CARDIOLOGY PRACTICE
OPTIONS™
A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE January 15, 2002

CONTENTS

Unconventional Group Embraces Innovation

When patients call the inTandem Medical Group in Portland, Ore., they are greeted by the receptionist with the following question: "How can I make your day easier?" This is just one example of how this group is taking an unusual approach to patient care.

The group's innovative ideas are part of its bold strategy for starting a medical practice, which involves rethinking everything from office design to e-mail communication between patients and providers. Perhaps most unusual is the $350 annual fee (not covered by insurance) that each patient pays for the expanded level of service and access that inTandem promises to deliver.

No Chairs, No Waiting

When patients call to schedule an appointment at inTandem, they get same-day or next-day appointments. When they visit the office, they do not start out in the waiting room because there is no waiting room, and they may spend up to an hour or more with their physician. But sometimes they won't even visit the office; instead, they might talk on the phone or exchange e-mail messages with their doctor.

Judging from the practice's steady growth (averaging about 15 new patients a week, toward a goal of 2,000) and patient approval ratings, the strategy is working.

Opened in July, inTandem is a pilot practice created by GreenField Health System. GreenField was founded by three veterans of more traditional health care practices who are determined to push the limits of traditional medical care delivery to show that improvements can be made. The two physicians and one health care executive are financing the venture with their own funds and bank loans.

Charles Kilo, MD, MPH, an internist and research fellow for the Institute for Healthcare Improvement in Boston, and the former head of IHI's Idealized Design of Clinical Office Practices, founded GreenField along with Steven Gordon, MD, a Portland-area internist, and Jill Arena, a health care executive formerly with Providence Health System in Portland. The trio aim to create practices that are technologically savvy and that serve people by embracing innovation from other industries. They also provide consulting services to other practices interested in changing the status quo. They focus on three core elements: service, relationship, and reliability.

Patient-Focused Care

"Service is what the patients see," says Eric Murray, MD, one of inTandem's four internists. "We want to make the clinic more patient-focused than office-focused in order to make things more convenient for our patients." A big part of that convenience comes from the use of open access scheduling, which enables patients to schedule same-day or next-day appointments, even for routine needs.

Being more patient-focused also

(Continued on page 10)

EDITORIAL

Common Sense Triumphs Over Gatekeeper Rules

The common sense of patients and their physicians may yet prevail over the artificial barriers to care that have been imposed by managed care.

One sign that managed care is losing its grip can be found in a study published in the Nov. 1 issue of the *New England Journal of Medicine*, “Leaving Gatekeeping Behind—Effects of Opening Access to Specialists for Adults in a Health Maintenance Organization.” The authors found patients exercise common sense when going to specialists. In fact, patients did not flock to specialists’ offices when Harvard Vanguard Associates, a large prepaid multispecialty group in Boston, allowed them to see specialists without being referred by primary care physicians.

This sensible patient behavior was predictable. In the real world, patients want to be masters of their own care and their own time. This behavior was described by Regina Herzlinger, professor of business administration at Harvard Business School in *Market Driven Health Care* (Addison-Wesley Publishing, 1997) and has evolved rapidly in some markets. Educated baby boomers and their aging parents have little tolerance for long waiting times, inconvenient care, and insufficient answers from nonspecialists.

For patients, gatekeeping means an extra doctor visit, a delay in needed care by a specialist, and a belief that physicians care more about costs than care. PCPs don’t like gatekeeping either, saying it adds to their workload, paperwork, and staffing requirements. What’s more, because the system often angers patients, it can increase the likelihood of malpractice suits, some experts say.

Gatekeeping started in large, prepaid, multispeciality clinics where PCPs and specialists often operated under one roof. Integrated and coordinated care was the rule. The gatekeeper concept was more workable under these circumstances because little patient time was wasted, referral was convenient, charts were shared, and physicians could reach a consensus on care decisions.

But care in large prepaid multispecialty groups is not care in the real world for most Americans and their physicians. Among U.S. physicians in the private sector, 80% practice alone or in groups or 10 or fewer. Less than 5% of physicians practice in prepaid medical groups.

Gatekeeping failed because it did not meet the commonsense standards of patients or their physicians. The managed care strategy of offering comprehensive benefits while restricting access offended their intelligence. To be sure, managed care is still very much in control of how health care is delivered nationwide, but at least physicians who value common sense are cheering a reduced role for gatekeepers.

Richard L. Reece, MD
Editor in chief
Phone: 860/395-1501
Fax: 860/395-1512
E-mail: Rreece@premierhealthcare.com

ADVISORY BOARD

This newsletter is published by Premier Healthcare Resource, Inc., Parsippany, N.J.

Publisher
Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054
888/457-8800
Fax: 973/316-5989
publisher@premierhealthcare.com

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

CASE STUDY

EMRs Help to Boost Productivity

By Richard L. Reece, MD, editor in chief

Many more practices would have electronic medical record systems if they didn't fear the implementation process and its effect on productivity. A family practice in Albany, N.Y., has shown that careful planning before system implementation can ameliorate many of these fears.

The Latham Medical Group has been using an EMR system since May 1999. The group includes eight family physicians and almost 80 staff members in two offices. "It became obvious to us that we needed an EMR system," says Bruce Bagley, MD, a partner in the group who has been a family physician for 25 years. "It was getting more difficult to transfer information between the offices and to ensure that patient charts were in the hands of clinicians during patient visits."

Getting a Return

The group recognized the enormous benefits of an EMR system, but it did not specifically focus on the return on investment it would achieve when deciding to go ahead with the implementation. "A strict ROI calculation may not show that an investment will ultimately generate cost savings," Bagley says. "In addition to ROI, we focused on quality of care and other benefits, including up-to-date, consistent medical records, which would be difficult to achieve with a paper-based system. So our decision to pursue an EMR system was based on more than just ROI."

The first step the group took in selecting an EMR system was to outline the functions that are most important to the practice. "Recording the notes from the patient visit onto an electronic record was only a small part of our goal," Bagley explains. "We were more interested in improving our office workflow and in how an EMR system could help us to redesign our processes. Bringing in a new system just to computerize the processes we already had would have been a missed opportunity. Accordingly, we looked at systems that had the basic recording function of an EMR and would also provide a more efficient and effective interoffice workflow."

The practice also wanted a system that was flexible, so that it could be customized to meet the group's needs. "We wanted the system to be fully integrated with many capabilities," Bagley says. "We recognized that even though we might not use all of the functions initially, we would eventually want to integrate laboratory ordering and reporting, scheduling, and billing into a seamless system. We also wanted the system to include Internet capabilities in the form of an interactive Web site that patients would be able to access to review their charts and lab results and to communicate with physicians by e-mail."

