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*December 2008*

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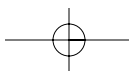
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## INNOVATIONS

### Conference Focuses on Innovation in Health Care

By Richard L. Reece, MD, editor in chief

This fall, officials from the federal Department of Health and Human Services (HHS) invited innovators in health care to attend a conference in Washington, D.C. The invitation came from Benjamin E. Sasse, PhD, HHS' assistant secretary for planning and evaluation. As the author of *Innovation-Driven Health Care: 34 Key Concepts for Transformation* (Jones and Bartlett, 2007), I was one of the innovators invited to participate.

Under the leadership of HHS Secretary Mike Leavitt, HHS has been working to advance patient-centered health care with payment systems that stimulate entrepreneurial ingenuity from physicians, hospitals, and others. Many experts believe innovation is of prime importance if the U.S. health care system is to be reformed successfully. But simply discussing innovation is insufficient. As one physician said recently, the word "innovation" means little without specific details involving what form these innovations will take. Here then are specific physician innovations:

- One of the forum speakers, Gordon Moore, MD, a founder of the Ideal Medical Home model (at [www.idealmedicalhome.org](http://www.idealmedicalhome.org)), suggests that physicians practice in small offices with no assistants but follow best practice guidelines.
- Physician groups should form partnerships with hospitals to offer predetermined payments for episodes of care for hospitalized patients. Also, groups should integrate using information technology to form "virtual groups" that would serve patients in wide geographic areas. Each group would use an electronic medical record (EMR) systems to aggregate data from all members of the group and offer the public information on prices and patient outcomes.
- Practitioners should offer genomic tests and use the results to match each patient's genome to target specific, personalized drugs.
- Medical groups should drop out of managed health plans and offer care designed to meet patients' needs. For this service, physicians could charge an annual fee for basic services and charge for more comprehensive services based on the time and expertise required. Patients would pay cash and bill their insurers. Cash-only practices have less overhead than practices that serve HMO patients because they do not need staff for medical billing.
- Those physicians dissatisfied with the current health care environment could become locum tenens doctors, thereby getting out of the daily practice grind but retaining practice skills while also traveling to different cities and towns as their services are needed.
- Practices seeking to cut costs could ask patients to enter their own histories and complaints via the Internet before seeing the doctor, thereby creating the basis for a fully documented medical record and more efficient and timely care.
- Those groups seeking to develop physician-led retail-based outlets and urgent-care centers could develop a comprehensive menu of services, such as X-rays, casting, and suturing, and thereby compete with nurse-run retail outlets.

Each of these innovations has the potential to succeed because physicians know what patients need and therefore are most likely to develop affordable ways to improve the care of patients in settings that are close to where patients live and work.

—More information on physician practice strategies is available on our Web site (see page 16).

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## DIABETES STRATEGY

# DPRP Aims to Improve Care

**M**ichael Hennigan, MD, believes the Diabetes Physician Recognition Program (DPRP) has helped him improve the care of his patients. A physician with the Diabetes & Lipid Center in Decatur, Ala., Hennigan says the center achieved DPRP recognition in 2000, and has continually renewed its DPRP status since then. The center's staff of two physicians and a nurse practitioner treat a population of approximately 2,000 patients with diabetes.

The DPRP helps the staff to focus on delivering the best care to patients. The recognition is granted to physicians who provide evidence-based care and document that care according to standard performance measures. "I have a passion for providing this type of care quality to my diabetes patients, particularly because I want to prevent cardiovascular disease," Hennigan comments.

### Collecting Numbers

The DPRP is a joint program of the National Committee for Quality Assurance and the American Diabetes Association. It requires physicians to submit performance data on such diabetes care indicators as annual eye exams, blood pressure tests, glucose levels, lipid control, and foot care. Physicians must reapply to the DPRP for recognition every three years. More than 4,300 physicians currently hold DPRP recognition.

"We had been tracking our quality of care for several years as part of the

Practice Partner Research Network (PPRNet), a group that participates in projects funded by the U.S. Public Health Service," Hennigan says. PPRNet (at [www.musc.edu/PPRNet/](http://www.musc.edu/PPRNet/)) audits practices quarterly on 80 different data points. "Our practice had been tracking data via the use of an electronic medical record (EMR) and had detailed measurements verifying the quality and timing of our preventive care," he adds. "When I learned about the DPRP, I realized that we could easily provide data on the indicators specified and earn DPRP recognition."

Hennigan's EMR uses templates that guide him through the steps required to deliver standardized comprehensive care to his patients with diabetes. "By going through the template on diabetes visits, I can address a comprehensive list of issues these patients face, including blood sugar levels, hypertension, lipid levels, urine microalbumin levels, foot examination, the date of the last diabetic eye examination, and appropriate patient education," he says.

### A Disciplined Approach

Like the Diabetes & Lipid Center, Medical Associates Clinic and Health Plans, a six-location, multi-specialty group practice in Dubuque, Iowa, has been a long-time participant in the DPRP. The practice has maintained its DPRP status since 1999. Medical Associates Clinic and Health Plans has 100 physicians, about 20 of whom are primary care physicians, and treats approximately

6,500 diabetes patients each year.

"In the early 1990s, one of our nurse practitioners attended a diabetes conference and saw a presentation on DPRP," says Christine Sinsky, MD, the primary care physician with Medical Associates Clinic and Health Plans. "She was very enthusiastic and convinced the president of the clinic to agree to pursue DPRP status.

"We felt this would be a good thing to do on its own merits, and would serve as an internal discipline for improving our practice," Sinsky says.

Finding the physicians at the practice supportive of the idea of seeking DPRP status, the practice performed a trial audit approximately six months before applying for DPRP recognition, Sinsky explains. "We wanted to get a baseline estimate of our performance and determine what changes we needed to implement from a systems perspective that would allow us to meet the goal," she recalls. The audit revealed that a number of preventive care activities, such as the foot exam and microalbumin testing, were not being provided to all patients with diabetes.

The findings prompted the practice to increase use of its nursing staff in diabetes preventive care and create a template for use in tracking the services that were provided and the services that patients required.

