Visit www.CardiologyOptions.com

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY March 15, 2003

CONTENTS

Features

Commentary
Physicians Find Ways to Comply 3

Strategy
Follow-up Care Cuts Mortality Rates 8

Interview
Consumer-Driven Focus, Chronic Care, IT Will Be Key to Success 13

Departments

Editorial
Advice for Physician-Owned Practices 2

Practice Management
EMRs Help Keep Patients Moving 6

Crisis Leads Physicians to Drop Insurance

Juergen Eisermann, MD, 48, never imagined he would one day relinquish the security of malpractice insurance. But last summer, his insurer, the Farmers Insurance Group, of Los Angeles, told Eisermann and his three partners in a Miami infertility practice that it was leaving the Florida market.

For minimum coverage with a new insurer, the group's liability insurance that had cost the practice $240,000 annually would more than double to $510,000, and, Eisermann learned, only two commercial insurers were willing to underwrite a new policy.

Insuring Thyself

"All four of us would have to work salary-free for four months to pay the premium," Eisermann says. "We are not risk takers but for that amount, we decided to self-insure." With certain caveats, self-insuring, or "going bare," is permitted under Florida law.

As rates across the country continue to rise sharply for the third year in a row, physicians in Miami-Dade County, where Eisermann practices, had the dubious distinction of having the most expensive premiums in the nation, according to the *Medical Liability Monitor*. Last year, obstetrician-gynecologists in Miami-Dade County paid $201,375 for malpractice policies that had a limit of $1 million per occurrence and $3 million per year; for the same policy, general surgeons paid $174,368, and internists paid $56,153, MLM reported. Physicians with claims histories paid even higher premiums, if they could find coverage.

As a result, in Florida and other states where coverage is either unaffordable or unattainable, increasing numbers of doctors are making the gut-wrenching decision to go bare. "It's hard to get data but my impression is that more doctors are being forced to consider that option," says Richard Anderson, MD, chairman of The Doctors' Co., a malpractice insurer in Napa, Calif., that has physician clients in every state.

Recognizing the difficulty physicians face, the AMA's Board of Delegates passed a resolution in December, altering its 22-year-old policy recommending physicians carry liability insurance to protect themselves and their patients. The new policy leaves the decision to physicians.

"We know bare doctors are out there," says Russell Kujan, a spokesman for the Maryland State Medical Society. "They don't want to announce it. The most paranoid doctors fear that someone will make an example of them."

Maryland allows physicians to self-insure. Other states, such as Florida, have no policies requiring malpractice insurance, according to an AMA report last year, *Summary of State Laws Mandating Minimum Levels of Professional Liability Insurance*. At least seven states, including Kansas, Massachusetts, and Wisconsin, require minimum

(Continued on page 10)

EDITORIAL

Advice for Physician-Owned Practices

Declining revenue, increasing expenses, and a mounting workload are putting physicians under pressure. For most physicians, these issues pose a dilemma because they are not trained to solve business problems, consultants say.

Michael E. Gerber, CEO of E-Myth Worldwide, a business consultancy in Santa Rosa, Calif., says that doctors believe they are entrepreneurs when they are not, and most lack the skills needed to manage a business. Gerber, the author of *The E-Myth Physician: Why Most Medical Practices Don't Work and What to Do About It*, calls this misperception the e-myth, or entrepreneurial myth. To succeed, physicians need to reform their practices, Gerber says. First they need to define their vision of a dream practice. Next they need to engage employees in that vision, identify key functions, and establish consistent processes.

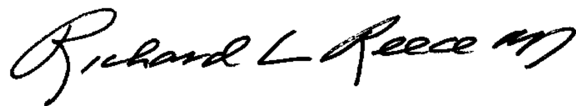
Nathan Kaufman, senior vice president for health care strategy at Superior Consultant Co., in San Diego, suggests that primary care physicians may want to begin charging extra for personalized services, such as being available 24 hours a day, making house calls, and interceding on patients' behalf with managed health plans.