As with any new office system, Bagley and his colleagues were concerned that the implementation of the EMR system would cause a drop in physician productivity. "Some vendors tell physicians that they will have a 20% to 30% drop in productivity for six months, so a practice will have to schedule a 20% or 30% reduction in patient visits to allow time for the clinicians to learn along the way," says Bagley. "My response to that is, 'I can't buy your product because I'll be out of business.' We tried to think of how we could bring our physicians up to speed without reducing their productivity."

Maintaining Productivity

To maintain productivity, the group implemented its system incrementally, starting with functions that would not interrupt patient flow. First, the group installed practice management software, the Windows NT network, and sent a member of the financial staff to Windows NT training, Bagley explains. "He became a certified Windows system engineer," says Bagley. "As a result, we now have in-house information technology knowledge. Next, we set up our Windows NT network at the workstations of the staff who manage the financial and scheduling aspects of the practice. Implementation of the practice management system did not interrupt patient flow or billing flow, and did not adversely affect practice operations."

The online prescription function was the first one implemented for the group's physicians. "When we implemented this function, physicians could still elect to write a prescription by hand; but within two weeks, almost all of them were printing and faxing prescriptions," says Bagley. "The physicians learned to use this function quickly, and they immediately

(Continued on page 4)

Even after choosing a system that was flexible and had the functions the practice wanted, the group learned that customizing the software to meet day-to-day needs took a long time.

> **"In addition to ROI, we focused on quality of care and other benefits, including up-to-date, consistent medical records, which would be difficult to achieve with a paper-based system. So our decision to pursue an EMR system was based on more than just ROI."**
>
> ***—Bruce Bagley, MD, Latham Medical Group***

(Continued from page 3)

recognized that this was a better, faster way to generate prescriptions."

The function allows physicians to write prescriptions and fax them directly to a pharmacy without printing them on paper. In addition, using the computer for this function automatically records the prescription in the patient's chart. Most important, the computer references the patient's record and checks for allergies and any possible medication interactions, thereby enhancing quality of care. The computer also ensures the correct spelling and the correct dosages, which reduces medication errors.

The second function introduced to physicians was interoffice e-mail. "The interoffice messaging function did not require physicians to stop seeing patients in order to answer their messages by computer," Bagley explains. "Since the physicians had already been batching their paper messages for review at the end of the morning and at the end of the afternoon, going to the computer at these times did not require a reduction in their productivity or a significant change in their work process."

Continued Improvements

To allow time for the physicians to get acclimated to the computers, the practice did not implement another function for three months. "Subsequently, we added new functions one at a time so that physicians could become comfortable with each one," Bagley observes. "As a result, we never needed to give physicians time off to learn how to use the computer."

Today, the physicians are using the computers during patient visits. "We are beginning to reach a stage at which the system is allowing us to request tests and document the patient visit at the point of care," Bagley says. "But achieving this level has taken us a while. When practices first implement an EMR system, only part of the patient's record is on the system, while the other part is still on paper, which requires the physicians to reference both sources. Now that we have enough data in the computer and are using most of the functions on the system, physicians can use the record on the computer to handle all documentation and requests."

For instance, the group's physicians can order laboratory work using the computer at the point of care. "If I decide that a patient needs a complete metabolic panel and a lipid profile, I just touch those buttons on the screen to submit that order," Bagley says. "By the time I leave the exam room, the nurse is outside the door with bar-coded, labeled test tubes. She draws the blood into the test tubes and sends them to our lab. The results from such routine tests are back on my computer within two or three hours. I can review those results and tell the nurse to call the patient before the end of the day. Patients appreciate this responsiveness. Furthermore, the system promotes the idea of continuous workflow. Lab results are not outstanding for a week while I await a report."

What's more, the EMR system has helped the practice participate in medical research. "Last summer a researcher approached us about studying our patients with diabetes," Bagley says. "She had set aside two weeks in her schedule to study a sample of our patients. But within 15 minutes we were able to give her a list of 1,500 patients with diabetes, the physicians who treated them, the medications they were on, the date of their last HbA1c test, and the value of that number. Her total time in our office was a day and a half. Although we are not set up to be a research practice, the ability to do research is a terrific by-product of the relational database in the EMR system."

Ensuring Compliance

While many functions have improved workflow, the practice still struggles to gather medical histories from each patient and create an actual chart note in a way that meets evaluation and management guidelines. Some physicians are concerned that creating a note using a computer will actually take more time than simply dictating it.

"Many systems require that physicians do a labor-intensive selection from a list of medical history items," Bagley says. "Only programs that break down the history and the physical examination into discrete items from a pick list—as opposed to recording a free-text entry—can review coding and ensure compliance."

The group is discussing how to resolve this issue. "Some physicians believe that the note should be created from a pick list of detailed data," Bagley says. "But to enter medical history that way is cumbersome. Rather,

Society Promotes EMR Adoption

The American Academy of Family Physicians, in Leawood, Kan., is helping its members to adopt electronic medical record systems. The goal of the AAFP is to have all family physicians using EMRs by 2005.

"The AAFP recognizes the need to have all family physicians using EMRs if we are going to keep up both technologically and economically," says Bruce Bagley, MD, a family physician in Latham, N.Y., and chair of the AAFP's task force on EMRs. The task force was charged with identifying and promoting EMRs that support the core business of family practice.

The task force produced a booklet, *The Results of the AAFP's E-Health Survey 2000,* which focuses on three areas. The first area is the use of the Internet for patient care by family physicians in their offices. "We studied Internet use by age range," Bagley says. "Not surprisingly, in the 35-and-under age group, 85% of physicians were using the Internet in their office for some purpose. What was more intriguing was that 40% of physicians aged 65 and older were also using the Internet. So although there is a drop-off in Internet usage with age, older physicians are still using it to a significant degree."

Second, the survey studied e-mail use among physicians. E-mail use by physicians is increasing slowly, Bagley says. About 18% of physicians reported using the Internet to e-mail colleagues, and a similar percentage were using it for continuing medical education or to research medical questions. Only about 10% of responding physicians reported using e-mail to communicate with patients, mostly to answer patient questions.

"There are many services, such as answering patients' questions, that physicians do face-to-face simply because of the way reimbursement systems are set up, and these services do not have to be done this way," Bagley observes. "Because of time pressures, physicians are looking for ways to leverage their time, so many are answering their patients' questions by telephone or e-mail or through triage nurses. These methods can enhance the doctor-patient relationship by prompting and expediting the transfer of information." The academy has designed a program on how to use e-mail to facilitate patient communication. It is available on the Web (at www.aafp.org).