### Point-of-Care Data

"We engage our nursing staff in diabetes management to a greater degree now than we did in the past, particularly in terms of performing and

*(Continued on page 4)*

**"The idea of pay for performance itself is sound and necessary, but physicians need to be reimbursed appropriately for the complexity of care that we are providing to our diabetes patients."**

**—Michael Hennigan, MD, the Diabetes & Lipid Center**

## DIABETES STRATEGY

(Continued from page 3)

documenting the foot exam,” Sinsky states. “In addition, one of our diabetes educators developed a template that we included in every diabetes patient’s chart. The template included all the elements of preventive care. Clinicians could review the dates and results of the patient’s last HbA1c test, microalbumin level, blood pressure, foot exam, eye exam referral, and pneumonia vaccination. Our nurses would consult the template in the chart before the patient’s visit and then prompt the physicians to provide the appropriate care.”

Initially, the template was a sheet of paper included in the patient’s chart. Now that the practice has implemented an EMR, the template has been translated to electronic format.

For practices seeking DPRP status, Sinsky recommends appointing a champion. “The champion could be a physician, nurse practitioner, or diabetes educator who believes in the initiative and is willing to take responsibility for understanding the concepts of quality improvement, handling the DPRP application process, and promoting the DPRP to the physicians and other practice staff,” she explains. “A second suggestion is to take a systems approach to the changes the practice has to make to improve quality. A systems approach, such as tasking the nurses with some of the elements of care and using checklists and templates, will ensure that all elements of care are routinely and efficiently performed for all eligible patients.”

### Quality and Compensation

Ideally, high-quality care, such as that confirmed by DPRP recognition, should be rewarded financially. In fact, the federal Centers for Medicare & Medicaid Services (CMS) recently designated the DPRP as a registry

## Program Helps Boost Quality, Satisfaction

**F**or the staff of the Diabetes & Lipid Center, the benefits of participating in the Diabetes Physician Recognition Program (DPRP) are numerous. “DPRP recognition has been associated with professional satisfaction, an enhanced reputation among our colleagues, and benefits associated with community awareness,” says Michael Hennigan, MD, one of two physicians in the center in Decatur, Ala. The group treats approximately 2,000 diabetes patients annually and achieved DPRP status in 2000.

Ultimately, though, the fundamental benefits he emphasizes are those related to clinical improvements in patient care. “I have no idea how many lives we have saved, but our practice has had no cases of blindness from diabetes in the last 10 years and only one amputation,” Hennigan says. Furthermore, the practice has sent fewer than 10 patients for dialysis in the last eight years, a remarkable feat, given the size of its patient population.

Although Hennigan’s practice had already been providing high quality care before it sought recognition from the DPRP, Hennigan notes that DPRP recognition has encouraged the practice to focus on quality and to seek other ways to enhance the care it provides. “For example, since receiving DPRP recognition, we have become the only physician practice in Alabama to create a formal diabetes education program recognized by the American Diabetes Association,” he says. “We employ three certified diabetes educators, who provide diabetes education in four hospitals that serve the entire northern portion of the state.”

—DJN

for quality reporting for purposes of the Physician Quality Reporting Initiative (PQRI). Physicians who have been recognized by the DPRP can request that the NCQA submit their clinical quality data to CMS. Physicians participating in the PQRI can receive financial rewards for collecting and reporting quality-related practice data. Under the program, physicians can earn a reward equal to 1.5% of each Medicare claim this year and 2% of each claim in 2009.

For Sinsky’s practice, DPRP recognition has resulted in some practical business benefits. “Our health plan marketing activities highlight our achievement of DPRP recognition,”

she says. “In addition, we have highlighted the recognition in our member newsletters.” While these benefits are significant, Sinsky emphasizes that they are not the main motivation for participation in the DPRP. “Quite simply, we do it because we think it’s the right thing to do,” she says.

Aside from the advantages DPRP recognition has conveyed to his practice in terms of delivering care to patients, Hennigan also hoped that his practice would reap some business benefits from providing high quality care. In this regard, however, he has been disappointed. “Providing excellent care quality is the moral and ethical thing to do, which is why we do

**Ideally, high-quality care, such as that confirmed by DPRP recognition, should be rewarded financially.**

it, and it's great to have recognition for it," he says. "But fair reimbursement for the time it takes to offer that kind of care quality is largely missing."

In most cases, reimbursement levels simply do not cover the costs of providing care to patients with diabetes, Hennigan says. By necessity, such care must be comprehensive, and so includes management of glucose, lipids, and blood pressure; monitoring renal function; coordinating referrals to ophthalmologists; managing neuropathic pain either in the office or by arranging a referral to a neurologist; addressing erectile dysfunction; and addressing and managing mood disorders.

"Clearly, diabetes patients can be a very complicated group of patients," Hennigan observes. "We make a concerted effort to deal with their numerous diabetes-related conditions, but we can't cover it all in a 15-minute visit. Reimbursement for preventive care simply does not reflect the value of the time we spend with our patients."

### The Business of Care

In theory, pay-for-performance (P4P) programs will compensate physicians who deliver comprehensive, high-quality care, but these programs are not widely available. Even when they are available, though, these programs may not be sufficient to compensate for the increased workload required to deliver appropriate and all-inclusive care.

"I had assumed that P4P would come to our area sooner than it has," Hennigan says. "Blue Cross of Alabama has indicated that they will be starting a P4P program next year, but they are still in the early stages of implementation. As proposed, a DPRP recognized physician in the Blue Cross Blue Shield program can

earn a \$100 bonus per patient with diabetes in the first year," he says. "However, the bonus is limited to \$20,000 per year or \$50,000 over three years. So in providing comprehensive care for all of our 2,000 diabetic patients, we can earn a bonus of only \$10 per patient."

"The idea of pay for performance itself is sound and necessary," Hennigan says. "But physicians need to be reimbursed appropriately for the complexity of care that we are providing to our diabetes patients. If, as a health care system, we wait until critical illness develops, we then have to spend huge amounts of money to salvage the patient's health. However, if we are reimbursed appropriately up-front for pre-

venting complications, which can be accomplished for the vast majority of diabetes patients with the tools we currently have available, we can save the system money while improving the health of our patients.