Kaufman also recommends that physicians drop HMO contracts that do not provide sufficient revenue to cover office costs and that they require copayments at the point of care. Physicians need to make these changes because revenue is dropping by 3% to 6% per year and expenses are rising by 6% to 8%.

Fitzhugh Mullan, MD, author of *Big Doctoring in America: Profiles in Primary Care*, predicts that PCPs will prosper because new technologies will create a growing demand for interpretation, coordination, and the human touch that many patients say is missing under managed care. However, solo practitioners will need to become more efficient and seek to appeal to informed consumers who want timely, personal, and high-quality care, he adds.

Daniel K. Zismer, PhD, a health care consultant for Dorsey/Health Strategies in Minneapolis, believes solo practitioners and small primary care groups are endangered because reimbursement is declining and they generally have little in cash reserves. He is more optimistic about single-specialty groups, saying they tend to generate more revenue, can expand into dominant specialty groups, add profitable ancillary services (such as ambulatory surgery), or invest in specialty hospitals.

Taken together, these experts are suggesting that regardless of specialty, all physicians need to develop new, more efficient business models in order to overcome the business pressures that are hindering their success.



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

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

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

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

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

ADVISORY BOARD

Neil Baum, MD
Urologist
New Orleans

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

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
Executive Vice President
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley
President and CEO
webEBM
Nashville, Tenn.

Peter R. Kongstvedt, MD
Partner
Cap Gemini Ernst & Young
Vienna, Va.

Richard Liliedahl, MD
National Director of Clinical Economics
Ernst & Young
San Diego, Calif.

John W. McDaniel
President and CEO
Physician Management Group
New Orleans, La.

Lee Newcomer, MD
Executive Vice President
Vivius Inc.
St. Louis Park, Minn.

James G. Nuckolls, MD
Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

Jacque Sokolov, MD
Chairman
Sokolov Schwab Bennett
Los Angeles

W.L. Douglas Townsend Jr.
Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

Physicians Find Ways to Comply

By Richard L. Reece, MD, editor in chief

After years of anticipation, the first portion of the Health Insurance Portability and Accountability Act went into effect in October; another deadline for compliance looms next month. HIPAA has major implications for all physicians, who must ensure that their practices comply so that they can receive payment on claims and avoid penalties for noncompliance with privacy standards.

Many physicians are concerned about, even overwhelmed by, the steps they need to take to be in compliance. As a result, physician readiness for HIPAA varies widely, according to James Weintrub, MD, a practicing plastic and reconstructive surgeon in Providence, R.I., and founder and CEO of Digital Physicians Network (DPN) an information technology firm that specializes in compliance. "Some physicians feel that HIPAA does not affect them, while others have made involved preparations for meeting the HIPAA standards for privacy, security, and transactions," he notes.

Last October, physicians who were not in compliance with HIPAA's transactions regulations had to send in a request for an extension, indicating that they would comply by this October. Completing this step alerted many physicians to the fact that HIPAA is a serious effort by the government that will be enforced, Weintrub says.

"The October 2002 deadline was the first of many HIPAA compliance deadlines," Weintrub explains. "That deadline dealt with electronic transactions and got a fair amount of publicity from physician organizations, professional societies, and health plans, and physicians were encouraged to file for the one-year extension for compliance with the transactions in HIPAA."

Taking Steps

Physicians who are bewildered by HIPAA requirements have several options: They can ask their local hospital or health plan for the name of a reliable HIPAA consultant, seek assistant from a medical society, or purchase a CD. "There is a host of resources available," says Weintrub. "Some sources are free on the Internet; others are available from professional organizations, and a whole array of consulting services are available as well. The costs of these services vary widely depending on the service and the nature of the deliverable."

