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Expert Foresaw Rise of the Internet in Medicine

In an interview seven years ago, Tom Ferguson, MD, predicted that refusing to use the Internet would not be an option for physicians. At the time, his prediction might have seemed unusual, at least for some physicians. But, of course, he was correct. A Harris Interactive Survey showed that 98% of graduating medical students and 90% of practicing physicians have Internet access today.

In his career, Ferguson had an uncanny ability to predict the future accurately. He articulated the concept of health care consumers using the Internet to educate themselves. He coined the terms “e-patients” and “disease tribes,” meaning patients who search the Web for disease-specific information and discuss their conditions in chat rooms.

Ferguson established a journal, *Medical Self-Care*, and served as its editor from 1975 to 1989. In 1998, he became editor and publisher of *The Ferguson Report*, the newsletter of consumer informatics and online health.

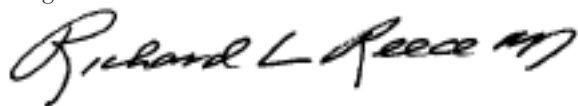
He was a senior associate at the Center for Clinical Computing, a research institution at the Harvard Medical School. He also served as an associate faculty member at the Texas Health Science Center and at the University of Arkansas Medical Sciences Center, and was a senior research fellow at the Pew Internet and American Life Project.

Perhaps earlier than many others, Ferguson recognized that health care consumers are willing to do their own research on the Internet. “The Web provides an environment in which some patients can play a role that differs from their traditional role,” Ferguson said in an interview in this newsletter in 1999. “The online revolution is changing the roles of both physicians and patients. Patients spend a good portion of their time away from the physician’s office, caring for themselves. When patients are motivated, they are willing to put almost endless time and energy into being a resource for their own care.

“Online technology has made it possible for people to gain access to disease support groups and to research information about their diseases,” he said. “Patient knowledge is different from physician knowledge. Depending on area of specialization, a specialist might have to stay current on 200, 300, or 400 medical conditions. A general practitioner might have to keep up with 600. Patients have to know about only one disease: their own.”

When asked what online patient self-education meant for physicians, Ferguson said, “Physicians who live in high-tech urban areas and want to treat well-educated young adults will have to be proficient on the Internet or they won’t have any patients left in five years.”

Sadly, Ferguson died last month in Little Rock, Arkansas, at the age of 62 of a long-term illness.



Richard L. Reece, MD

Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

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Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

Neil Baum, MD

Urologist
New Orleans

Daniel Beckham

President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD

President and CEO
Policy Planning Associates
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Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
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Evidence-based Medicine
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BAR Health Strategies
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James M. Schibanoff, MD

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Milliman Care Guidelines
Milliman USA
San Diego

Jacque Sokolov, MD

Chairman
Sokolov, Sokolov, Burgess
Scottsdale, Ariz.

Connecticut Group Easily Implements Document-Based EMR

Deterred by real or perceived obstacles such as high costs and a steep learning curve, cardiologists in many practices are reluctant to install electronic medical record (EMR) systems. They still want the potential improvements that come in care quality and efficiency, however.

To avoid the obstacles other groups face with EMRs, some cardiology groups are choosing to implement document-based electronic medical record systems rather than EMRs that require extensive data entry. A data-entry EMR requires physicians and staff to type information into a structured database that they can use whenever a patient chart is needed. Many of these systems require physicians to change their practice patterns to meet the needs of the EMR.

In contrast, a document-based EMR requires no change to physician practice patterns. Practices don't need to transcribe data or enter notes that had previously been handwritten. Instead, lab reports, images, and other documents are scanned and imported directly into the system, allowing users to access an image of these pages on screen.

More Benefits, Lower Cost

Cardiac Specialists, PC, a 10-member practice in Fairfield, Conn., chose to implement SRS Freedom Chart Manager from SRS Software, in Montvale, N.J. (at www.srssoft.com), a document-based EMR system. "Because the system does not require cardiologists to change their practice patterns by inputting data at the point of care, our group has enjoyed several benefits without incurring the time and

money typically associated with EMR implementation," says Robert Hendler, FACMPE, the group's administrator. "Our cardiologists' practice patterns are basically the same, but the EMR enables them to be incredibly more efficient."