"It's more likely that physicians will pursue quality activities on a widespread basis if providing high quality care is reimbursed at a rate that makes for a good business model," he adds. "It doesn't make sense to spend tens of thousand of dollars to treat a complication that could have been prevented for a fraction of that cost."

—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 16).

## Participation Fosters Innovation

Christine Sinsky, MD, found that participation in the Diabetes Physician Recognition Program (DPRP) has spurred her practice to become involved in other quality initiatives. A primary care physician with Medical Associates Clinic and Health Plans, a multispecialty group practice in Dubuque, Iowa, Sinsky says the group has maintained its DPRP recognition since 1999.

"While we have been recertifying our practice in the DPRP, we also have become involved in NCQA's Heart-Stroke Recognition Program (HSRP), and in fact we were one of the first five clinics in the nation to receive HSRP recognition," she observes. Last year, the practice achieved the highest of three levels of recognition in NCQA's Physician Practice Connection Program.

A physician-owned practice, Medical Associates Clinic and Health Plans has implemented a number of diabetes care quality programs as part of its population management focus. "These initiatives benefit our entire population of diabetes patients," Sinsky comments. In addition, the practice offers one-on-one and group diabetes education classes and has sponsored a number of diabetes-oriented events, such as diabetes health fairs.

Overall, the practice's experience with the DPRP has been positive. "The program has promoted a culture in our organization that supports the development of quality improvement initiatives," Sinsky concludes. "It also gives us the framework within which to examine our practice from a care quality standpoint. Over time, our statistics have improved as a result of tracking our performance."

—DJN

**The physicians wanted to pursue DPRP because it had merit and would serve as an internal discipline for improving the practice.**

## PRACTICE MANAGEMENT

# Survey Reveals State of Primary Care

By Richard L. Reece, MD, editor-in-chief

**P**rimarily care physicians have been struggling in recent years as the cost of delivering health care has risen and their income has declined. At the same time, fewer graduates are choosing primary care just as many older physicians are leaving the profession. Now a new survey shows that the plight of primary care physicians (PCPs) is so severe that many plan to leave the profession within three years and that few are recommending primary care to medical students.

In November, the Physicians' Foundation, a charitable foundation in Boston that represents members of state and local medical societies, including most of America's 900,000 physicians, released the results of a survey of 270,000 primary care physicians and 50,000 specialists (at [www.physiciansfoundations.org](http://www.physiciansfoundations.org)). Titled *The Physicians' Perspective: Medical Practice in 2008*, the report on the survey revealed a widespread loss of morale, and pointed out that many physicians are sufficiently overworked and demoralized that they wish to quit or reduce their practice hours. The results of the survey were reported on CNN and other major media outlets.

### Survey Highlights

In the survey, an overwhelming majority of physicians—78%—said they believe there is a shortage of PCPs in the United States today. Also, 49% of physicians—more than 150,000 doctors nationwide—said that over the next three years they

## Physicians Look Ahead

Within three years, almost half of the survey respondents said they plan to make changes in how they practice.

Close practice to new patients	7.38%
Cut back	20.26
Continue practicing as usual	51.48
Seek nonclinical job in health care	13.40
Retire	10.95
Work part time	10.15
Seek job unrelated to health care	10.14
Work locums	7.54
Switch to concierge/boutique	7.04

Source: *The Physicians' Perspective: Medical Practice in 2008*, The Physicians' Foundation, Boston, 2008.

plan to reduce the number of patients they see or stop practicing entirely. The responding physicians said that by 2011:

- 11%, or more than 35,000 doctors nationwide, plan to retire
- 13% plan to seek a job in a non-clinical setting, which would remove them from patient care
- 20% will cut back on the number of patients they see
- 10% will work part-time.

Also, the survey shows, 60% of doctors would not recommend medicine as a career to young people. Declining reimbursement was rated highest on the list of issues respondents identified as impediments to delivering patient care, followed by demands on physician time.

When asked about the business aspects of their practices, only 17.5%

of respondents said their practice was healthy and profitable, 47.91% said their practice was profitable but with low margins, 22.39% said they were breaking even, and 12.2% were unprofitable. If they had the financial means, 45% of responding physicians said they would retire today.

Practices are struggling in part because payers provide reimbursement that is less than the cost of providing care. Less than 8% of respondents said payers covered the cost of care. In the survey, 64.84% of respondents said Medicaid provided reimbursement that was less than the cost of care and 43.28% said some HMOs and PPOs did so as well.

Asked about proposed cuts in Medicare reimbursement, 82% of respondents said their practices would be unsustainable if the cuts

**Declining reimbursement was rated highest on the list of issues respondents identified as being impediments to delivering patient care, followed by demands on physician time.**

were made. Already, 36% of respondents said Medicare does not provide reimbursement that covers their cost of providing care. When the survey was conducted last summer, more than 33% of respondents said they had closed their practices to Medicaid patients and 12% had closed their practices to Medicare beneficiaries.

### Cutting Expenditures

The result of flat or declining reimbursement is that 39.86% of respondents said they would be unable to provide staff raises, 35.65% said they would be unable to buy needed equipment, 34.62% said they had to reduce uncompensated care, and 34.54% said they had to reduce the time they spent with patients.

While reimbursement is lower than most practices need, overhead is high. Among respondents, 35.77% said overhead represented 51% to 60% of income last year and 24.36% said overhead was 61% to 90% of income.

PCPs find paperwork so burdensome that it cuts into the time they would otherwise spend seeing patients. In the survey, 63% of respondents said nonclinical paperwork has caused them to spend less time with their patients, 60% said they spend 11 hours or more per week on such paperwork, and 94% said the time they devote to it in the last three years has increased.

The result of these factors is that most physicians were demoralized. Only 5.86% of respondents described the professional morale of their colleagues as positive, and 41.87% said the professional morale of their colleagues is either poor or very low.

Not surprisingly, respondents rated

## Patients Per Day

More than 60% of respondents saw 21 or more patients daily.

Per-day volume	Percent responding
0 to 10	7.40%
11 to 20	31.71
21 to 30	41.28
31 to 40	13.68
41 to 50	3.71
51 to 60	0.99
61 or more	1.23

Source: *The Physicians' Perspective: Medical Practice in 2008*, The Physicians' Foundation, Boston, 2008.

reimbursement and managed care as being among the issues that they find most unsatisfying about medicine. At the same time, patient relationships rated highest on the list of issues physicians find satisfying about medicine. Among respondents, 78% said medicine is either no longer rewarding or less rewarding than it was previously.

