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HHS Cites Imperatives for Electronic Records

Among groups with 50 or more physicians, more than two thirds (68%) have adopted electronic medical record systems. But for groups of five or fewer, only 12% have adopted EMRs, and among solo practitioners and small groups of two physicians, only 1% have adopted EMRs, says David Brailer, MD, PhD, national health information coordinator for the U.S. Department of Health and Human Services.

To Brailer, these small groups, which make up roughly half of all practicing physicians in the United States, are “the elephant in the room,” explaining that if they don’t adopt EMRs, the government’s plan to establish an interoperable seamless computer system that links all components of the U.S. health care system will be useless. President Bush appointed Brailer to his position last year and gave him a mandate to create this system and get physicians to adopt EMRs nationwide.

The challenges Brailer faces are significant. One of the most daunting involves finding a way for the government to support those physicians who operate in small groups. These doctors are either too busy or don’t have the management resources to take a deliberate and detailed approach to installing information technologies. Conversely, large groups, which often dominate their markets, have capital set aside for EMRs, and can plan for IT implementation.

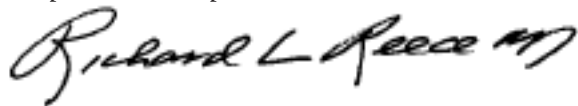
Another hurdle involves what Brailer calls the interoperability challenge. Most hospitals and doctors’ offices have customized systems that cannot communicate with other customized systems. These disconnected proprietary silos, as Brailer calls them, cannot serve as the foundation of an interconnected system.

To overcome these obstacles, Brailer says there are three building blocks that need to be added to the health care system to support interoperability. The first of these blocks is to develop communication and interoperability standards so that physicians will be able to make intelligent decisions about which EMR systems to use.

The second and perhaps most significant building block involves finding a way to give financial support to physicians to adopt EMR systems. Currently, many of the smallest physician practices cannot afford an EMR.

The last building block involves establishing regional health organizations, which would be networks of hospitals, health plans, and physicians in any given market that can adopt the particular technologies to fit the peculiarities and specifications of their market.

Clearly, these obstacles and building blocks represent a formidable challenge to Brailer, physicians, and the entire health care system. But fortunately, Brailer insists his mission is to let the marketplace, rather than the government, drive the process of computerization.



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Excellence Drives Group's Success

Quality of care is crucial to the success of any cardiology practice. But at Cardiovascular Medicine PC, an 18-member practice with two locations in Marietta and Austell, Ga., the definition of care quality extends beyond excellence in clinical care to include superior service to all its constituents: staff, patients, and referring physicians.

How a group defines quality is revealing and will drive the culture of the practice. "What is quality to a patient?" asks Richard Siegel, executive director of the practice. "Of course, the clinical skill of the cardiologist is important. But other factors patients consider include how office staff treat them, whether their time is respected, and how quickly they can get an appointment. These issues contribute to the quality of the total care experience."

Gregory Simone, MD, president of Cardiovascular Medicine PC, agrees. "Patients can't really judge clinical quality very well, so they have to use different parameters as indicators of care quality," he says. "These parameters include the cardiologists' listening skills, a caring and concerned demeanor, trustworthiness, and a general sense that the cardiologists are doing their best to help the patient."

The business benefit that results from all of these efforts is difficult to

quantify, Siegel says. "We know that our practice is growing," he notes. "We have experienced a 15% annual increase in patient visits, revenue, and other indicators over the past few years. Some of that growth is due to demographics, but some of it is simply due to the fact that we are a group that people seek out for care."

Staff Satisfaction

"The foundation of a medical practice is the interpersonal relationships among stakeholders: patients, physicians, staff members, referring physicians, vendors, and hospital administrators," Simone comments. "The central interface of those relationships is most often the staff. That's why excellent staff leadership and management are crucial to the success of a practice. Staff members' performance and attitude reflect the underlying satisfaction with their work environment and has a direct impact on patient care."

