their families, while helping the elderly to maintain a quality of life in familiar surroundings.*

## Doctors Making House Calls

For many Americans, the house call conjures up images from old black-and-white movies, with a doctor stepping out of a horse-drawn buggy, a black leather bag in hand. But just as the practice of making house calls seemed on the verge of disappearing in the United States, a number of factors—ranging from shifting demographics, to changes in Medicare reimbursements, to improvements in technology—have come together to make treating elderly and disabled patients in their own homes a more viable health care option, even for busy primary care physicians.

Perhaps the biggest driver in the trend towards house calls is the aging of the population. With life span longevity, there are greater numbers of elderly patients who need regular care from a physician. Many of these patients are frail, or suffer from chronic illnesses that limit their mobility. An estimated 2 million Americans will be homebound due to chronic functional impairment by 2020. To help the elderly and disabled stay in their homes, and minimize emergency room visits and extended stays in hospitals and nursing facilities, Medicare reimburses physicians and nurses for providing care to patients with limited mobility. As reimbursement rates have improved, the number of house calls paid for by Medicare has increased from 1.5 million in 1995 to 2.3 million in 2009.

As part of the Federal government's ongoing efforts to lower Medicare costs, the Independence at Home program and accountable care organization (ACO) provisions of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to further increase incentives for physicians and other health care providers to offer in-home services to chronically ill and disabled patients. These programs will be partially modeled after house call networks instituted by the Veterans Administration (VA), which have

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## Improving Profitability with Mix of Patients

In any given community, people with a wide range of medical problems and economic resources are likely to seek care from primary care physicians. While few family practices attempt to treat all types of patients, most will accept patients with different insurance providers and varying capacities to pay for additional services, as well as varying clinical needs and health goals. However, medical practices may find they can improve group profitability and enhance physician satisfaction by making a more strategic effort to adjust their mix of patients.

### *Finding Potential Revenue Sources*

Getting the right mix of patients involves more than simply attracting patients who can pay out-of-pocket, or have insurance plans with high reimbursement rates. It is, of course, advisable for practices to have a certain number of patients covered by payers with competitive reimbursement rates. Yet, having patients with excellent insurance coverage with little need for medical services due to age or other factors, may not add to overall profitability. Therefore, when looking at potential revenue, practice groups should consider not only the amount of reimbursement for a given service, but also the present and future volume of services and procedures patients may want or need, as well as the efficiency levels of those service deliverables.

The practice should also take into consideration whether certain patients are likely to take advantage of elective care services with co-pays or out-of-pocket payments. Additionally, if a practice can only afford to invest in a limited amount of high-tech equipment, bringing in patients more likely to require services or procedures using medical devices already in place may be the better option. Another factor in determining the patient profitability may be whether occasional care provided by physicians can be coordinated with regular care provided by a nurse practitioner or physician assistant.

### *Analyzing Patient Data*

To assess the quality of its patient mix, a practice should analyze patient data across a number of different variables such as age, gender, diagnosis

codes, and CPT codes indicating the services provided to see which patient and service types are most profitable.

### *Marketing Your Practice*

There are steps physicians can take to shift the mix gradually without alienating the existing patient base. Marketing materials distributed in waiting rooms (brochures, newsletters, and posters) can alert existing patients to medical procedures and services that may interest them. An online presence can also be adjusted to attract the types of patients expected to deliver higher revenues.



Smaller physician groups struggling to meet the needs of all patients may want to consider establishing cross-selling and referral arrangements with other practice groups to make better use of the facilities and expertise of each practice. In some cases, this could include distributing marketing materials of practices that offer complementary services, in exchange for referrals.

Being aware of the current patient mix can also help physicians optimize scheduling to increase the number of patients seen. Limiting appointments for certain categories of patients who are expected to take more time can raise the volume of patients seen in a given time period. This would not exclude certain patients from receiving care, but would try to balance resources to better serve the maximum number of patients, while maintaining a healthy level of profitability. *P*

## Visual Aids Help with Patient Communications

According to an April 2011 study published in the *BMC Family Practice* journal, the use of colorful charts, graphs, and other visual aids by physicians when communicating with patients at risk of heart disease can improve comprehension.

The article, “How Do Family Physicians Communicate about Cardiovascular Risk?” by researchers at the University of Zurich was based on results from a group of Swiss general practitioners who audiotaped sessions with patients at risk of cardiovascular disease (CVD) to find out whether patients better understand information about risk if communicated in numerical or visual formats rather than verbally only.