Third is EMR adoption. The survey found that although about 15% of family physicians now use some form of EMR, only about 1% have a fully integrated, paperless system.

—DJN

some aspects of the history can be free-text. I am coming to the conclusion that we need to meld different functions. For us, the history could be free-text, because a regular clinical office such as ours would seldom need to search that data. The physical exam lends itself to pick lists quite well."

Reading the Signs

Other processes go more smoothly. By delegating certain activities to a nurse, for example, the practice reduces some of the time that physicians would spend otherwise. "The nurse does the visit agenda, writing down the patient's chief complaint and the questions the patient would like to have answered," Bagley says. "This nurse's note is created from pick lists and free text. The nurse uses another template to record vital signs, and reviews the medication list and allergies. Before seeing the patient, the physician reviews the nurse's note and past office notes. During the visit, the physician dictates a note much like what was done in the past. But the diagnosis, billing, and medications are entered into the computer in a way that allows certain items to be searched."

The Latham group's experience shows that introducing an EMR system becomes an ongoing project involving trial and error, particularly in the beginning stages of implementation. "When physicians select a system, they must recognize that it will be a work in progress for some time," Bagley observes. "We selected a system that was tremendously flexible and could do anything we wanted it to do. But to customize it to meet our own needs took a long time and creating all the templates that mirrored our interoffice processes took a lot of development work on our part."

Bagley believes that the adoption of EMR systems by other practices will accelerate in the next several years. "The systems will be ready," he says. "But it will take about two or three years for a practice to select a system, purchase it, install it, and then motivate all physicians to use it. This last step is the stage at which most of the failures occur due to a lack of leadership and a lack of a structured implementation plan that does not reduce physician productivity. These steps are crucial. Physicians cannot continue to provide high-quality consistent care without information technology support."

—Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Hospital Groups Can Succeed

By John W. McDaniel

Today, it's hard to believe how eager hospitals were to acquire physician practices in the 1990s. They were spurred to engage in this buying spree largely by investor-owned physician practice management companies, which had themselves bought up physician practices in large numbers. Back then, the frenzy in many markets associated with buying medical practices and employing physicians created enormous competition among hospitals. Administrators thought they needed to own physician practices in order to be closely affiliated with physician groups that would refer patients to them. Physicians benefited greatly from this situation: Their practices were purchased at unreasonably high prices, and many of them received employment agreements rivaling those of professional athletes.

Practicing for Success

Now, most of the physician practice management companies (PPMCs) have gone out of business and many hospitals have been saddled with severe operational losses associated with their medical practices, forcing them to exit this line of business. After a decade of seeing what works and what doesn't, the elements necessary to achieve successful hospital-affiliated practices can be defined as follows:

- A long-term strategic plan involving physicians and the hospital
- Alignment of professional and financial incentives for physicians and the hospital
- A reasonable compensation model that allows physicians and the hospital to succeed
- Active participation of physicians in governance activities
- Efforts on the part of administrative and physician leadership to meet mutual objectives.

John W. McDaniel is president and CEO of Physician Management Group Inc., physician practice improvement advisers, in New Orleans. Readers may contact him by phone at 800/764-2633 or by e-mail at pmgcode@eatel.net. More information on practice management is available on our Web site (see page 16).

A common thread among successful medical groups is the active involvement of physicians in governance matters.

—Michael Guthrie, MD, Premier Inc.

Hospitals that have been successful at building physician practices have learned from the mistakes that PPMCs made when they were acquiring physician groups. Take the employment agreements the PPMCs inked with their physicians in the 1990s. Under these agreements, doctors were paid both a salary and a bonus; such contracts were attractive to the physicians but did nothing to boost their productivity.

Today, more knowledgeable hospital-affiliated group practices have sought to avoid that oversight by basing compensation on physician productivity. This productivity model is based on the relative value units (RVUs) of a physician's efforts, a method many consider to be the true measure of an individual's productivity. Under this model, physicians focus only on seeing patients and coding appropriately.

Gilmore Memorial Hospital is an example of a hospital that has been successful at building physician practices. Located in Amory, Miss., Gilmore was in a difficult market in the 1990s because large hospital systems were approaching local physicians as potential acquisition candidates. Seeking to sustain and grow business in this market, the hospital created Gilmore Clinic Services in 1994, in part to protect its market share from competitors that were seeking to acquire primary care practices. Gilmore also wanted to facilitate physician recruitment and develop a multispecialty group practice after it had established a primary care physician base. Gilmore has made strides toward achieving that goal; at this time, it employs 11 primary care physicians and seven specialists.

Gilmore acquired its first clinic in 1994, in Sulligent, Ala., with a solo physician. Today, the hospital operates nine clinics, with a total of 18 physicians and six nurse practitioners. Three of the physicians are in rural health clinics, located as much as 35 miles from the hospital, and six of the clinics are in the hospital's primary service area.

Robert Letson, president and CEO of Gilmore, believes that the hospital has been successful at acquiring physician practices and making them successful from an operational standpoint because the hospital treats physicians as partners, not employees. In general, this factor seems to be the overriding reason for the success of hospital-affiliated group practices.

The employment agreements between the physicians and Gilmore include incentive production standards, and physician productivity is benchmarked against national standards established by the Medical Group Management Association with respect to RVU compensation and productivity. Will Wood, director of clinic services, who sought to change the structure of the physician contracts from being based on a salary and bonus, says that the new approach is consistent with the philosophy of treating physicians as partners because the RVU compensation model ensures that both parties have mutual objectives for practice growth.

As the hospital's clinic services operations grew, it became feasible to develop a central business office for all practice operations, which it did in 1997. Several initiatives were undertaken to improve reimbursement systems, billing and collection processes, and accounts receivable management. Specifically, efforts focused on installing an automatic claim rebilling system that rebills unpaid claims every 60 days; and improving insurance verification and authorization at clinic sites, thereby decreasing the number of claim denials and rejections from insurers. These improvements were accomplished primarily by educating front-office staff on insurance verification and eligibility; obtaining correct demographic information on patients; and increasing efforts regarding over-the-counter collections of copayments, deductibles, noncovered services, and outstanding patient balances.

For fiscal year-end 2001, Gilmore marked a 9% increase in charges, an 18.8% increase in collections, a 2.5% increase in expenses, a 4% decrease in accounts receivable, and a 1% increase in visits.