Siegel believes that staff satisfaction unquestionably contributes to the health of the practice. "Staff turnover creates significant additional hiring and training costs for a practice," he says. Cardiovascular Medicine PC employs 120 full-time employees, including 11 nurse practitioners and physician assistants. "When a practice is growing and it wants to maintain an excellent organization, employee stability is

absolutely critical."

Ellen Langford, RN, RDCS, MBA, the director of clinical services, agrees, adding that staff attitudes contribute to patient satisfaction. "Staff retention creates stability, which in turn adds to patient trust and a sense of security," she notes.

The practice's board of directors holds Siegel responsible for employee retention. "Every time an employee leaves, I am questioned about it," he notes. "There is a big emphasis here on stability and long-term employment." Given this emphasis, the practice carefully considers job candidates before extending an offer of employment. "We spend a lot of time and money on recruitment to ensure that we are hiring the right people," Siegel says, adding that employment testing at the management level is also performed.

Performance Expectations

In addition, the practice stresses quality of care and the practice's mission during training so that job performance expectations are clear. "During a new hire's first few days, we emphasize the message that it is everyone's job to provide excellent patient care, whether they are clinical or non-clinical personnel," says Langford. "This message is reinforced on an ongoing basis. Our practice culture embodies the belief that quality is everyone's responsibility."

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"Patients can't really judge clinical quality very well, so they have to use different parameters as indicators of care quality," says Gregory Simone, MD, president of Cardiovascular Medicine PC. "These parameters include the cardiologists' listening skills, a caring and concerned demeanor, trustworthiness, and a general sense that the cardiologists are doing their best to help the patient."

While the board expects much of Siegel, it also gives him leeway in terms of keeping the staff happy. For example, the practice demonstrates its commitment to staff development via a tuition-reimbursement program. "We implemented our tuition-reimbursement policy last year, in response to staff requests," says Siegel. "We want to support each other in our professional development, and we take that commitment very seriously on behalf of employees at all levels of the practice."

Cardiovascular Medicine PC also empowers staff to make their work environment more enjoyable via a social committee composed of front-line staff. "The committee is charged with planning fun activities for the staff," Langford explains. "Committee members plan our summer picnic and our Christmas party. They schedule casual days and special events each month. For example, each summer we have a luau day, when everyone on staff wears Hawaiian shirts to work and a luau lunch is provided."

The work of the social committee represents a grass-roots effort that

connected to each other and to the practice. A quarterly newsletter, *Heart to Heart: From Our Heart to Yours*, communicates practice events and includes profiles of employees and physicians.

Patient Satisfaction

A second newsletter, produced monthly by the practice's customer service committee, discusses customer service activities and publishes patient compliments. This customer service committee is one way the practice demonstrates its focus on patient service quality. This committee includes nurses and other practice staff members.

"Physicians and upper management do not serve on the committee," explains Siegel. "We give them the support and resources they need, but we want customer service to be an employee-driven effort."

Comments from patients demonstrate the successes of the customer service committee. "The cardiologists notice how many of their patients comment on the friendliness of the front-office staff, the profes-

sionism of the practice staff, and how smoothly their appointments are managed," says Siegel, adding that patient satisfaction and staff satisfaction are linked inextricably. "Such positive feedback is clearly the result of having satisfied employees who provide excellent service to our patients."

To encourage patient comments and to boost staff satisfaction, patients can complete comment cards, called applause cards, on which they can offer a compliment about a particular employee. But these applause cards are more than a pat on the back. "Each year, we send the top three recipients of applause cards to The Disney Institute in Orlando, Fla., to attend a three-day seminar on the Disney approach to quality service," Siegel comments.

While the trip to Orlando is a great perk by itself, the attendees come back and can help rejuvenate the practice staff with ideas collected about excellence in customer service. When seminar participants return, they serve for one year on the practice's customer service committee.