Weintrub notes that HIPAA compliance is hard work. "Doctors must spend time, money, and energy to become HIPAA compliant," he says. "That's the stumbling block. HIPAA is an unfunded mandate declaring that physicians have to meet certain requirements. Furthermore, the federal government has not provided tools and forms that would make compliance easier to achieve. For example, when it comes to paying taxes, the federal government is very explicit in terms of what people need to do and how they need to do it. The forms are provided. In contrast, for compliance with HIPAA, forms are not provided, no context is given, and simplified information (such as the information that can be found on the government's Web site with respect to taxes) is not available. As a result, compliance with HIPAA is not easy to accomplish."

Several companies have produced compact disks that attempt to provide context for the HIPAA regulations, strategies for achieving compliance, and forms to facilitate the compliance process. DPN, which provides strategic solutions to physicians, has produced a CD for Blue Cross-Blue Shield of Rhode Island entitled, "Getting Your Practice Ready for HIPAA." BCBS of Rhode Island has given the CD to its participating physicians.

The Physician's Perspective

The best CDs will present the information from the physician's perspective, rather than focusing on the legal or regulatory issues of the information technology requirements of the act, Weintrub says. The most useful CDs on HIPAA compliance present the information in a straightforward and unambiguous way so that a practice knows what it needs to do to meet the requirements, he adds. Lists of other sources for help and sample forms and sample agreements that are required under the act are the type of other useful information that should be included.

"Health plans are interested in promoting electronic claim submissions in order to avoid the expensive proposition of processing paper claims," says James Weintrub, MD, of Digital Physicians Network.

Health plans are promoting

(Continued on page 4)

(Continued from page 3)

HIPAA compliance among physicians for cost reasons. "BCBS of Rhode Island and other health plans are interested in promoting electronic claim submissions in order to avoid the expensive proposition of processing paper claims," Weintrub explains.

The cost to a health plan of processing an electronic claim is considerably lower than it is for handling a paper claim. "Processing electronic claims costs a health plan only several cents each compared with the $4 to $7 on average it costs to process paper claims," Weintrub says. "Therefore, it is in the best interest of health plans to encourage HIPAA compliance by physicians."

Such savings will also accrue to the government, as Medicare and Medicaid claims will be less costly to process electronically than paper forms would be. "The federal government has identified the need to drive down administrative health care costs, especially in Medicare and Medicaid," Weintrub observes. "One way to accomplish this goal is to process health care transactions in a standardized and electronic fashion. In a few years, it may be mandatory for physicians to submit all Medicare and Medicaid claims electronically. So the physicians who submit claims to Medicare and Medicaid (which means most physicians in the United States) may eventually have to submit those claims electronically."

Society Support

The state medical societies are another source of help on HIPAA compliance. The Connecticut Medical Society, for example, has done intensive work in helping to prepare doctors for HIPAA. "In 2001 we began to receive solicitations from consultants, vendors, and law firms that were promoting HIPAA compliance products," says Cameron Staples, general counsel for the society. "We wanted to become more conscious of what the marketplace was offering and to review the products that were going to be offered in our state."

Society members met with representatives from the county medical associations, the Connecticut Medical Insurance Co., and an IPA to review the proposals and meet with vendors. The society chose to work with PrivaPlan Associates, Inc., a company in Santa Fe, N.M., that offers a CD to help physicians comply with HIPAA. The PrivaPlan CD is also used by medical societies in Louisiana and California.

"We had the CD customized to meet the requirements of Connecticut law, and then made it available to our members," Staples says. "In October, we offered a series of six promotional seminars free to our members."

A CD product is useful for physicians in Connecticut because about two thirds of all doctors in the state practice solo or with one other doctor. "Our concern was that it would be those very small groups that would be the least financially able to hire a consultant at a considerable cost in order to become compliant," Staples says. "As a result, we thought some might not go through the steps to meet the act's requirements. We wanted to find an inexpensive product that they could use."