Right Strategy, Poor Execution

Hospitals had the right strategy in purchasing physician practices in the 1990s, but they executed the strategy poorly. In fact, some statistics show that more than 90% of hospital-owned physician practices have reported a financial loss.

Hospitals sought to acquire physician practices largely because they wanted to increase inpatient and outpatient business and build managed care networks. Initially, operating practices efficiently did not seem to be a major concern, partly because many hospital executives believed the increased business the practices would bring to the hospital would far outweigh operational losses. But physician practices focus on caring for patients, increasing managed care business, offering more ancillary services (often in competition with hospitals); and (under full-risk capitation) keeping patients out of hospitals. Therefore, physicians trying to make a profit would not necessarily be sending more patients to their affiliated hospitals.

It is now apparent that physician practices that fail under the leadership of hospitals do so for the following reasons:

- Lack of physician involvement in governance and management
- Physician compensation that is not aligned with hospital objectives
- Excessive practice acquisition prices
- Inexperienced physician practice management
- High fixed costs (for information technology, for example)
- A physician focus on primary care versus a hospital focus on other kinds of care
- Overly aggressive valuation.

The valuation of medical practices is generally based on the current assets of a practice or the discounted net present value of the practice. Under the asset-valuation method, the major assets of the practice are valued at fair market prices. Under the discounted net present value method, the purchaser projects the excess cash flow over five years and discounts that figure to the net present value today. Now, it is clear that aggressive valuations did not set an accurate value of a 40-year management agreement, nor did they take into account the difficulties associated with physician recruitment, changes in managed care contracts, or the rising cost of care for an aging population.

—JM

A Group Focus

Timothy P. Schier, vice president of Cain Brothers, investment bankers in Houston, has been involved in numerous hospital and physician group transactions during the past 10 years. He credits successful hospital-affiliated practices with having a group focus rather than an individual or entrepreneurial focus.

Michael Guthrie, MD, MBA, executive vice president of Premier Inc., a health care alliance in San Diego, concurs with Schier. A group's objectives in a successful medical practice must supersede the objectives of the individual members, he says. A "covenant" exists with respect to the role of the physician in terms of both the practice of medicine and the commitment to the business of medicine, he adds. A common thread among successful medical groups, he says, is the active involvement of physicians in governance matters, as well as the involvement of physician leaders who can inspire colleagues to achieve the objectives of the group and the affiliated organization.

—Edited by Paula Grant, in Lincoln, Va. More information on physician practice strategies is available on our Web site (see page 16)

Technology Improves Efficiency

By Richard L. Reece, MD, editor in chief

Physicians who want to practice more efficiently, improve their productivity, and reduce overhead may be wondering whether new technologies can help them to accomplish these objectives, and if so, how. Neil Baum, MD, a urologist in New Orleans who has incorporated a variety of new technologies into his practice operations and procedures, predicts that technology can and will help physicians become more efficient while improving the quality of care they deliver.

"In the past, physicians relied on technology for clinical matters," says Baum. "We used advances in computers to help us diagnose and treat patients. Unfortunately, most physicians today have not implemented similar technological advances in the business component of their practices. Those physicians are missing the opportunity to boost their productivity by using technology to streamline their office operations and to see more patients without sacrificing the quality of the care they deliver."

In fact, the technologies exist to improve practice efficiency in a broad range of office operations, Baum argues. But because the time it takes to learn to use new technology systems and to integrate them into office practices can sometimes be somewhat lengthy, Baum suggests that physicians select one or two technologies first, implement them slowly, and then add additional technologies over time.

Baum is on the clinical faculty at Tulane University and the Louisiana State University School of Medicine in New Orleans. His books *Marketing Your Clinical Practice Ethically, Effectively, and Economically* (1999), and *Take Charge of Your Medical Practice Before Someone Else Does It For You* (1996) are published by Aspen Publishers, in Gaithersburg, Md.

Raising Productivity

On a practical level, computers can boost the efficiency of a practice's entire office staff. Computers can be used to provide patients with the results of their lab tests when those results are normal, which occurs 60% to 70% of the time, says Baum. Also, computers can be used to contact patients to remind them to make follow-up appointments. Both of these strategies result in tremendous time savings for office staff.

Saving time on routine tasks performed continuously throughout the day can also enhance a physician's productivity. Computer programs that send prescriptions to the patient's pharmacy by fax or by e-mail save 15 to 30 seconds each time a doctor writes a prescription.

"A doctor who sees 20 to 30 patients a day and writes two to three prescriptions for each of those patients could end up writing 50 to 75 prescriptions a day," says Baum. "Using an electronic prescription pad to manage this function can save a physician almost 20 minutes a day—time the physician can use to see more patients. In addition, using computers to perform this function helps to avoid the medication errors that result from misinterpreted handwritten prescriptions, which have been shown to account for nearly 20% of all physician errors."

Another way Baum uses technology to save time and see more patients is by making videotapes of certain medical procedures and concepts and then using the videos to educate his patients. "Several years ago, I created a video for my patients that discusses the purpose of the medication for erectile dysfunction and how it should be used," Baum relates. "At the end of the videotape, I tell the patient watching it that I will return to answer any questions he may have and to provide a written summary of what I discussed in the video. Meanwhile, during the time the patient is watching the video, I can see at least one and sometimes two other patients."

Saving Time

This strategy, Baum says, allows him to make more effective use of the time—from five to 20 minutes—that he would normally spend discussing the videotaped topics with his patients. By anticipating the patients' questions and answering them during the videotape, Baum has reduced the number of questions they have and

> **"Some physicians are missing the opportunity to boost their productivity by using technology to streamline their office operations and to see more patients without sacrificing the quality of the care they deliver."**
>
> ***—Neil Baum, MD***

therefore the amount of time he would otherwise spend answering those questions. "I have created videos on nearly 90% of the topics that I cover with most of my patients, which has allowed me to become significantly more efficient and productive," Baum explains.

EMRs, a Practice Tool

Many vendors tout the benefits of electronic medical records, but do physicians find them effective practice tools? Baum says yes. "EMR programs can help physicians to maximize their coding reimbursements and to increase patient volume, while decreasing the costs associated with paper charting and minimizing the risks associated with the new compliance regulations," he adds.

"I have tried dozens of EMRs," Baum continues. "Some are powerful, cost-effective clinical documentation tools that are designed to run on a desktop personal computer; a laptop computer; or a portable, battery-operated, pen-based computer. Developed especially for physicians and for other providers in general, these tools allow users to create comprehensive records, including a patient history and a record of the physical exam, and to report on any problems, diagnoses, and treatments.