Commitment to Service

"They bring back new ideas that the committee can implement," says Langford, noting that annual customer service training is provided to both physicians and staff members as a result of a Disney customer service program idea. "We use a customer service training video and other associated materials we purchased from an outside vendor. The program is valuable because everyone can use a refresher on customer service and it impresses upon employees our commitment to this ideal."

The customer service committee also plans a patient appreciation week each year. "We provide healthy snacks in the waiting area and hold random drawings in which patients can win prizes such as a music CD or an American Heart Association cookbook," Langford explains.

Another service-oriented initiative involves employing a patient advocate, who helps ensure patient satisfaction by managing patients in the lobby. "The patient advocate acts as a liaison between patients and staff and facilitates patients' movement throughout the visit," Langford explains. "She monitors wait times and circulates among patients to find out if they need anything. Every medical practice has that desk in the waiting area that forms a barrier between the staff and the patients.

"The patient advocate acts as a liaison between patients and staff and facilitates patients' movement throughout the visit," says Ellen Langford, RN, RDCS, MBA, of Cardiovascular Medicine PC.

allows employees to have control over an important aspect of their work environment. "The committee adds an element of fun to our work, keeping staff spirits high even though we are often meeting with patients who are very ill," Siegel explains.

Interestingly, patient comments on special event days are extremely positive, Langford notes. "They seem to enjoy the festive atmosphere as much as the staff does," she says.

As the practice grows, internal newsletters help staff members feel

That can be very intimidating. We believed that putting a practice staff member on the other side of that barrier would make patients feel more comfortable, improve our service, and prompt patients to ask questions that they might otherwise feel reluctant to raise.”

The group also implements both internal and external patient satisfaction surveys. “We do formal patient surveys using an outside company every two years, but we survey patients on our own more frequently,” Siegel notes, adding that, for example, post-visit face-to-face interviews with patients were performed this spring to gather their opinions on practice performance.

Responding to Concerns

Staff responsiveness to patients is important, Siegel says. Members of the customer service committee write letters to patients or call them when they hear about a problem or when a patient complains. “Dr. Simone and I review all patient survey responses and all comment cards,” Siegel continues. “In this way, we can address every complaint, concern, and suggestion. When a patient tells a doctor something about the practice—good or bad—there is a lot of credibility in that comment.”

Siegel emphasizes that the group’s cardiologists are supportive of all staff and patient satisfaction activities, even given the costs involved. “We believe that there is a definite payoff to these activities,” he says. “Our cardiologists know that we must invest in our infrastructure, including our staff members. And we will do anything feasible to make an office visit to Cardiovascular Medicine PC an excellent experience for patients.”

With a stable practice and satisfied patients, it is no surprise that the cardiologists’ relationships with referring physicians are excellent.

“The first element in ensuring solid referral relationships is to provide excellent patient care,” says Simone, who was voted a top doctor in the July issue of *Atlanta Magazine*. “After all, a patient’s good experience at a cardiology practice also reflects well on the referring physician, who has chosen to send the patient there.” Simone adds that the referring physicians’ interactions with the staff should always be positive, and that the cardiologists should be cordial and communicative.

“There is a clear link between patient satisfaction and referring physician satisfaction,” asserts Langford. “If primary care physicians hear about negative experiences here, they will think twice about sending more patients. Excellent clinical and service quality ensures that patients have a positive experience to report when they go back to their primary care physicians.”

In addition, Langford notes that the group’s cardiologists do not take referrals lightly. “The cardiologists are constantly nurturing those relationships so that physicians feel comfortable referring their patients to us,” she notes.

The practice faxes thorough reports with progress notes to the referring physicians; in some cases, a cardiologist will call the referring physician personally to discuss a patient. “Furthermore, if a physician has a patient who needs to see us immediately, we make sure we work that patient into the schedule the same day,” Siegel notes. “Access is a very important

factor in maintaining satisfaction among referring physicians. Finally, we never steal a patient from a referring physician.”