### Declining Satisfaction

Asked to rate their current level of satisfaction, only 5.4% of respondents said the practice of medicine was very satisfying, 28.68% said it was satisfying, 48.09% said it was less satisfying than previously, and 17.77% said it was unsatisfying.

Most respondents described their practices as either at capacity (44.92%) or overextended and overworked (31.37%). Only 23.71% have time to see more patients and assume more duties. Among respondents, 41.28% are seeing 21 to 30 patients each day and 13.68% are seeing 31 to 40 per day.

"Going into this project we generally knew about the shortage of physicians; what we didn't know is

how much worse it could get over the next few years," said Lou Goodman, PhD, president of the Physicians' Foundation. "The bottom line is that the person you've known as your family doctor could be getting ready to disappear, and there might not be a replacement."

Walker Ray, MD, the foundation's vice president, said the shortage of PCPs could have a negative effect on President-elect Obama's plans to reform the health care systems. "At a time when the new administration and new Congress are talking about ways to expand access to health care, the harsh reality is that there might not be enough doctors to handle the increased number of people who might want to see them if they get health insurance. It's as if we're talking about expanding access to higher education without having enough professors to handle the influx of students. It's basic supply and demand."

### Assessing the Challenges

Any plan to reform health care will likely need to address the shortage of PCPs. In the United States, only about 30% of physicians deliver pri-

(Continued on page 8)

**Reporting that reimbursement did not cover the cost of care, more than 33% of respondents said they had closed their practices to Medicaid patients and 12% had closed their practices to Medicare beneficiaries.**

## PRACTICE MANAGEMENT

(Continued from page 7)

mary care. In other nations, 50% or more physicians do so. Research shows that nations with broader primary care bases have lower overall costs for health care and better outcomes than those reported in the United States. Other studies show that those states in the United States that have higher proportions of PCPs (such as in the Southwest and Middle West) than other states have better patient outcomes as well.

Raising the number of PCPs would represent a significant step toward ending the fragmentation of the current health care system, in which specialty care is predominant. The present system consists mostly of specialists isolated in separate unconnected silos. PCPs, who know what their patients need and refer patients to specialists when necessary, are required to connect them. But since there are not enough PCPs, patients often see specialists, even though no one is coordinating their care.

### Financial Factors

One of the reasons that so few graduates choose the primary care specialties of pediatrics, family medicine, and internal medicine, is that PCPs generally earn one-third to one-half less than specialists.

In fact, the gap in pay between

## About the Survey

**T**he *Physicians' Perspective: Medical Practice in 2008* survey was conducted between May and July by Merritt, Hawkins & Associates, a physician search and consulting firm in Dallas. The survey was mailed to 270,000 primary care doctors and more than 50,000 specialists. The total number of responses received was 11,950, representing a response rate of approximately 4%. The overall margin of error for the survey is less than 1%.

The Physicians' Foundation provided funding for the survey. The charitable foundation in Boston represents members of state and local medical societies, including most of America's 900,000 physicians. Through a commitment to working with physicians nationwide to create a more efficient and equitable health care system, the foundation seeks to advance the work of practicing physicians and to improve the quality of health care for all Americans. Founded in 2003 through settlement of a class-action lawsuit between physicians, medical societies, and third-party payers, the foundation pursues its mission through grant-making and research. Since 2005, it has awarded more than \$22 million in multi-year grants.

PCPs and specialists in the United States is much greater than it is in other developed nations. PCPs in America average about \$150,000 in annual earnings, while specialists in the United States command \$250,000 or more per year. In the United Kingdom, primary care doctors earn on average \$220,000 per year, which is more than many specialists earn.

Physicians should be rewarded for

spending more time with patients, for managing the overall health of patients, and for providing patient-centered and patient-friendly care. Rewards for patient-centered care might include bonuses for making same-day appointments and providing prompt responses to e-mail messages, phone calls, and patient inquiries. The fact that physicians are not paid for making phone calls is particularly nettlesome to them, since some physicians report that they spend as much as one-third of each day on the phone.

If expanded or universal coverage is to be achieved, policymakers and legislators must make purposeful decisions to invest in more medical schools, create more residency slots for primary care, and subsidize primary care training. Investment in a broader primary care base and in more residency slots for all specialties will not only make care more accessible to more patients, but it also will have a positive effect on local and state economies.

—Edited by Rev DiCerto. More information on physician practice strategies is available on our Web site (see page 16).

## Reimbursement Is Less Than the Cost of Care

Among respondents, few were receiving reimbursement that covered the cost of care.

Payer	Percent responding
Medicaid	64.84%
Some HMO/PPO	43.28
Medicare	36.10
CHAMPUS	20.57
Indemnity plans	14.14
SCHIP	13.61
None of the above	7.35

Source: *The Physicians' Perspective: Medical Practice in 2008*, The Physicians' Foundation, Boston, 2008.

## INTERVIEW

# Texas Group Supports National Efforts

As chief executive officer for the past 11 years of the Texas Medical Association (TMA), **Louis Goodman, PhD**, has been a national leader in defending the cause of physicians. In addition, for the last year, he has served as President of the Physicians' Foundation, previously known as the Physicians' Foundation for Health System Excellence, a charitable foundation that represents state and local medical societies. The foundation aims to improve the health system and give private physicians a more prominent role in influencing the direction of health care reform. Goodman has a doctorate in health economics and public policy from New York University. He has worked for TMA for 21 years. Editor-in-Chief Richard L. Reece, MD, conducted this interview.

**Q:** What do you regard as your greatest accomplishments at the Texas Medical Association?

**A:** Our 2003 tort reform effort would fall into the category of a major accomplishment for the state of Texas, and it is now used as a national model. That reform put a cap of \$250,000 for noneconomic damages for physicians, a \$250,000 cap for hospitals, and another \$250,000 cap for a second hospital or nursing home. This is referred to as a stacked cap, \$250,000 for each party. The total is \$750,000, but only \$250,000 of that falls on the doctor's side.