The first benefit is improved patient care. All records are immediately available, enabling speedy decision-making based on full information. "Furthermore, patients who call their physicians with a question receive a much quicker response," Hendler says. "We have two locations and admit to several hospitals, so physicians are out of the office quite often. Prior to EMR implementation, a non-emergency message might sit on the doctor's desk for several days. Now, the cardiologists have 24-hour on-line access to all patient records. Patient calls are messaged to the doctors within the EMR system, and the chart is attached."

A second benefit is financial. "With EMR implementation, we were able to eliminate three full-time medical record staff positions, saving the practice about \$100,000 a year," Hendler says. "The EMR has also eliminated the need to purchase

chart supplies, saving us another \$5,000 to \$10,000 per year."

Increased Efficiency

A third benefit relates to efficiency. For example, chart retrieval is much more efficient, and charts are never lost. "At times, all practices temporarily misplace or even lose paper charts," Hendler comments. "With an EMR, that problem is a thing of the past."

Also, the system imports typed transcriptions directly into the EMR. "This means that we are getting access to dictated letters and visit notes much more quickly and efficiently," Hendler says.

Cardiologists themselves have become more efficient as well. "The cardiologists can access patient information much more quickly," Hendler observes. "They are now able to squeeze in an extra patient or two each day due to this increased efficiency, thereby increasing practice revenue."

Quick access to charts allows the practice to offer better service to referring physicians, Hendler continues. "If a referring physician calls to inquire about a case, our cardiologist

(Continued on page 4)

Going Digital

Use of EMR varies by group size

Number of physicians	Percentage with EMR
1 to 5	14.5
6 to 10	16.1
11 to 20	20.9
21 and more	25

Source: *Assessing Adoption of Health Information Technology*, Medical Group Management Association Center for Research, Englewood, Colo., and the University of Minnesota School of Public Health in Minneapolis, 2005.

(Continued from page 3)

can quickly pull up the chart and discuss the patient without having to put the caller on hold while frantically looking for the chart," he says.

Not surprisingly, professional satisfaction has increased since adopting the EMR. "The physicians are thrilled with the system," Hendler says. "They no longer need to stay late to review charts and make phone calls. They are able to complete almost all of their work during standard working hours, because the system makes it so much easier to keep up with their workload. They know they are giving better service to their patients, and they feel good about that."

What's more, since the administrative burden on the whole practice has been reduced, the tension level in the office has fallen as well, Hendler adds. In many ways, the system has made a positive impression on patients as well. "Patients know we are using a computerized medical record system," he says. "We have a computer in every examination room, which patients don't necessarily see in other medical offices. This feeds their belief that our practice is on the cutting edge."

After only two years, the practice has already seen a return on its investment in the software. "We have more than broken even on the software, in part because the cost of the system is much lower than that of a typical EMR," Hendler says. The cost of document-based EMRs can be as low as one-third the cost of data-entry EMRs.

Hardware Required

But Hendler cautions that a robust computer network is needed regardless of the type of EMR adopted. "We spent a lot of money on computer hardware," he notes. "We didn't have computers in every examination room, and the computers we did have were not integrated. We also needed to purchase printers and scanners. So the amount of time that passes before a positive return on investment is

EMR Implementation Not Widespread

Fewer than 15% of cardiology-specialty medical groups have fully implemented an electronic medical record system and 19% are currently in the process of implementation.

This is one finding of a survey conducted as part of the "Assessing Adoption of Health Information Technology" project undertaken by the Medical Group Management Association Center for Research in Englewood, Colo., and the University of Minnesota School of Public Health in Minneapolis. More than 3,300 group practices participated in the project funded by the federal Agency for Healthcare Research and Quality in Rockville, Md. The survey was conducted in January and February 2005, and the results were published last fall.

Some 20% of cardiology groups plan implementation of an EMR within 12 months, and 18% plan to do so in 13 to 24 months, the researchers said. About 28% have no plans to implement an EMR within two years.