To address follow-up questions about the CD's content, the society developed a list of frequently asked questions on its Web site (at www.csms.org). "We also direct people to the Web site of the federal Centers for Medicare & Medicaid Services (at www.cms.hhs.gov), which also has a series of frequently asked HIPAA questions," Staples adds.

It is important that CDs offering HIPAA assistance be customized, as needed, for each state. "Usually, federal laws supersede any state law they impact," Staples says. "But Congress felt that HIPAA should permit stronger state privacy requirements to remain in place. So state law would not necessarily be preempted if it is stronger in a particular instance.

"We hired a law firm to go through all the statutes and regulations in Connecticut that might relate to the privacy of health information and then determine in each case why that requirement was more or less stringent than HIPAA," Staples continues. "The lawyers estimated that they had to consider about 5,000 statutes and regulations in Connecticut that had an effect on privacy. Only after they reviewed all of them could they determine when state law superseded federal law, and what medical practices would need to do to be compliant."

HIPAA Benefits

Such CDs will make it easier for physicians to comply with HIPAA and will increase physicians' ease of doing business. "In the long run, HIPAA will benefit physician practices," Weintrub says. "The act will ultimately make available much more information about a patient's health insurance and about a particular claim."

HIPAA is expected to help physicians avoid the common problem of treating a patient who is ineligible for coverage. The act also may help speed payments and claims processing.

One common problem in physician practices is that a doctor may see a patient and then submit a claim but find out later that the patient was ineligible for coverage. HIPAA will help physicians avoid this problem.

"Two HIPAA transaction standards have to do with eligibility: the eligibility query and the eligibility response," Weintrub notes. "The eligibility query is sent by the physician's office to the health plan, and the response is sent back as a second transaction. Under these standards, an office can determine in advance whether a patient has health insurance in place and is eligible. In theory, practices would be able to eliminate the problem of submitting claims, tracking claims, and pursuing accounts receivable where there is little chance of ever being paid."

In addition, HIPAA should alleviate two other common problems for physicians: slow claims processing and mounting accounts receivable. "HIPAA transaction standards specify one standard electronic form for claims, whereas currently various health insurers use about 40 different forms," Weintrub says. "With the implementation of HIPAA, it should be easier for physician practices to complete that electronic form and submit a clean claim. A larger number of clean claims will increase the speed of claims processing and payment, thereby reducing accounts receivable."

Going Private

While HIPAA makes some tasks easier, the privacy and security regulations of the act add to the administrative burden practices face, says Staples. The first real burden is simply becoming compliant with the act's privacy regulations.

"Before April 15, practices need to assess how much out of compliance they are through some sort of gap analysis," Staples explains. "They need to examine the way they handle what the act calls protected health information (PHI) and decide how they will need to handle it in the future. They then need to develop policies and procedures and inform and retrain the staff on these procedures.

At a minimum, practices will need practice management software that can submit claims and queries in the standard HIPAA-compliant format.

"Practices also need to understand a variety of new opportunities patients have," Staples continues. "For example, patients now have to sign an acknowledgement that they have been informed of their privacy rights. They also have opportunities to amend records. As a result, there is a range of potentially new administrative procedures."

Practices that are not compliant will be taking a risk. "A patient, or an office staff member, might file a complaint," Staples explains. "If practices have done nothing to become compliant, essentially ignoring HIPAA, they stand a much greater chance of having some punitive reaction from the enforcement agencies than if they are making a compliance effort but are falling short in some area."

Penalties for noncompliance will vary. "Depending on the infraction, possible penalties include fines, jail time, and loss of Medicare provider status," Weintrub says. "The government has some resources to audit practices for noncompliance, but most of the noncompliance issues will be brought by disgruntled patients or employees. These infractions will be reported to the Office of Civil Rights, the enforcement arm of HIPAA privacy."