This model appeals to legislators because it's fair and differentiates between physicians and other providers in the system. The model also can help attract physicians to a state. Before we passed our tort reform, Texas was losing all of its liability carriers. But now we have 15 or more in the state, all competing for the business.

Most important, access to care was shrinking in rural and other underserved areas. But during this past

year, the number of physician licenses increased from 2,000 to 4,000, and physicians are now settling and practicing in underserved parts of Texas, such as the Rio Grande Valley. Both primary care and specialist physicians are coming to Texas. The specialists are not restricting access to high-risk procedures for fear of liability penalties. Patients are getting better care and highly specialized procedures are being done. All of this is attributable to the tort reform legislation.

**Q:** Is it true that medical malpractice insurance premiums also have dropped in Texas?

**A:** Yes. Premiums have dropped by 50% or more, and the largest carrier, Texas Medical Liability Trust, is actually providing a dividend to physicians. Also, carriers have been able to rebalance their reserves. So we can stabilize the market and bring more doctors in to provide coverage.

**Q:** What is the mix of primary care physicians versus specialists in Texas?

**A:** It's about 40% primary care physicians, 60% specialists. However, we have a significant short-

age of primary care doctors in the state. Texas is a sunbelt growth state, and given the shortage of doctors, even with the draw to the state attributable to tort reform, it isn't keeping up with the increasing demand. With the aging baby boomers, we think the shortage of primary care doctors will only be exacerbated. The shortage of primary care doctors, based on multiple surveys, and taking into account the fact that the Baby Boomers will be entering Medicare in 2011, is unquestionably an impending crisis.

**Q:** Has the shortage of physicians in Texas been addressed from a training perspective? Is there an educational or training factor contributing to the problem?

**A:** In Texas, where we have eight medical schools, we have a shortage of postgraduate medical training programs. So, many of our medical school graduates go to other states for training. Then they tend to settle in those states, rather than return to Texas.

We have a shortage of residency slots, and many of our graduates now live and practice in California, New York, and Massachusetts, states that

*(Continued on page 10)*

**“Before we passed tort reform, Texas was losing all of its liability carriers. But now we have 15 or more in the state, all competing for the business. Most important, access to care was shrinking in rural and other underserved areas. But during this past year, the number of physician licenses increased from 2,000 to 4,000, and physicians are now settling and practicing in underserved parts of Texas, such as the Rio Grande Valley.”**

**—Louis Goodman, PhD, Texas Medical Association**

## INTERVIEW

(Continued from page 9)

have invested heavily in postgraduate medical education. One of our big legislative pushes is to increase funding for postgraduate medical education.

**Q:** *What argument are you using to support the push to increase postgraduate medical education funding with Texas legislators?*

**A:** The argument is that we're putting tens of millions of dollars into undergraduate medical education, expanding the number of medical graduates, and building new medical schools; but without residency programs, we're losing half of our graduates. That means a lot of that money is going to waste as far as the state of Texas is concerned.

**Q:** *Do you feel that the medical home concept has potential as an answer to the physician shortage?*

**A:** Primary care physicians' main problem is that the services are underfunded. If medical homes address that underfunding through new payment mechanisms, by providing greater payments for managing and coordinating comprehensive services for chronic disease, then medical homes will be a great thing. The TMA strongly supports the medical home model.

**Q:** *Let's discuss the work of the Physicians' Foundation. What do you see as the foundation's primary mission?*

**A:** The Physicians' Foundation is set up to help practicing doctors. It was founded on state medical society actions and lawsuits under the Racketeer Influenced and Corrupt Organizations Act. We used this act to try to address the deceptive trade

## TMA Membership Hits 44,000

**T**he Texas Medical Association (TMA) is one of the strongest of the 50 state medical associations serving physicians in the United States. It is reputed to have among the highest percentage and greatest number of doctors belonging to an association of any such group.

"This year our membership will probably reach the 44,000 mark, which is 79% to 80% of all of the doctors practicing in Texas," says association CEO Louis Goodman, PhD. "I attribute that to strong grassroots efforts on the part of our members, a strong advocacy and legislative program, and a strong patient safety program."

Even though Texas has about one half the population of California, the California Medical Association has fewer members than the TMA has, a factor that Goodman attributes to competition in the Golden State.

"California has a very competitive market, with a heavy managed care market penetration," he says. "This competition has wrought havoc among private independent practitioners. The result has been fractionation in the California Medical Association. One of the TMA's great strengths is that we work closely with our county medical societies. We work shoulder to shoulder from the ground up. California has many large groups in which there are far fewer incentives to be members of organized medicine. On the other hand, California is considered to be the gold standard when it comes to liability tort reform. We looked at California as the tort reform model."

Another factor that distinguishes the TMA from other state medical societies is its leaders have high-profile positions in the industry. In fact, the incoming president of the AMA is James Rohack, MD, a cardiologist, who heads up the Health Policy Institute at Scott and White, a physician-run health care organization in Temple, Texas.

—RLR

practices that insurance companies had used. A federal judge agreed with our cause, and class action suits were set up in 21 different jurisdictions that were remanded to Miami.

As part of the \$1.3 billion prospective and retrospective relief that doctors received nationwide, a foundation was set up to help physicians in their practices using information technology (IT) to ensure patient

safety and increase efficiency. This is an unusual niche that no other foundation has addressed.

As part of the foundation's effort, we just did a national survey of all primary care physicians and a few selected specialties, to ascertain the morale and financial status of doctors. I call it taking the temperature of the physician population. We are hoping the results will bring

**"We're putting tens of millions of dollars into undergraduate medical education, expanding the number of medical graduates, and building new medical schools; but without residency programs, we're losing half of our graduates."**

**—Louis Goodman, PhD, Texas Medical Association**

attention to an impending crisis relating to the number of physicians available, the morale of doctors, the challenges that physicians face, and the immediate need for proactive solutions and ideas so the nation and the aging baby boomers will have access to a doctor when they need one.

Another purpose of the foundation is to give doctors a place at the health reform table to influence legislation. We would like the media to pick up the results of the survey so the public will understand that the way things are going, soon they may not have their doctors when they need them.