Physicians communicated CVD risk to patients using only verbal qualifiers, or using verbal qualifiers together with numerical and/or graphical information. Most of the visual formats were tables with a color-coding system showing low, medium, and high values. The numerical information consisted of percentages reflecting the risk levels of the patients. The tapes were transcribed and analyzed, and both patients and physicians were asked to complete a questionnaire immediately after each session.

In explaining the purpose of their study, the authors noted that, while there is no clear evidence demonstrating which format is most effective for

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reduced total VA and Medicare costs for patients receiving in-home care by an estimated one-third.

While physicians considering house calls may be concerned about the time involved, a careful examination of appointment schedules may show that it is possible to integrate house calls into existing schedules by clustering visits according to location. When house calls are spaced close together, a doctor can see as many as five patients in a half-day session. If several doctors in a practice are making house calls, they can divide up the number of patients they visit by location. Although payment for travel expenses is not covered by Medicare, mileage and other car-related expenses can be deducted as a business expense. Physicians seeking to attract new patients may also find that making house calls boosts their reputation in the community, helping to potentially bring more patients into the office.

A housebound patient with one or more chronic illnesses or disabilities is generally cared for by a team of health care professionals. Therefore, it is important for traveling doctors to coordinate patient care with visits from other health care providers and agencies.

Technological advances are making it easier to treat patients at home. In addition to using electronic health records (EHR) systems to access and

update patient data quickly and efficiently, most health care providers are now using smartphones and notebook computers to access clinical information, such as medical dictionaries and drug formularies; and are performing basic medical tasks with online calculators and converters. Portable diagnostic equipment also allows doctors to test blood, urine, oxygen levels, and blood pressure out of the office. Depending on the needs of the patients, doctors may carry intravenous medications, as well as portable X-ray, ultrasound, and EKG machines.

In many cases, home visits can improve the quality of patient care. By observing the home environment of a patient, and interacting with caregivers, the doctor may better understand the circumstances contributing to a patient's condition. For example, by visiting a patient with mobility problems, the doctor can check if the patient has proper equipment to move around the home safely, and can help order any additional supplies or services the patient may need. The doctor can also better determine the patient's eating habits, and ability to take medications as prescribed. While the multiple needs of these patients can be complex, many doctors often report a great sense of satisfaction in building better relationships with patients and their families, while helping the elderly to maintain a quality of life in familiar surroundings. *P*

## New Reimbursement Models

Coping with rising operating costs, adapting to new technologies, and preparing for new reimbursement models are among the major challenges facing medical practice professionals, according to a 2011 report by the Medical Group Management Association (MGMA).

The survey of 1,190 MGMA practice managers identified the top five challenges of running a group practice: reimbursement models that place a greater share of financial risk on the practice; participating in the Centers for Medicare & Medicaid Services' EHR Meaningful Use incentive program; operating costs; launching a new electronic health record (EHR) system; and implementing an accountable care organization.

Researchers revealed that implementing a patient-centered medical home was rated as 8.5% more challenging than last year, while using standardized, machine-readable patient ID cards was rated as 9.1% more challenging.

Further, results showed that differences were found between medical specialties. Cardiology practices reported new reimbursement models as more challenging, while orthopedic practices considered a new EHR system to be more challenging compared with their peers in other specialties.

William F. Jessee, MD, president and CEO of MGMA, advises practice leaders to balance their attention between serious financial issues related to their practices, and the need to rapidly adopt new technology.

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communicating risk, research showed that using information on natural frequencies, as well as bar charts and other graphics, or combinations of these formats leads to better comprehension than just using percentages or verbal qualifiers, and that patients tend to prefer these formats to percentages.

Results indicated that verbal formats alone were rated lowest in comprehension and effectiveness, while visual formats had significantly higher levels of subjective understanding of the information given. Specifically, colors in visual formats appeared to be familiar to patients, for example, red suggesting urgency and the need to change behaviors. However, 73% of respondents used



exclusively verbal formats to communicate CVD risk to their patients.

“Our findings demonstrate a gap between the recommendations of medical associations, which favor numerical and visual formats for communicating risk, and the reality in clinical practice,” the authors said.

Further, the authors observed that CVD, in particular, is a major public health concern, but cardiovascular risk is often perceived inappropriately by primary care patients, leading to an over- or underestimation of the risk. Therefore, communicating risk using comprehensible formats has the potential to correct misperceptions among patients. At the same time, physicians acknowledged that they may face many barriers in communicating risk factors effectively to patients, including statistical uncertainty, and lower reimbursement rates for time spent presenting risk factors to patients. *P*