Some of the best programs contain an interface that promotes true-to-life clinical note writing, Baum says. "The extensive knowledge base of some of these types of programs consists of more than 200,000 codified elements, which can be accessed via windows or templates covering all major specialties," he explains. "Such templates can also be customized to meet the needs of a primary care practice, a specialty practice, or a multispeciality group.

"What's more, these templates function as a filter to the knowledge base, a core foundation of the system," he continues. "Therefore, from any template a physician would be able to reach anywhere in the knowledge base. For example, if a patient arrives with a headache but later reveals to the doctor that he has the symptoms of a sexually transmitted disease, the doctor can easily move through the knowledge base from headaches to STDs. Consequently, both PCPs and specialists can use these programs quickly and easily."

Another benefit of some of the programs, Baum says, is that they allow doctors to chart by exception. In other words, only the abnormal findings need to be entered into the system. "This feature makes these types of programs user-friendly and fast, since many patients have normal findings for most of their system reviews and physical exams," Baum explains.

Given that claims coding is such a critical function in all practices, tools that can enhance the efficiency and accuracy of this task are worth investigating. EMR software can compute and suggest the appropriate code that corresponds with the documentation performed at the time of service. In addition, EMRs can also help physician groups to improve the accuracy of their coding and help them to avoid losing thousands of dollars that might otherwise be left on the table from undercoding.

"A good program can quickly and accurately provide the appropriate code for evaluation and management and can alert the doctor when a code is incorrect for the service provided or it can offer suggestions for moving to another code if appropriate," Baum says. "Not only will this aspect of the EMR add to the practice's coffers, but it will prevent costly errors if overcoding is discovered during a federal audit."

Cultivating Referrals

Computers also can be used to help physicians cultivate patient referrals from colleagues. Developing referrals can be systematically and easily accomplished using voice recognition software, Baum says. "When it comes to physician referrals," Baum says, "I would like my name to cross the mind and the desk of referring physicians as often as possible and in a positive fashion. With that goal in mind, I make every effort to communicate with referring physicians as often as possible using voice recognition software. For every patient I meet who was referred to me by another physician, I send a brief note to the referring physician mentioning the diagnosis, the treatment plan, and any medications that have been prescribed for the patient. In my experience, that is the type of information that most referring physicians are interested in.

The urologist has shown that cultivating patient referrals from colleagues can be systematically and easily accomplished using voice recognition software.

"I see to it that a referral letter is on the desk of the referring physician before the patient returns to see his or her primary care provider," Baum continues. "The note created by voice recognition software can be sent by fax directly from the computer to the PCP or it can be included as an e-mail message."

For physicians who are uncertain about how easy voice recognition software is to use and about its accuracy, Baum offers reassurance. "I have had no problems using voice recognition software," he says. "What's more, I find that dictating in front of my

(Continued on page 12)

(Continued from page 1)

means opening up multiple avenues for communication between providers and patients, and relying more on the telephone and e-mail than most practices do. inTandem promotes the use of secure e-mail as a significant complement to face-to-face contact. "What might have traditionally required a follow-up visit, like medication adjustments or interpretation of test results, can be handled on the phone or through e-mail," says Murray. "We offer our patients that alternative when it's appropriate."

Kilo brushes off questions about confidentiality issues when using e-mail. "People will always find reasons not to innovate," he says. And while he admits that confidentiality is important, he believes concerns about electronic breaches are overblown and that the requirements for ensuring the privacy and security of medical information in the Health Insurance Portability and Accountability Act of 1996 go too far.

"Most patients are more concerned about convenience and couldn't care less if people know that they have hypertension," Kilo argues. Before entering an electronic relationship, all patients receive inTandem's e-mail guidelines, and most appreciate the opportunity to correspond electronically with their doctor when appropriate, Kilo explains. "However, if a patient is HIV-positive, for example, I might not offer e-mail as an option," he says. But generally, patients decide.

Equally progressive is the fact that inTandem patients have access to their medical records through the practice's secure Web site. inTandem is also developing the means for patients to keep a personalized electronic health record on the practice's Web site, where they can record insurance and pharmacy information, emergency contacts, health goals, and other relevant information.

More Communication

The inTandem founders believe giving patients the opportunity to communicate with providers in several ways is one key to better patient-provider relationships. Such communication is not just good practice, they say; it is good business. Given that an estimated 26 million U.S. families switched physicians in the past two years, turnover is a major problem and expense for physician groups. inTandem's goal is to keep patient turnover below 5% annually.

Many patients may need to adjust to the group's new ways of delivering care. When Robert Reimer, an inTandem patient, first called the practice and began to explain his needs to the person who answered the phone, he was surprised by the suggestion that he speak directly with the doctor. "I was so taken aback that I said no," Reimer relates. "I didn't want to bother the doctor." Overcoming his reluctance, Reimer spoke with Kilo at length on the phone, and came in shortly thereafter for a two-hour visit.

Recently, Kilo gathered a new patient's history almost entirely outside of the office. "The patient and I did a tremendous amount of work by phone and e-mail before he came to the office," Kilo says. "By the time I saw him, I had consulted with a specialist and knew what he had and what he needed." One problem with this approach, Kilo acknowledges, is that he can bill an insurer for only a one-hour office visit even though he may do six hours of work on behalf of the patient. Hence, the necessity for the annual patient fee.

The annual patient fee helps to pay for the team of inTandem providers—consisting of a physician, a nurse practitioner, and a health coordinator—that is created for each patient. The health coordinator serves as an advocate and a personal medical assistant to the inTandem patient by facilitating appointments, lab tests, and follow-up; coordinating care; providing relevant health information; and assisting with benefit questions or referrals.

> **"What might have traditionally required a follow-up visit, like medication adjustments or interpretation of test results, can be handled on the phone or through e-mail. We offer our patients that alternative when it's appropriate."**
>
> ***—Eric Murray, MD, inTandem***

Access and Care

Reliability, the third of the practice's core promises, refers to reliable access and reliable high-quality care. The physicians practice evidence-based medicine and use tools, such as a computerized patient registry, to identify patients who need tests and procedures, Murray says. The group is also considering other clinical innovations, such as group visits.

Kilo recognizes that the group is walking a fine line in its pursuit of an ideal medical practice. In an era when patients and physicians alike complain about not spending enough time together, inTandem's strategy is to reduce the office time a doctor and patient would spend together and

(Continued on page 11)

> **"In this model, the physicians can return to what they are best suited to do: engage in high-level knowledge management, make difficult decisions, and manage relationships."**
>
> ***—Charles Kilo, MD, inTandem***

(Continued from page 10)

replace it with telephone and e-mail contact. Some might argue that creating a clinical team for each patient is actually a way to unload some direct patient care from the physician.