With the new administration, we want medicine to have a prominent seat at the bargaining table, which was not the case the last time we looked at sweeping health reform. I don't think the public generally appreciates the magnitude and implications of the looming physician shortage. There's some sense among the public that doctors are troubled by the hassles of insurance companies, that health care is not as affordable as it used to be, and that services are not as readily available as they ought to be. But as far as how doctor shortages will affect everyone, what's happening and what's likely to happen will come as a big surprise to a lot of people.

**Q:** *What are your expectations for the steps the foundation will take going forward?*

**A:** Our expectations are that the issue of health care will be moved to center stage, that many voices will be heard, and that people in the medical field will have a prominent role in shaping the future of health care. The issues are: How do we

address the uninsured? What do we do about cost increases? And how do we maintain a high level of quality in the service that we provide? There are three items on the new administration's agenda. The first item is the economy. The second item is guns and butter. Health care is third on the agenda.

With health care, long-term sav-

ings may accrue through the use of information technology, preventive care, and chronic disease management. But our view at the foundation is that these savings depend on scale, and it will take five to 10 years to achieve them.

—*Edited by Rev DiCerto. More information on physician practice strategies is available on our Web site (see page 16).*

## Physician Practices Support Communities

**A** study commissioned by the Medical Association of Georgia and carried out by the Carl Vinson Institute at the University of Georgia found that physicians in private practice support their communities by providing jobs and tax revenue.

The study shows that 18,500 private physicians in Georgia (not including those physicians employed in hospitals) supported 100,000 jobs, paid \$10 billion in payroll, generated \$20 billion in economic activity, and contributed \$1.2 billion in state government revenue and \$1.5 billion in local government revenue. The study also found that if physician shortages were not addressed by 2020, the state would lose \$32 billion in revenue.

Another study showed medical practices have a significant economic effect in many states. For the study by the American Academy of Family Physicians, researchers analyzed the financial effects of family physicians on various states. In New York, the researchers found that each family physician is responsible for \$1 million of economic activity on average, for a total collective economic effect of \$2.9 billion. In Florida the average family physician generates \$941,000 in economic activity, for a statewide total of \$3.5 billion. In Ohio and Texas, the averages are \$923,000 and \$1.1 million, respectively, per family physician, for statewide totals of \$2.4 billion and \$5.4 billion, respectively.

Louis Goodman, PhD, chief executive officer of the Texas Medical Association, said the association is analyzing these studies. "We are reviewing the data, especially in light of the financial meltdown and with health care being such an economic lifeline in a faltering economy," he said. "With national and regional economies foundering, perhaps national and state governments will start taking a hard look at economic production factors and look at health care differently, as a revenue generator rather than as an expense. Timing is everything. We should look at health care as above rather than below the line."

—RLR

**“Our expectations are that health care will be moved to center stage, that many voices will be heard, and that people in the medical field will have a prominent role in shaping the future of health care.”**

## HEALTH POLICY

# Forum Shows a Shifting Paradigm

By Richard L. Reece, MD, editor in chief

**O**ne significant challenge President-elect Obama will face when he takes office in January involves how to fund Medicare in the future. Speaking at a conference earlier this month in Washington, D.C., federal officials painted a bleak picture.

Benjamin Sasse, PhD, assistant secretary for planning and evaluation of health policy for the federal Department of Health and Human Services (HHS), said experts have projected that Medicare could be bankrupt by about 2015. Bankruptcy would mean the federal Centers for Medicare & Medicaid Services would no longer have money to pay hospitals and doctors for treating the nation's elderly. "The time has come to deal with economic and political realities and to exchange views of which changes are needed and can be made," Sasse says.

## Presenters Offer Insights

Sasse was one of several speakers at a conference on Dec. 10, at which 56 national innovators, policymakers, and HHS officials and managers met in Washington, D.C., to explore innovative ways to save Medicare and Medicaid and the U.S. health system from bankruptcy.

Titled "The Innovation Imperative: Aligning Payment Incentives and Reforms to Encourage Health Innovation," the conference focused on practical innovations, rather than on national reform. HHS staged the conference, with help from the Lewin Group, consultants in Falls Church,

Va. (at [www.lewin.com](http://www.lewin.com)). Jason Hwang, MD, MBA, executive director of the Healthcare Innosight Institute (<http://innosightinstitute.org>) delivered the keynote address. Hwang is the co-author of *The Innovator's Prescription: A Disruptive Solution for Health Care* (McGraw-Hill, 2008). He suggested no overarching or disruptive solution for the problems facing the system. Instead, he presented the pros and cons of various business models.

The first presentation was titled "Alternative Practice Solutions." In this address, William Sage, MD, JD, vice provost for health affairs at the University of Texas, spoke about retail clinics and noted that 50% of Americans live within five miles of a Walmart. Rushhika Fernandopulle, MD, MPP, the founder of Renaissance Health (at [www.renhealth.net](http://www.renhealth.net)), described how his primary care-based organization had developed low-cost care solutions while conducting business with the Boeing Corporation, Atlantic City companies, and janitors in Houston.

In the next presentation, titled "Innovations in Management of Chronic Disease," Ariel Linden, DrPH, MS, president of Linden Consulting Group (at [www.lindenconsulting.org](http://www.lindenconsulting.org)), pointed out that disease management doesn't always work well in the real world, and gave reasons to support his claim. Chad Boulton, MD, PPH, MBA, a geriatrician and a professor at Johns Hopkins University in Baltimore, described how health care costs for the chroni-

cally ill with multiple illnesses can be cut by 11% with a structured approach featuring active nurse guidance. John Goodman, PhD, president and CEO of the National Center for Policy Analysis (at [www.ncpa.org](http://www.ncpa.org)), spoke about the effectiveness of market forces in cutting costs and improving care.

In the last presentation, "The Ideal Meets the Real in Healthcare—Incentives and Uncertainties in Medical Practice Design," Michael Millenson, president of Health Quality Advisors, LLC (at [www.healthqualityadvisors.com](http://www.healthqualityadvisors.com)), and Gordon Moore, MD, the founder of the Ideal Medical Practice movement ([www.idealmedicalhome.org](http://www.idealmedicalhome.org)) discussed information technology. Millenson described the negative consequences to the health care industry of the information revolution, and Moore argued that solo practitioners making use of information technology are making a positive difference in patients' lives.

