

We Get Letters... QUESTIONS & ANSWERS FROM MIEC

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We Get Letters

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THE MAN WITH A NEW IDEA IS A CRANK UNTIL THE IDEA SUCCEEDS. MARK TWAIN

New ideas may solve old problems but they often spawn new ones. As physicians re-examine their practices and search for better, more innovative ways to conduct their businesses, they must also avert the potential hazards that lie in wait. This issue of We Get Letters addresses questions by physicians as they contemplate two recent trends in non-traditional medical models: (1) “concierge” or “boutique” practices and (2) “retail” or “store-based” clinics.

Q: A few colleagues have opened what they call concierge practices in my corner of the state. According to an article I read in the *San Francisco Chronicle* last year, concierge—or boutique, or retainer—medicine “is inherently discriminatory,” but I can understand why my colleagues want to see fewer patients. What about their patients who can’t or won’t pay additional fees? What increased liability risks, if any, do these physicians face?

A: Two years ago, a study of patients’ willingness to pay extra fees for extra service indicated that one of six American adults visit out-of-network physicians, and 53% were willing to do so if the physician offered something they wanted and was recommended by a trusted source. Forty-two percent of the respondents said they would pay extra for specialized treatment or services, 33% for “after hours” appointments, 23% for more time with the physician, and 21% for priority appointments. On the other side of the equation, many physicians sought to escape red tape, high volume, over-extension of their time, and low reimbursement rates. Some began to opt for practices in which patients paid an annual fee for value-added services in addition to the care for which health plans pay.

Value-added services often include: same day or next day guaranteed appointments; 24-hour access to the physician; house calls; a private waiting room; physician-coordinated hospital or specialist care; preventive health and wellness advice; telephone and e-mail consultations; more attractive environment; spa amenities; and “free” physicals and check-ups. There are those who would argue that some of these “services” are—or should be—associated with non-concierge practices that require no additional fee.

Physicians who establish concierge practices, either on their own or through an administrative entity that provides benefits such as marketing, scheduling, and patient newsletters, often report smaller patient panels and enhanced incomes. Studies indicate that they tend to see fewer Medicaid, diabetic and minority patients.

Of what risk prevention considerations should a physician be aware when contemplating a transition to a concierge practice? Before contemplating the *risks*, physicians should 1) survey patients to determine what they want and need beyond what is already provided; 2) decide what he/she (the physician) wants to provide; 3) decide what health care coverage (if any) to accept; 4) determine a menu of services and fees based on what patients want; 5) create a practice style and message to be conveyed in marketing materials; 6) consult with a health care attorney familiar with the issues related to concierge practices; 7) determine in advance what options will be available to patients who either can't or won't participate in the new practice model; 8) prepare to inform patients well in advance of the impending changes and how they will manifest; and 9) learn how to facilitate the transfer of patients who will seek healthcare elsewhere. Then, the physician should know and act upon the following recommendations to reduce liability risks related to the concierge practice style.

MIEC recommends the following (the first five recommendations are adaptations of guidelines adopted and first promulgated in 2003 by the American Medical Association):