This argument, says Kilo, stems from flaws in more traditional systems of care. "Patients don't have faith that a health care team functions as a team," he says. "They fill out health status forms when they arrive at the doctor's office; then a nurse takes the forms to the exam room but asks the same questions; finally, the doctor comes in and asks the same questions all over again. Does anyone come out of that with faith in the system?" This lack of trust, says Kilo, is the reason most patients are satisfied only with a face-to-face visit with their physician.

Kilo expects his group to build patient trust in the team, so that physician time will be less in demand. He feels that physicians in this model can return to what they are best suited to do: engage in high-level knowledge management, make difficult decisions, and manage relationships.

Walking the Line

Aiming to improve medical practice, Kilo bristles at the suggestion that he has developed "boutique medicine" for the wealthy. He cites clinics that charge annual fees from $900 to $20,000 per year for extra special service and attention, including catered meals, plush robes, and physicians who are willing to make house calls or fly to remote locations to treat traveling patients. "The motivation for these clinics is to escape the health care system, to circumvent it by charging the patient directly," he says, adding that the hassles and waste that most physicians deal with on a daily basis make this approach understandable.

In contrast, inTandem is trying to take on, not escape, the hardest issues of the system, Kilo says. "We want to be technologically savvy, to serve patients in unique ways, to be innovative, and to use the best clinical tools," he explains. "The costs make this almost impossible to do in the current system. We don't believe this is an area where venture capitalists belong, so we determined that the only plausible solution was to ask the patients to pay an extra fee." In fact, part of a healthy doctor-patient relationship includes a more direct financial connection than is currently the norm, he adds.

So far, the fee doesn't seem to be creating a one-dimensional patient base at inTandem. "I was concerned that all the patients would be well-to-do and incredibly self-actualizing," says Elizabeth Muckler, MD, an internist with inTandem. "But the panel I am serving is representative of patient populations I have known in other settings."

Administrator Samantha Charles says the practice expected to attract busy professionals who have little time for health care hassles, which it has. But she says it is also signing on patients with a range of profiles, including Medicaid beneficiaries whose parents are paying the annual fee. The practice has opted out of the Medicare program, at least for now, but several Medicare patients have signed on anyway and are paying for office visits themselves. The practice offers all self-paying patients a 20% discount.

Making It Work

Despite the advantages, this approach has its skeptics. Michael Millenson, a health care consultant in Chicago and author of *Demanding Medical Excellence: Doctors and Accountability in the Information Age* (University of Chicago Press, 1997), applauds the idealism of inTandem, but questions its viability. "The question isn't whether it's worthwhile; but rather, in a market of third-party payers, how to make it run," he says.

Suzanne Mercure, a health care consultant in Falls Church, Va., says that inTandem's approach is a good short-term strategy to solving some of health care's problems but that it does not offer a long-term solution because it is not equitable. Nevertheless, the work inTandem does is important and valued, she says. "We need people to lead the way, to create innovation in small pockets," she says. "Then we need to expand what works and disseminate it widely."

Kilo and his partners are hoping to make their practice more widely available to patients for whom the fee would be prohibitive. "As we become more financially viable, we will direct some of our resources toward the care of folks who can't afford our fee," he explains. "That is part and parcel of what we are trying to do: improve health care for everyone."

—Reported and written by Ann B. Gordon, in Wayland, Mass. More information on physician practice strategies is available on our Web site (see page 16).

(Continued from page 9)

patients has many advantages. First, I am able to recall the information more accurately than would be the case if I dictated at the end of the day or several days after I have seen the patient. Also, if I make any mistakes when recording the patient's history, the patient can correct me, which is not possible when I dictate in private. Finally, dictating in front of the patient allows me to spend an additional few minutes with the patient. As for accuracy, the program is 90% to 95% accurate, and I have the nurse coordinator check all correspondence before it is sent to the referring doctors."

Telephone Efficiency

Other problems can be solved with technology as well. One frequent complaint patients have about contacting a doctor's office by telephone is the frustration they feel when their call isn't answered in a timely manner, Baum says. This problem, he argues, can be solved with a well-programmed automated telephone system.

"When selecting an automated telephone system, a physician must first consider the nature of his or her patient population and the type of practice involved," Baum says. "For example, younger patients tend to be more receptive to automated technology than elderly patients are."

Patients should also be introduced to the telephone system in positive terms, Baum explains. He suggests that the telephone recording could begin by saying, "Thank you for calling Dr. Welby's office. To help our patients, we have installed an automated call routing system." If the patient must be placed on hold, Baum suggests that the message apologize for the delay.

When provided with a list of telephone routing options, most callers will accept only three or four, Baum says. By the time a fourth option is presented, the caller will usually have forgotten the first one. In any recorded telephone message, callers should be given the option of hearing the menu again. Most patients will generally accept call routing for nonurgent phone calls, Baum says, but when they are sick or have an emergency, they want to talk to a compassionate human being, not a recording. Therefore, Baum says the telephone answering system should provide the patient with the option of reaching a live person immediately.

—Edited by Paula Grant, in Lincoln, Va. More information on practice strategies is available on our Web site (see page 16).

E-technology Improves Prescribing Efficiency

One of the ways technology is helping to improve the efficiency of medical practices is by making prescription writing and processing more efficient and more cost-effective. Electronic prescribing also is helping to increase patient safety compared with traditional paper prescriptions and helps to enhance efficiency by decreasing paperwork, speeding up claims processing, and improving access to patient information. When prescribing processes are streamlined, costs tend to go down. In general, e-prescribing software works in tandem with wireless handheld devices known as personal digital assistants (PDAs), experts say.

E-technology uses the Internet to route transactions to local retail, mail-order, and Web-based pharmacies and to provide connectivity to managed care and other organizations at the point of care, experts say. Using PDAs allows physicians to be mobile, and therefore to prescribe at the point of care as they would with a paper prescription pad and pen.

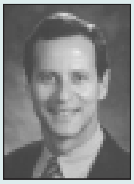
A joint study by several companies showed that when physicians use e-prescribing systems, they realize efficiency improvements that help them make better prescribing decisions. The study was done by AdvancePCS, a pharmacy benefit management company in Irving, Texas; ConnectiCare, a managed care organization in Farmington, Conn.; and ePocrates Inc., a software company in San Carlos, Calif. In the study, researchers tested whether e-prescribing via PDAs would improve care, while also helping to manage drug costs and reduce inefficiency. As a result of using the ePocrates software, physicians could access most formularies and thereby reduce the need to clarify or revise prescriptions, the researchers say.