Last year, the practice surveyed its referring doctors, including primary care and emergency department physicians. Says Siegel, “We asked service-oriented questions, such as: Do you receive reports from our practice in a timely fashion? Do you feel that the access to our practice is what it should be? This allowed us to check their perceptions.”

Making Improvements

The results were positive, but the cardiologists received several suggestions for improvement. This fall the practice will implement an open access schedule based on referring physician feedback. “Every afternoon, one cardiologist will not have patients scheduled,” Siegel explains. “This will enable patients to receive same-day service without having to wait and be worked in to a full schedule.”

To pursue successful activities focused on staff, patient, and referring physician satisfaction, cardiology practices do not have to be large. “Some practices may not have the financial resources we have, but many activities simply do not require a lot of money,” Siegel says. “However, they do require creativity and commitment at the highest levels of the practice. Cardiologists should not just pay lip service to these ideals. They should act on them, measure results, and continue to pursue improvements.”

—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).

Based on comments from referring physicians, the practice will implement open access this fall. Every afternoon, one cardiologist will not have patients scheduled, enabling patients to receive same-day service.

Cautions on Implementing an EMR

By Neil Baum, MD

Many physicians are adopting electronic medical record systems, and most have made the transition without too much trouble. But others have horror stories to tell about the experience when new systems don't work well. Or worse yet, when a new system doesn't work and the company that makes the system stops answering your calls for support.

Many physicians, hospital executives, and others consider Jeffery Daigrepoint, a consultant with The Coker Group, health care consultants, in Alpharetta, Ga., to be one of the nation's leading independent and objective experts on EMRs.

Daigrepoint emphasizes that there is a steep learning curve to make an EMR work before physicians will be able to enjoy the benefits of this electronic marvel. He cautions that EMR implementation success depends on solid preparation by training physicians and staff to use the tools and by preparing them emotionally for the change.

Homework Required

The most successful implementation occurs when the practice allows plenty of time to use the program before going live. In every practice in which Daigrepoint has served as a consultant, the physicians agree that it was a mistake to rush the implementation. In fact, many times physicians wish they had provided more time for training and learning the program than they had allotted. The minimum time to practice with the pro-

gram before going live should be four months. Doctors and staff can familiarize themselves with the program on a home PC or after office hours in the office.

Also, Daigrepoint suggests allowing staff and physicians to voice their concerns about implementation. Your staff may worry, for example, about losing their jobs, and the doctors may be concerned about a decrease in productivity during the early phases of implementation. You can allay such fears by reassuring staff of job security and by allowing the physicians ample time to become accustomed to the new processes required of the EMR.

The most successful implementation occurs when the practice allows plenty of time to use the program before going live. In fact, many times physicians wish they had provided more time for training and learning the program than they had allotted.

Coker recently surveyed several practices about their EMR experiences and asked what they would do differently. The top response was, "Would have spent more time on training and preparing."

In my practice, the first few days of having an EMR consisted of using the program only twice: once with the last patient in the morning and once with the last patient in the afternoon. Each of the first two patients required nearly an hour to complete the visit using the EMR. I told the patients that they were the first to experience the new technology and that the visit would be a longer than usual. Most patients were understanding.

When I became more comfortable

with the program, I used it with every third patient, then every other patient, and finally with every patient. Of course, there were still times when I would encounter a problem and would temporarily return to paper and then complete the EMR at the end of the day.

Starting Slowly

Another way to encourage physicians to get comfortable with the EMR is to have them begin using the EMR with tasks that don't require significant changes in office processes. A doctor who uses e-mail should quickly get the hang of the EMR

messaging system, for example. From there, he or she can move to automating incoming faxes, then adapt to prescription writing, reviewing lab reports, and then move to the more complex point-of-care documentation with a patient. These simple tasks help physicians become confident with the system and facile with the computer without significantly affecting productivity.