- ◆ Because patients don't have to switch to a concierge practice, it is important to present the terms of the retainer contract clearly and honestly, with no undue pressure to persuade patients to participate. Warn patients if their health care coverage will be compromised by signing the agreement. Allow patients to opt out of the contract without undue inconvenience or financial penalties.
- ◆ Ensure that the quality of patient care continues to be the primary consideration. Make it clear that the concierge practice does not promise more or better diagnostic or therapeutic services than you previously provided. Physicians who continue to treat patients in a multi-tier (mixed) practice must offer the same standard of diagnostic and therapeutic services to both categories of patients, and ensure that they are afforded the same "courtesy, respect, dignity, responsiveness, and timely attention" to their medical needs.
- ◆ If the concierge physician maintains a two-tier practice, we recommend that s/he avoid the appearance of preferential treatment by practices such as "bumping" the scheduled non-concierge patients' appointments in favor of those in the concierge office, or requiring the non-concierge patients to wait longer to be seen in order for the physician to accommodate the concierge patients.
- ◆ To maintain the continuity of care, facilitate the transfer of patients who will not remain in the practice to other physicians. In some cases, the physician who opens a concierge practice may be obligated to continue caring for patients who are particularly sick or vulnerable, if the community lacks other physicians to assume their care.
- ◆ Know and apply the laws for honest and legal reimbursement. Ensure, when at all possible, that contracts clearly delineate special concierge services from those already reimbursable.
- ◆ Remember that the American Medical Association reminds physicians of their obligation "to provide care to those in need, regardless of their ability to pay, particularly to those in need of urgent care." Physicians who practice in the concierge setting are well-advised to participate in opportunities—outside the practice, if necessary—to provide care to those in need.
- ◆ If you transition to an exclusively concierge practice, and some patients choose to leave your practice, acknowledge their decision in writing to formally end the doctor-patient relationship.
- ◆ Because many concierge practices operate with minimal staff presence, to err on the side of the prudent, we suggest that chaperones be made available, as recommended by ACOG, for all exams of a "sensitive" nature, such as breast, pelvic, or genital examinations.
- ◆ If house calls are a service of the new practice, when making house calls, ensure that someone besides the patient is present, to avoid the appearance of any impropriety or a situation in which a patient might allege inappropriate activity.
- ◆ When making house calls, document all examinations, treatment, and significant discussions—including who participated, advice given, decisions made, and recommended follow-up—as carefully as for in-clinic or in-office care.
- ◆ Establish documentation criteria to ensure that all progress notes are accurate and legible, plus adequately detailed and consistently documented. The use of an electronic medical record (EMR) may enhance medical charting and help to ensure that medical information is forwarded efficiently to pharmacies, hospitals, labs, and/or other entities.

(For more information about EMR, or for information about forms and templates and other documentation advice, contact MIEC's Loss Prevention Department.)

- ◆ Create written materials that explain the policies, procedures, limitations, scope of practice, and patient responsibilities in the doctor-patient relationship. Consult MIEC and your personal healthcare law attorney before launching your concierge venture. MIEC's Loss Prevention Department would be happy to review patient informational materials notifying patients of change once you have established what you will do and how you will do it.

Q: A local “big box” store has asked me to participate in establishing a store-based clinic, but when I mentioned this to some of my colleagues they gave me nothing but negative feedback, telling me that I would be undermining other physicians’ practices and that I would be increasing my liability risks for nothing. I happen to think that “mini-clinics” are practical solutions to current problems of patient access. What is happening in regard to store-based clinics today and how can I participate without “shooting myself in the foot?”

A: Since 2002, interest in store-based clinics (frequently dubbed mini-clinics, doc-in-the-box, or retail clinics) has grown and some states have experimented with the concept and reported the results and reactions related to their existence. However, their data remains too limited to comment on their success or failure. The arguments for and against store-based clinics generally fall into the following camps:

For:

- Patients see store-based clinics as more convenient for minor medical problems than most primary care practices.
- Patients can be seen with minimal waiting time, and often at less expense than a visit to a physician's office practice.
- Nurse practitioners and physician assistants often staff store-based clinics, and attend to minor complaints, perform routine screenings, and administer vaccines. This leaves patients and physicians freer to respectively pursue and provide more complex care in traditional venues. (Store-based clinics do not provide emergency or on-going care, but refer patients to emergency departments or to their own physicians for follow-up.)

Against:

- Store-based clinics may take business away from primary care practices and contribute to the “fragmentation” of medicine.
- Physician-patient relationships may be diminished by what some characterize as the “drive-by” or “fast-food” nature of store-based care, which is often accomplished in very little time.
- Some are concerned that there is too little physician involvement, supervision, over-sight and/or participation, jeopardizing the quality and continuity of care.
- There are those who express concern over a potential for poor hygiene (such as lack of running water or bathrooms) in store-based clinic facilities that lack the necessary means to maintain standard guidelines for cleanliness.

The development of store-based clinics has caused many physicians to re-evaluate their accessibility to patients. In response, some have expanded their office days and hours; offered blocks of time for drop-in appointments for working patients with minor problems and limited time; implemented team-based practice habits that confer more responsibility for paperwork and preliminary discussions to non-physicians; and invited patients with shared diagnoses (diabetes, hypertension, high cholesterol, etc.) to participate in group office visits.