In addition to saving physicians time, lowering costs, and increasing safety, e-prescribing leaves physicians more time to spend with patients, says David Trager, MD, a pediatrician with San Jose Medical Group. E-prescribing takes the most time-consuming and labor-intensive physician activities—prescribing medications, dictating notes, and capturing charges—and reduces them to three steps: entering the patient's name, providing a diagnosis, and selecting a prescription.

To date, only about 2% of physicians write e-prescriptions, but as many as 20% of all physicians carry PDAs and many could use them to prescribe medications electronically within the next three years, according to one report. Medical school instructors are encouraging residents to incorporate PDAs into their practices.

—Reported and written by Susan Howell, in Fairport, N.Y.

Expert Predicts Strong Growth of Consumerism in Health Purchasing



David B. Nash, MD, MBA, FACP, is the founding director of the Office of Health Policy and Clinical Outcomes at the Jefferson Medical College of Thomas Jefferson University in Philadelphia. He also serves as the Dr. Raymond C. and Doris N. Grandon Professor of Medicine and Health Policy at the university. A board-certified internist, Nash began his work at Thomas Jefferson University in 1990. In 1996, he was named the first associate dean for health policy at Jefferson Medical College. He received his BA in economics from Vassar College, his MD from the University of Rochester School of Medicine and Dentistry, and his MBA in health administration from the Wharton School at the University of Pennsylvania. His national activities include appointment to the JCAHO Advisory Committee on Performance Measurement, the Foundation for Accountability (FACCT) Board, and the Disease Management Advisory Council of the National Committee for Quality Assurance's three key national groups focusing on quality measurement and improvement. He is also on the National Advisory Committee for the Robert Wood Johnson Foundation Partnerships in Quality Education program. Nash has been the editor of 12 books, including Connecting With the New Healthcare Consumer: Defining Your Strategy *(Aspen Publishers, Gaithersburg, Md., 2001). In this interview with Richard L. Reece, MD, editor in chief, Nash discusses the Office of Health Policy and Clinical Outcomes, as well as the consumerism trend in health care.*

Q: *When was the Office of Health Policy and Clinical Outcomes created, and what is its mission?*

A: When I joined the faculty of Thomas Jefferson University Hospital in 1990, my marching orders were to create a new unit as a locus of support for issues that few other faculty members cared about: quality measurement and improvement, changing physician practice behavior, evaluating the cost impact of new technology, and related subjects. At that time, these were not "front page news" kinds of topics.

The mission of the Office of Health Policy and Clinical Outcomes, which was created in 1990, is to continue Jefferson Medical College's long-term strategy of ensuring that the students, graduates, faculty, and staff are able to adapt to the rapidly changing environment of health care delivery. The office and its health policy programs provide research, education, and consulting services to support Jefferson Medical College and, increasingly, the Jefferson Health System, which includes 13 hospitals and 3,000 physicians.

The office is a research and education unit housed within a medical school and an academic medical center, and is staffed by more than 20 individuals. Our activities cover numerous topics, including quality improvement, evidence-based medicine, benchmarking, and performance assessment. Only about two dozen groups that are similar to ours exist around the country. We share some similar goals with those groups, including one that involves doing research and creating academic credibility in this arena. But our focus is somewhat different in that we place a heavy emphasis not only on the research mission but also on education and training.

"Informed consumers will seek providers that have achieved better outcomes at lower costs. In a word, savvy consumers will seek value in the marketplace."

Q: *You have written about a book by Malcolm Gladwell entitled* The Tipping Point: How Little Things Can Make a Big Difference. *Do you think we're at a "tipping point" now with regard to consumerism in health care?*

A: I do. Malcolm Gladwell's book highlights how trends reach a crucial, or tipping, point, after which there is a change in society's behavior. Health care is facing such a tipping point in two ways. First, consumer empowerment in health care is about to reach a point at which it will become a tremendous force for change. Second, purchasers of care are beginning to recognize that health care quality is not a given; as a result, greater numbers of purchasers will begin to expend a significant amount of energy in becoming savvy shoppers for health care services. Purchasers will step up their attention to health care quality in response to demands by employees that they do so.

(Continued on page 14)

(Continued from page 13)

Q: *Do you think that baby boomers will drive consumer empowerment in health care?*

A: The baby boom generation will be a potent force that will drive dramatic change in health care toward a consumer-centric system. As the baby boomers age and become Medicare recipients, or at least members of AARP [formerly known as the American Association of Retired Persons], they are going to exercise tremendous market power in health care. Informed consumers will seek providers that have achieved better outcomes at lower costs. In a word, savvy consumers will seek value in the marketplace.

But the consumerism trend will move well beyond the baby boomers. As Mark Chassin, MD, [professor and chairman of the department of health policy at the Mount Sinai School of Medicine, and senior vice president for clinical quality at the Mount Sinai Hospital and Health System], has noted, the problem with U.S. health care is poor quality, not managed care. Quality is substandard in both managed care and fee-for-service medicine, but managed care organizations at least measure what they do. The Foundation for Accountability (FACCT) in Portland, Ore., and other organizations play a crucially important role in studying consumers' real needs and desires about health care, and by creating valid tools that researchers can use to drive an understanding of what patients really want from the health care encounter. To a growing extent, consumers will give their business to health care providers that understand and meet their needs.

Q: *How did you come to write your most recent book,* Connecting With the New Healthcare Consumer?

A: I have to give credit for the idea for the book to my co-editor, Barbara Bozarth. Three years ago, she said to me in the midst of unrelated work we were doing with other research sponsors: "Everywhere we turn the voice of the consumer seems to be emerging in our work. Maybe we ought to inventory and catalog that voice in the form of a book."

I was reluctant at first, but Barbara persisted in her belief that no one had adequately cataloged the strengths of the consumer movement in health care. I was fortunate that I was able to call upon my national network of professional contacts to help us write the book, which includes 21 chapters, each devoted to a different aspect of consumerism in health care. Certainly, no individual or single group had all of the expertise necessary for this project.

"If we pay doctors to do procedures, that's what they will do. If we pay doctors to be educators, they will fill that role."

I am pleased that *Connecting With the New Healthcare Consumer* has received significant recognition within the health care community. Its themes seem to have resonated with individuals in the industry.