Daigrepoint recommends having regular meetings with physicians, the office manager, and any staff involved with the implementation. It is important to allow all staff to vent frustrations, provide suggestions, and let the group know about deficiencies that need to be commu-

Neil Baum, MD, is a urologist in New Orleans and the author of Marketing Your Medical Practice Ethically, Effectively, and Economically (Sudbury, Mass.: Jones and Bartlett Publishers, 2004). Readers may contact him at neilb89@aol.com.

Smoothing the Way

Jeffery Daigrepoint, a principal of health care consultants the Coker Group, in Roswell, Ga., and head of the Coker Technology Division, specializes in integrating information systems for medical practices. He also is the author of *Automating the Medical Record* (Chicago: 2004, AMA Press).

He suggests physicians take a number of steps to help ensure that the implementation of the EMR in your office will go smoothly. Typically, a physician group will work with a consultant to ensure success. Initially, the consultant will assess the readiness of your practice for an EMR, including doing a physical inventory of your hardware, a review of the existing infrastructure, and a study of what you may need. The goal of this phase will be to fully understand the specific operational characteristics and corresponding priorities of your practice. The consultant then likely will provide your practice with a recommendation for an appropriate technology solution and a qualified vendor.

The consultant should help your practice understand the following issues about installing an EMR:

- How to leverage technology to increase your revenue
- How your practice can succeed with an EMR
- Why physicians fail to use EMRs effectively
- How to avoid compromising productivity
- What implementation challenges you can expect
- Strategies for converting your paper records to digital format
- Getting a return on your investment
- Hidden fees and recurring costs
- How to successfully convert or disconnect your existing systems
- Operational challenges (specific to your practice) that need to be addressed before undergoing the transition
- Practice-specific interfacing requirements.

The most important of these factors involves understanding the true cost. The true cost of owning and implementing technology, especially an EMR, can be difficult to ascertain because it does not appear on the vendor's proposal. For example, during the first few weeks of implementation, your productivity will decrease as your practice acclimates to the new technology. Converting to a paperless environment is a big change, and you will need to commit a substantial amount of resources to the process. Practices need to fully understand the economic ramifications of this decision. Given the substantial cash outlay, other costs, and unforeseen expenditures, consultants should provide a thorough analysis that includes recommendations on how to contain costs.

nicated to the vendor's technical support department.

While becoming accustomed to a new EMR is a significant hurdle in any practice, there may be other barriers to overcome as well. Some of these obstacles may involve your relationship with your system vendor. For all issues regarding a vendor,

experts advise physicians to get all promises in writing. Ask the vendor for a locked-in fee for your annual service contract, for example. Agree to a limit on the percentage that fees may increase (for example, 1% or less than the Consumer Price Index) within a year. If additional training is necessary, agree on the availability

and cost of additional training. Consider requesting a discount off the annual maintenance cost once your use of the vendor's support staff levels off.

Staff Experience

Also, ensure that the vendor's trainers are not the company's newest staff members. You don't want to be learning while they are. Daigrepoint suggests that these staff have at least two years of experience in their current role with the vendor.

It is reasonable to request that the vendor accept responsibility that the hardware and software meet your performance expectations for at least 90 days after the installation and going live with your EMR. You don't want to start the performance clock during the learning phase but only after the program goes live.

Since most practices have a practice management system (PMS), ensure that it will work with your EMR and specify the vendor's responsibility regarding the interface. Otherwise, the interface can be costly.

Most EMRs need to be tweaked or adjusted once the program is used in practice. Daigrepoint suggests you request at least 50 hours of specialized support at no charge and a reduced rate for the first year following installation.

Finally, the computer business is fraught with risk, and many vendors have cash flow problems. Therefore, it is important to get a written agreement that the vendor will pay to establish an escrow account to protect you in the event of bankruptcy, liquidation, or sale.

Installing an EMR can be a daunting experience, but taking the right steps in advance can smooth out some of the bumps that are inevitable.

—For more information, readers may contact Daigrepoint at 800-345-5829 or by e-mail at jdaigrepoint@cokergroup.com. More information on physician technology strategies is available on our Web site (see page 8).

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