Patients, in a 2005 Harris Interactive poll, indicated that although only 7% of respondents had visited a store-based clinic, 41% said they would. Even though 75% questioned the standard of care that might be practiced in a store-based clinic, 78% said that they thought such clinics would be a time-saving way to obtain basic medical care at less cost. Employers of several large corporations have jumped on the bandwagon and implemented “work-based clinics” on the same model, and report as much as 25% savings in health care costs, and a marked decrease in employee absenteeism, by making onsite clinics available to employees.

While it isn't possible to tell you how to cope with naysayers who discourage you from participating in store-based health clinics, the following recommendations will help you, if you chose to participate in the establishment and/or maintenance of one, to avoid unnecessary liability risks. (These recommendations reflect those published by the American Academy of Family Physicians and guidelines from the American Medical Association.)

- ◆ Involved physicians should insist that store-based clinics clearly define in writing, post, advertise, and adhere to specific and limited services offered within a narrow scope of practice.
- ◆ Ensure that store-based clinics maintain a **formal relationship with a physician**, and that the physician(s) and non-physicians conform to local, state and federal regulations that apply to the practice. Physician involvement should include direct access to, supervision of, and frequent communication with clinic non-physician clinicians, whatever is required by law and sound clinical practice.
- ◆ Involved physicians should insist that clinic personnel know and adhere to evidence-based practice protocols developed by physicians.
- ◆ Insist that the store-based clinic physician and staff establish **written policies and procedures** that include: how to obtain the names of patients' primary care physicians; specific referral plans for follow-up care and treatment outside of the clinic's scope of practice; how to manage emergency contingencies; explicit medication policies (e.g., no refills or prescription of chronic medications); how to respond to requests for medical records; documentation responsibilities; safety and security precautions; billing and collection guidelines, and more. These contribute to ensuring the continuity of optimal care.
- ◆ Ensure that documentation from the store-based clinic encounter is copied to patients' primary care providers (PCP).
- ◆ Develop written **patient information materials** about the scope of clinic services; the qualifications of the non-physician clinicians who serve patients at the site; the fact that the store-based clinic is not a substitute for an on-going relationship with a PCP; the importance of establishing a relationship with a PCP if one does not already exist; the limitations of clinic services; and more.
- ◆ Develop written **patient education materials** about the common conditions seen in the clinic, the likely medications that will be prescribed from the clinic encounter, and advice to coincide with the oral advice given.
- ◆ Guarantee that the store-based clinic is **adequately stocked, sanitary and hygienic** according to common-sense and good clinical standards, and designed to ensure patient safety.
- ◆ **Establish documentation criteria** to ensure that all clinic encounters are accurately, legibly, adequately, and consistently memorialized. The use of an electronic medical record (EMR) may enhance medical charting and help to ensure that medical information is forwarded efficiently to the PCP, pharmacy, and/or other entity. *(For more information about EMR, or for information about forms and templates and other documentation advice, contact MIEC's Loss Prevention Department.)*

MIEC will continue to monitor the progress, pitfalls, and effects of new practice models, and will report on significant changes that are relevant to MIEC's policyholders.

Call the Claims Department for advice in responding to specific patient complaints that allege liability or for patient-specific situations that have potential liability.

For all MIEC policyholders, the Loss Prevention Department is an available resource for risk-reducing information in many aspects of medical practice. Its newsletters, advice line, and survey services are available at no additional cost to policyholders in good standing.

For further information, go to www.miec.com, or call the Loss Prevention Department at 800-227-4537 (or 510-428-9411) and tell us how we may help you.

To Reach MIEC

Phone:

Oakland Office: 510/428-9411
 Honolulu Office: 808/545-7231
 Boise Office: 208/344-6378
 Outside: 800/227-4527

Fax:

Loss Prevention: 510/420-7066
 Oakland: 510/654-4634
 Honolulu: 808/531-5224
 Boise: 208/344-7903

Email:

Lossprevention@miec.com
Underwriting@miec.com
Claims@miec.com

MIEC on the Internet: www.miec.com