Q: *One chapter focuses on the pharmaceutical industry. How has consumerism in health care affected pharmaceutical industry advertising?*

A: The growth in direct advertising by the pharmaceutical industry is an excellent example of how the industry is recognizing the new consumerism. Pharmaceutical companies now spend $1 billion a year in advertising directly to consumers. The tremendous economic return on investment of direct consumer advertisements was not tapped until relatively recently. As a consequence, advertising in medical journals has plunged. There is a $4 to $1 return on direct consumer advertising, compared with a $1.50 return on advertising to professionals. Pharmaceutical companies achieve this high return because consumers are influenced by these ad campaigns and they approach their doctors with requests for specific drugs.

Q: *Your book also discusses the self-care movement as an element of the new consumerism. Why has that movement developed?*

A: Self-care is a burgeoning field that actually predates the Internet. Because people today are better educated, live longer, and have access to more information about health care than ever before, they want to play a role in their own care—and appropriately so. This movement is consistent with the better-educated public, a less paternalistic teaching model in medical school, a frustration with Western medicine, and a frustration with many health care providers in general.

The Internet has essentially fueled the self-care movement by providing unfettered access to an enormous amount of high-quality information. The Internet also has put people in touch with others who suffer from the same conditions. Individuals with chronic conditions that may not be dramatically improved by standard therapy can find a lot of solace in talking with other similarly affected individuals.

Q: *Does the self-care movement have a downside?*

A: Yes. This manifestation of the new consumerism has its downside in that much inaccurate information is out there. Physicians need to develop an expanded role of health educator, health advocate, and community health leader. It will be impossible to contain the consumerism trend, but the best antidote to bad information is appropriate

“Organizational training as taught in business schools can be an important element in training doctors. If we in the medical profession do not train people to be leaders, we will have no leaders.”

training and education. We are not very far along that path, because training and education is not a reimbursable activity. If we pay doctors to do procedures, that's what they will do. If we pay doctors to be educators, they will fill that role.

Q: *Why do you think consumers are increasingly interested in the care offered by complementary medicine practitioners?*

A: What patients want from their doctor is someone to listen, hold their hand, offer compassion, spend time, and appear concerned. Unfortunately, we do not deliver the goods. At less than 10 minutes per primary care office visit, physicians simply cannot deliver that level of service.

Q: *Do you think that the Internet, by providing information to practitioners, will help to improve quality of care?*

A: Slowly. Physicians are recognizing the power of the Internet to market their practices, answer patients' questions, and to make their practice more efficient. The power of the Internet can also link physicians to the best evidence-based medicine through national repositories of practice guidelines and the like. National benchmarks for practice can also be readily accessed, and physicians can harness the power of the Internet to improve their day-to-day performance.

Q: *How has the media affected the trend toward greater consumer empowerment?*

A: The power of the media has basically changed. The medical profession and health organizations are recognizing that the media no longer represent a cross to bear but rather serve as an indispensable resource. On the other hand, the media have discovered that medicine is a deep resource of endless stories. For example, the media have exhibited great power in fueling negative impressions of managed care by highlighting the relatively few health care disasters that have occurred. Unfortunately, managed care organizations have not responded well enough or quickly enough by touting their many successes.

The media can create unrealistic expectations as well, which are difficult for physicians to manage. Patients' expectations for possible outcomes of care can be unrealistic because they are fed by the media's reporting of the Human Genome Project and of other cutting-edge research.

This trend has driven high expectations for health care among Americans. I have heard people say that only in the United States is death an option. As a result, Americans resist restraints on spending for medical technology and want absolute access to the most advanced medical technology. The demand for unlimited access at low cost to cutting-edge technology is entirely consistent with our national character. And, of course, physicians are products of that culture too.

Q: *How should physicians respond to the consumerism trend?*

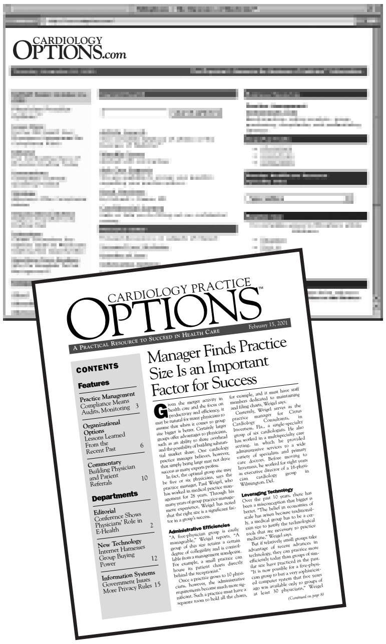
A: Physicians must take constructive steps to reform the current health care system, otherwise consumers may believe that the only alternative is government intervention. I have always been a proponent of activism within the profession as a way to forestall government involvement. As physicians, we are sometimes our own worst enemy. Regrettably, we have not always done the right thing for our profession for a whole constellation of reasons. First, the socialization and training process of becoming a doctor emphasizes the autonomous nature of decisionmaking and pays scant attention to working in a group and understanding organizational hierarchies. Second, we have not practiced medicine based on the evidence. We call this the performance gap—the gap between what we know is supported and what we do in everyday practice. Third, the reimbursement structure often stands in our way and prevents us from supporting our role as educators and counselors, while promoting our role as interventionists.

The most important job of a leader is to train future leaders. To address this need, the Office of Health Policy and Clinical Outcomes has launched a two-year program called Chief Resident Education for Success Training, or CREST. This two-day program will give medical residents exposure to numerous concepts that they have not had in medical school or in training, such as leadership, time management, stress management, dealing with difficult colleagues, and many of the issues routinely taught in business school. As a graduate of the Wharton School, I have found my business training to be essential in my work. Organizational training as taught in business schools can be an important element in training doctors. If we in the medical profession do not train people to be leaders, we will have no leaders.

—Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

SOLUTIONS FOR THE BUSINESS OF MEDICINE™

CARDIOLOGY OPTIONS.com



Our FREE online resource includes:

- ▶ A complete database searchable by keyword, subject, or issue
- ▶ Tools to develop and implement strategies to build your practice
- ▶ Interaction with experts on all aspects of the Business of Medicine™
- ▶ Links to business resources such as group purchasing, practice management, marketing, and CME
- ▶ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let CardiologyOptions.com come to you! CardiologyOptions.com can keep you up-to-date automatically on the latest developments in the **Business of Medicine™**. You can sign up at CardiologyOptions.com or fill in your name and e-mail address below and fax it to us at **973-316-5989**.

Name: ____

E-Mail: ____

CARDIOLOGY PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

January 15, 2002

Premier Healthcare Resource
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

PRSRT STD
U.S. POSTAGE
PAID
S.HACKENSACK,NJ
Permit No. 664