## Drawing Conclusions

The presentations and sideline conversations featured a noticeable lack of discussion of any one political ideology or a single political fix for the health care system. None of the presenters seemed to suggest that one large-scale solution, such as universal coverage, would simultaneously cut costs, improve care, and establish a system based on compassion.

It was possible to draw a number of conclusions from the presenters' remarks. First, the health care system

**"The time has come to deal with economic and political realities and to exchange views of which changes are needed and can be made."**

**—Benjamin Sasse, HHS**

is facing a genuine crisis of rising costs. This crisis is pushing Medicare toward insolvency, bankrupting states, and threatening to ruin the competitiveness of U.S. businesses in the global economy. Many of the presenters remarked that surely the United States can develop a system that is more efficient and more effective but that many of the current ideas being discussed will not help patients or providers. The presenters also made the point that providers of care must become more aware of patients' needs and the need to make care more affordable.

### **Profound Change**

Listening to the speakers, it was clear that the health system is undergoing profound structural changes. Hospitals are employing more physicians than they have in the past, and the Internet is making health care information more accessible to patients. More home care is being administered, telemedicine and remote care monitoring are becoming increasingly common, and nonphysician professionals are administering more care than they did in the past. Physicians agree that nurse practitioners and other physician extenders with power to treat and engage patients directly in their homes will be necessary if the health system is going to be able to manage the needs of the elderly and other underserved populations who often have chronic conditions.

Also, it is clear from the conference that a new openness and pragmatism exists toward free market solutions. These solutions include retail clinics, concierge practices, consumer-driven care consisting of health savings accounts (HSAs) and high-deductible health plans, cash-for-care rather than prepaid care, and innovative delivery systems that self-funded employers use

to cover 100 million Americans. Small-scale and solo practices can deliver more cost-effective and efficient care than large, integrated, multispecialty groups or hospital-based systems.

At the same time, the speakers acknowledged that there is a widespread recognition that the primary care shortage is a monumental problem. This shortage is attributable to inequitable reimbursement from payers and a lack of respect from policymakers toward primary care. The speakers also agreed that a robust primary care-based system could help to reduce the cost of care while also improving patient satisfaction and outcomes. One way to reach all three of these goals is by developing patient-centered medical homes that coordinate care and thus provide a solution to the problem of fragmented care.

In November, the American Medical Association (AMA) voted to adopt the "Joint Principles of the Patient-Centered Medical Home," joining the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association in endorsing the principles. The principles include guidelines for the coordination of care to improve the patient-physician relationship, quality and safety, access to care, and payment for coordinated services.

"A patient-centered medical home can improve the ability of physicians and other health care workers to provide the best care to patients by better coordinating care," said AMA board member Samantha Rosman, MD. "The AMA will continue to study the medical home concept with a focus on funding sources and payment structures, as adequate compensation is vital to make coordina-

tion of care a viable solution."

As the AMA's action demonstrates, more physicians and other health care professionals are seeking ways to improve the delivery of care. During the innovation conference, it was clear that large and small businesses are willing to follow the lead of innovative physicians and other professionals with deep knowledge of the health care system to introduce more pragmatic and innovative approaches, such as the patient-centered medical home, to delivering care in an effort to save money and produce healthier workers.

### **A Changing Landscape**

More than at any time in the past, the conference showed that a consensus is developing around the idea that entrepreneurial primary care physicians who develop innovative ways to deliver care can be a powerful force for providing good and compassionate care. At the same time, there is a consensus among physicians that universal adoption of electronic medical record (EMRs) systems in physician offices appears to be unlikely, mostly because these systems are too costly for more practices to afford. While EMRs are costly, physicians say they are useful for collecting data on the quality and value of care.

Finally, there is an emerging consensus among health care experts that practitioners know how to reduce costs and improve care and have shown it can be done. But empowering these practitioners to make the necessary improvements requires encouraging more physicians to pursue careers in primary care, and ensuring that they are adequately compensated.

—Edited by Rev DiCerto. More information on physician practice strategies is available on our Web site (see page 16).

**The speakers acknowledged that there is a widespread recognition that the primary care shortage is a monumental problem.**

## TECHNOLOGY

# How to Avoid EMR Buying Mistakes

By Michael Uretz

As most physicians know, implementing an electronic medical record (EMR) system can be costly and complicated. While some advocates view universal adoption of EMRs as a crucial step in addressing many of the problems physicians face every day, many doctors remain skeptical of their value and are reluctant to make a significant investment in this technology.

Large hospitals and health care organizations have long recognized the value of EMRs. Small and medium-sized practices and physicians in solo practice, however, tend to view them as an expense that contributes little value to a busy practice when weighed against the additional work involved to choose, buy, install, and learn these systems.

## Assessing Value

Nevertheless, businesses increasingly depend on computers for record keeping and health policy experts suggest EMRs will boost physician efficiency, meaning doctors and staff may want to invest the time and money seeking the best EMR options for their practices. After all, some day, all physician practices are likely to be required to install these systems. Therefore, physicians should at least consider the possibility of making the necessary investment in hardware and software sooner rather than later.

*Michael Uretz is the executive director of The EHR Group, health IT consultants in Seattle, Wash. (at [www.ehrgroup.com](http://www.ehrgroup.com)). This article is adapted from a report, *Seven Costly Mistakes Made When Purchasing Electronic Medical Records and Health IT—And How to Avoid Them*. The full report is available on the Web (at [www.ehrgroup.com/special-report.htm](http://www.ehrgroup.com/special-report.htm)).*

But whether a physician practice views the investment as a waste of capital, a necessary evil, or a step toward a more integrated health care system today, there are ways to avoid overpaying for an EMR and to ensure that the investment is put to the most effective possible use.

In a recent report, *Seven Costly Mistakes Made When Purchasing Electronic Medical Records and Health IT—And How to Avoid Them*, The EHR Group of Seattle (at [www.ehrgroup.com](http://www.ehrgroup.com)) informs physicians considering purchasing EMRs of the ways they can avoid overpaying for this important upgrade. The seven mistakes are:

1. Selecting the wrong EMR
2. Overpaying for your EMR
3. Accepting poor payment terms
4. Giving up your rights to data and intellectual property
5. Not planning for the worst case
6. Accepting inadequate warranties
7. Not asking for service and support guarantees.