The survey also found that about 62% of cardiology groups maintain paper medical records filed in a record cabinet. About 4% use scanned images filed electronically using document image management systems (DIMS), about 13% use a dictation and transcription system combined with a DIMS, and 18% use an EMR that stores information in a relational database. —DJN

realized will depend heavily on the hardware that exists in the practice."

Document-based EMR systems can be implemented in a practice much more quickly and easily than data-entry systems can, Hendler says. "The strength of a document-based system is managing documents," he explains. "These systems do not have a module to document point-of-care visits, in which physicians point and click their way through an examination. Rather, the physician documents a patient encounter in the traditional way, either by dictation or by writing notes. Then the resulting documents are scanned or imported into the system. Therefore, the training required is much more limited. As a result, the probability of successful implementation is higher with a system of this kind, while the more complex systems face a higher implementation failure rate." SRS says its Freedom Chart Manager's implementation success rate has been 100% over the past five years.

No data entry was required for the practice to begin using the new system. The cardiologists at Cardiac Specialists needed only about 20 minutes to learn the basics of the system and call up the scanned patient records on the computer screen, Hendler reports.

Improved Functionality

The EMR is a repository of information that presents all of the medical records that a chart might contain in a user friendly and logical way, Hendler explains. "Dictated documents and images such as x-rays, problem lists, notes, and all other documents, can be called up on the screen," he says.

The system also can import documents and data created on other systems. "For example, the EMR is interfaced with our digital nuclear stress testing system so that the images of the patient's heart can be directly imported into the EMR," Hendler comments. "It is also linked

to our digital echocardiography system, so the data from those reports can be similarly imported.”

Clinicians can page through the record on screen as if reading a paper chart. But there’s an important enhancement: the documents are organized into meaningful sections, such as diagnostic tests, prescriptions, letters, and x-ray reports. Within each section, entries are organized by date. “Because of the electronic organization of documents, physicians can quickly find what they are looking for, without having to shuffle through a large pile of papers,” Hendler says.

In addition to document scanning capabilities, the system offers screens with templates, so that clinicians can type in the answers or print out forms, write on them, and then scan them back into the system.

The system has a medication module, so that a physician can point-and-click to create a prescription. Then, the physician prints the prescription form to hand to the patients.

The system also has a messaging module. “This is an important workflow feature,” Hendler says. “A nurse can send a message to the doctor along with the attached patient record, allowing the doctor to respond to questions immediately. This feature facilitates communication among our clinicians, thereby streamlining our workflow, reducing frustration, and ultimately allowing us to provide enhanced service to our patients.”

Custom Made

Finally, the system offers an optional module that provides search capabilities, so that physicians can gather practice-wide information on physicians’ practice patterns and outcomes to enhance quality improvement efforts.

“The system can be customized to serve physicians in any specialty,” Hendler says. “For example, we have

Adding Office Forces Decision

Before opening a second office, Cardiac Specialists, PC, did not have a pressing need for an electronic medical record (EMR) system. But after the 10-member practice in Fairfield, Conn., opened a second office, it decided to implement SRS Freedom Chart Manager from SRS Software, in Montvale, N.J. (at www.srssoft.com). It did so in October 2003.

“We had been aware of the potential benefits of EMRs and had been toying with the idea of implementing one,” says Administrator Robert Hendler, FACMPE. “However, the main factor that drove our decision to purchase an EMR was the opening of a second office location. Our two offices are only 10 miles apart, and many patients are seen at both offices. But transporting the patient charts between the two offices became chaotic. We were constantly shuttling charts back and forth, which became a burden on the office staff. At times, we failed. The patient would show up for the appointment and the chart would not be there.”

The practice considered how to resolve this problem. “A messenger service would have been costly and would still be prone to mistakes or delays,” Hendler notes. “But we knew an EMR would solve our problem.”

Nevertheless, the cardiologists had various levels of enthusiasm for an EMR. “Some physicians were excited, and were proactive in assessing different systems,” Hendler says. “But other physicians were not enthusiastic about the idea at all. However, when we were at the point of making the commitment to purchasing the EMR, we held a meeting with all the physicians and everyone agreed to move forward.”

Two factors helped ensure success. “First, when we began implementing the system, we started with the more enthusiastic doctors,” Hendler says. “Second, we implemented the system slowly, with a few physicians brought on board each month over 10 months. As a result of these two factors, the first few adopters were singing the praises of the system, and the remaining physicians were anxious to start.” —DJN

developed various tools just for cardiology, such as a cholesterol log, a warfarin tracking sheet, and a pacemaker/ICD analysis log specific to cardiology patients.”

Among the only drawbacks of the document-based EMR is that it does not help to improve a physician’s accuracy and thoroughness of documentation or provide decision support, functions found in some data-entry EMRs. “Obviously, the choice of EMR depends on the needs of the particular group,” Hendler comments. “But physicians should carefully weigh the benefits of more complex systems against what those sys-

tems cost the practice in terms of time, money, and effort. It may not be a good trade-off.

“Then the practice should purchase the best system available that is consistent with the effort the practice is willing to expend,” Hendler explains. “Cardiologists and cardiology administrators should be cognizant of the fact that a full-blown EMR implementation is a big undertaking that requires a lot of training and planning.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 8).

Mega-Groups Boost Efficiency, Revenue

By Albert Santalo

As health care has become more complex, many physicians have found it is virtually impossible to see more patients while also attending to such business functions as billing, collections, and insurance eligibility. While costs rise, reimbursement has declined.

Recognizing these trends, physicians are seeking ways to increase efficiency and revenue while also improving billing and collections.

Revenue Cycle Management

Physicians who struggle with labor-intensive insurance claims, re-submissions, and slow payments or denials have several options. One is to buy and maintain billing software. A second option is to contract with a billing service. And a third option is to contract with a vendor that provides billing service software and support and collection services. Those physicians who choose this third option find that these vendors help them increase collections and decrease the time spent on back-office operations. What's more, contracting with such vendors enables the physicians to consolidate their operations with other practices, increasing size and efficiency.

Before they even consider consolidating with other practices, however, most physicians are seeking billing service software and support and collection services. Some of the systems that provide these services have no capital costs and no software maintenance or upgrade fees. The charge to a physi-

cian group is a percentage of revenue collected or a fee per encounter.

The benefits of a comprehensive, Internet-based practice management and billing and collections system are significant. Physician group personnel can use personal computers with an Internet connection to determine whether a patient is insured, ensure

physicians can focus more on patient care and evaluate ways to grow or enhance the practice.

Larger Groups

One way physicians can enhance their practices is by consolidating with other physicians, and some billing and collection systems available online are

Contracting with some system vendors enables physicians to consolidate their operations with other practices.

accuracy in claims coding, and track the billing until payment.

The best vendors in this relatively new field provide automatic updates on changes in covered procedures and charges. They also catch errors in coding at the point of entry, saving time and improving cash flow. Collection success rates for such vendors can exceed 90%.

The advantages of contracting with such a vendor are a low initial investment, variable costs based on patient volume, a reduced number of back office employees, better access to key performance metrics, fewer denials, daily tracking of unpaid claims, and an account manager who is responsible to track billing and to follow up with payers. Having an account manager who takes on these responsibilities may mean the physician practice could reduce the number of office support employees on staff.

Practice management experts find that such billing systems offer physicians the ability to review a number of office metrics at once. This real-time "dashboard" includes data on patient and billing activity, receivables, and payment and denial analysis.

Once a system is in place, the physi-

facilitating such consolidations. Some observers believe that the solo practitioner and small-group models in which physicians had fee-for-service payment and paper-based information systems are being replaced by technology-savvy physicians who merge and acquire other practices to form a mega-group, which is composed of many physicians in previously unaffiliated practices who join together to operate as one large group.

The purpose of mega-groups is to increase profits and leverage with payers, obtain additional managed care contracts, and use technology to increase efficiencies. In a mega-group, physicians can negotiate higher rates with managed care companies, purchase supplies and equipment at volume discounts, and eliminate redundant costs.