## The Proper Choice

The report lists some of the various ways in which practices select the wrong EMR. Typically, mistakes lie in acquiring more information than is needed or failing to organize the information in a way that meets the practice's needs. The report suggests that physician practices research EMR systems thoroughly. As any professional would do, the practice should issue a request for proposal (RFP) to each vendor. This step costs nothing but communicates the practice's needs, priorities, and expectations. When the practice receives the proposals, it can then compare each proposal side by side and prepare legal documentation on each vendor's commitments to the buyer.

At a minimum, a proposal from

each vendor should include the following:

- A vendor profile
- A list of EMR features that the practice requires in order of priority
- A description of the EMR's underlying technology
- A description of the implementation, training, and support the vendor will provide.

One way practices stumble when selecting an EMR is by allowing vendor demonstrations to lead purchasers into choosing the wrong EMR, the paper says. A key to avoiding this pitfall is to approach the demonstration with a defined set of objectives, and allowing only a specific amount of time for the demonstration. Understanding what types of patients the practice sees most frequently and what it documents from each encounter will help the practice choose the EMR capabilities it wants.

Before or during a demonstration, the physicians and staff should take note of how many and what types of questions the vendor asks. If the vendor doesn't ask questions about the practice's needs, it may not be interested in meeting those needs. "Be wary of vendors who tend to have one-sided conversations, discussing solutions before they understand your needs," the report says.

One way to avoid overpaying for an EMR is to understand how important your practice might be to a vendor or how the practice could help the vendor in promoting its systems, for example, the report says. A vendor may be facing a sales quota and need to make a sale quickly, or may recognize the practice as a good referral for other potential customers, or a way to break into the practice's geographic area or specialty.

In addition, it certainly is useful to understand how pricing works in the

EMR marketplace. Vendors tend to play fewer games, the report says, when dealing with purchasers who are knowledgeable. It may be important, for example, not to pay too much up front. If the vendor has received the majority of its payment before any of the work has been done to install the EMR, the practice would have little leverage when trying to push the vendor to complete the job. A good contract will include a plan by which payments are made as the vendor achieves certain milestones in implementing the system.

### Ensuring Good Service

Warranties are intended to hold a vendor accountable for all claims it makes. Most vendors include a warranty in their contracts. However, it is not unusual for such warranties to be insufficient in duration and scope. Be sure that a vendor's warranty guarantees that the hardware and software will be installed according to the agreed-upon schedule, that the system will work as the vendor has claimed, that the vendor does not have the right to disable the software, and that it will support the system.

The final costly mistake addressed in the report is failing to ask about service guarantees. A service level guarantee provides a plan for maintenance, support, and upgrades to an EMR after it has been installed. The plan should include guarantees for how quickly a vendor will address problems and what penalties, if any, the vendor will incur if it fails to act according to the agreement.

The report also suggests levels of service that the practice should understand before closing the deal. The practice should know, for example, what hours of support are available. "Don't accept terms such as 'support during standard business

hours,'" the report says. "What if your vendor is based on the East Coast? ...If you're located on the West Coast, this means you can't get support after 2 pm your time."

Service guarantees should specify that agreements are made for the practice's local time, and should include details pertaining to off-hours requests. The practice should know, for instance, if service is available during nights and weekends and if there is an additional charge. Also, the contract should include response time guarantees, stipulating how quickly the vendor will act when a

problem arises. Finally, the guarantee should include allowances for updates and new versions of software, and should guarantee that older versions of a product will continue to be supported for a specified period.

Purchasing an EMR may appear to be a daunting task. But when a practice is armed with the proper knowledge, it can enter into the process knowing that it will not waste its capital or its time, and that it is equipped to get the best system and the best service for its needs.

—More information on practice strategies is available on our Web site (see page 16).

## Report Says: Protect Your Rights

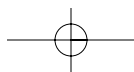
**M**any practices that buy electronic medical record (EMR) systems accept terms that allow the EMR vendor to use the data the physicians collect with their EMRs for their own research. A report, *Seven Costly Mistakes Made When Purchasing Electronic Medical Records and Health IT—And How to Avoid Them*, published by The EHR Group of Seattle (at [www.ehrgroup.com](http://www.ehrgroup.com)) suggests physicians should not allow vendors to use a group's data in this way.

"Never accept any clause in a contract in which the vendor has the right to use your data for research purposes, unless you are planning on getting something in return, since 'research' is one of those terms that can be interpreted a number of ways," the report says. If you do allow a vendor to use your data, be sure that the contract spells out specifically how it will be used. The contract should not allow the vendor to make money by using your data.

In addition, practices often develop their own templates for use with their EMRs. It is not unusual for vendors to include clauses in their contracts claiming that custom templates designed by purchasers are their own property, on the grounds that anything designed with the use of the vendor's software should belong to the vendor. The report advises against allowing a vendor to do so: "Don't accept this premise—and ensure your contract states that any templates you develop remain your property."

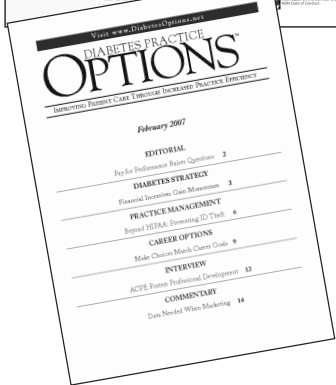
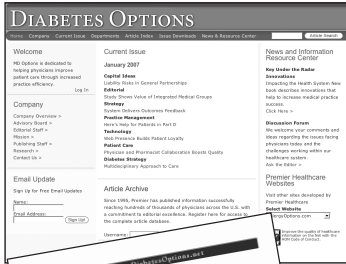
Purchasers should plan for contingencies such as the EMR vendor going out of business or dropping support for the product they purchase. "You have a right to request that your vendor put their software and documentation in escrow for a rainy day should the vendor not be there at some point in the future," the report says. The report also advises purchasers to be sure vendors agree to help if the practice needs to transfer to another system. —MU

**The report explains why practices select the wrong EMR and suggests physicians request proposals and research the responses thoroughly.**



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