In addition, a mega-group offers important benefits concerning physician ownership and on-site availability of ancillary services as specified in the Stark laws. If a physician is part of a mega-group, an exception enables the physician to own and prescribe ancillary services such as laboratory testing and diagnostic imaging. For many doctors, this exception not only improves

Albert Santalo is the founder of Avisena, a health care management company in Miami that uses technology to improve front and back office processes. Founded in 2001, Avisena (at www.avisena.com) services more than 150 physician practices throughout the Southeast United States.

the quality of care provided to patients, it also can result in additional revenue.

While the mega-group affords benefits, the transition and implementation process requires careful planning. When structuring a new practice organization, it is important to ensure the cultures, personnel, contracts, and systems work together. Doing so requires attention to detail in the form of pre-planning meetings, financial accounting and legal audits, and an analysis of managed care agreements.

Size Matters

With any medical practice, the practice management and billing and collection system can mean the difference between having a thriving, efficient mechanism to handle patient flow, insurance, eligibility, bill processing, and collections, or having one that slows the practice through inefficiency.

For physicians forming larger groups and seeking a practice management and billing system that will increase efficiency, the typical issues to consider include minimizing the initial investment, avoiding disruptions in cash flow during the transition to a new system, and standardizing daily functions such as coding, billing, and collections.

Many mega-groups are working with vendors that offer practice management technology and billing and collection services together in one system. In some instances, virtually all information, claims processing, communications, and reporting is done via the Internet. These vendors typically charge a percentage of collected revenue or a fee per encounter.

Unlike a traditional medical billing company, these vendors have the software and support to streamline the billing process, decrease errors in coding and billing, and increase the likelihood of payment. These systems enable a physician's office staff to determine insurance eligibility for a procedure, avoid entering information

Practices Have Billing Options

Physicians have several options when choosing a billing system. Two of the most popular options are buying software and contracting with a billing service. Here are the advantages and disadvantages of these options.

The first method is buying and maintaining software for billing and reimbursement. This method requires an initial investment in software that can be significant and is likely to require ongoing maintenance and upgrade fees. Although some of these systems provide support for collecting from insurers, most do not, and so most of these systems would require the practice to incur costs for staff payroll and benefits. The practice still has to invest in forms, office supplies, postage, and telephone and office costs as well.

These systems mean keeping up with changes in billing codes and coverage restrictions. The initial investment can be well over \$100,000, depending on the size of the practice. Typical collection success rates range from 70% to 90%.

The advantages of such a system are that the physician has 100% control since the practice owns the software. The disadvantages include a high capital investment, challenges involving staff training, the need for software updates, and a focus on billing but not necessarily on collections. Also, such software does not support the practice in adopting industry best practices, typically has poor reporting capabilities, and the reimbursement rates are frequently lower than they are with other options.

The second method involves contracting with a billing service. Claims are submitted using off-the-shelf billing software and staff manually follow up on late payers and denials. Costs range from 6% to 15% of collections depending on volume and specialty, and collection rates range from 70% to 90%.

The advantages of contracting with a billing service are a minimal capital investment, fewer back-office employees, and access to billing expertise and experience through the service's staff.

The disadvantages include a loss of control since much of the billing work is done off site, and a focus on billing but not necessarily on collections.

that would result in claim denials, record and access real-time information regarding daily business activity, generate reports relating to patient claims and payments, and track all billings until payment is received. Also, these systems allow physicians to scan and store identification, medical records, and financial records for easy retrieval at any time.

Since practice information is available to physicians over the Internet, it is always accessible from any computer with Internet access. This means a physician can access patient records from home, the office, or a hospital. It also means a physician can affiliate with other groups with

no additional costs for software. The newly affiliated physicians would simply access the practice's records as the other physicians do: via the Internet.

In today's health care environment, forming a mega-group can make sense for many physicians. With a sound yet flexible structure, a mega-group will adapt to the changing trends in health care. The next step, partnering with a management company that continually invests in processes and technology, will help reduce administrative and financial problems, improve collections, and increase profit.

—More information on physician practice strategies is available on our Web site (see page 8).

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