Speeding Payment

Because HIPAA standards for transactions relate to electronic transactions and not to the submission of paper claims, some practices may try to get around HIPAA by submitting claims on paper. "But this is not a good strategy because those claims will need to be processed by the health plan individually and payment will be held up," Weintrub cautions.

At a minimum, practices will need practice management software that can submit claims and queries in the standard HIPAA-compliant format. "An upgraded practice management system is generally required for submitting electronic claims and for the ability to do the full collection of HIPAA transactions," says Weintrub. "Alternatively, some practices may choose to use their old system and transmit claims to a clearinghouse, which can reformat the claims and then send them on in the HIPAA-compliant format."

The Connecticut society recognizes the importance of HIPAA compliance, Staples says. "We urge our members to understand that there may be some benefits to HIPAA compliance," he says. "Payment will probably be expedited, and electronic transactions will simplify the claims process. The practices that submit solely paper-based claims, and are therefore not within HIPAA's reach today, must decide whether they'd like to get into this electronic world."

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

EMRs Help Keep Patients Moving

By Hayward Zwerling, MD, FACP

In December 2001, the nurse who had been working in my office for the previous five years had to quit abruptly in order to tend to a medical emergency in her family. Although we immediately began advertising for a nurse to replace her, it took six weeks to fill the position. During that time, we had to redefine the processes in our small office.

While the experience was one that we do not want to repeat, we nonetheless learned some important lessons that might be instructive for other physicians trying to meet the increasing demands imposed on physicians today. One significant lesson was that if we had not previously invested heavily in computers, we would not have been able to continue seeing the same number of patients as we normally do.

I work as a solo practitioner in internal medicine, and I have a consultative practice in endocrinology. My staff consists of a secretary, a nurse, and a nurse practitioner.

Information Solutions

On a typical day, we see 25 to 30 patients. Some visits are simple and quick (such as those involving patients with urinary tract infections), but other visits are more prolonged and complicated (such as those involving patients who have poorly controlled diabetes and other medical problems).

Relying heavily on computer-assisted technology, we try to run a paperless office by using electronic medical records software. We use this technology to file lab reports and dictate progress notes and radiology results. We also use a computer-operated telephone answering machine and have a Web site (at www.drzwerling.com).

To accommodate our normal patient load while we were without a nurse, we had to minimize the amount of time spent interacting with patients. This was a choice we did not want to make, but it was necessary. When we explained the situation to our patients, they were quite understanding.

When we had a full staff, for example, one of them would mail new patients a pamphlet about the practice, including a map and letter of introduction, and request information from them (such as a medical history and health insurance data) prior to the new patients' first visit to the office.

In an attempt to use my secretary's time more efficiently after my nurse left, these forms were posted on our Web site and patients were directed to download them, fill them out, and bring the completed forms with them for the first visit. This strategy allowed us to save the time that would normally be needed to print the forms, address the envelopes, and mail the letters. In our community, about half of the patients can access the Web; for the others, we mail them the forms prior to their first office visit.

Also, we eliminated double booking in an attempt to keep my schedule on track. In the past, we had at least two double-booked appointments each day.

When a nurse quit, a practice learned that if it had not previously invested heavily in computers, it would not have been able to continue seeing the same number of patients as it did previously.

Message Triage

During the time we were short staffed, we relied heavily on our computer phone system to triage messages. When a patient called, he or she heard a message stating that telephone calls regarding medical issues could not be returned due to our staffing shortage except in the case of an emergency, which we handled in a medically appropriate manner. To discuss a medical issue, all patients needed to schedule an office visit.

Patients who called the office requesting a prescription refill heard a voice message saying that they could pick up the prescription during the following business day or, if they preferred, we would mail a prescription to them or to their pharmacy. The voice message informed the patients that we did not have the staff available to call in prescriptions. In reality, our electronic medical records program permits us to fax prescriptions directly to many pharmacies, but not all pharmacies have fax machines.

When a patient arrived for his or her office visit, I brought the patient into the examination room myself. In an attempt to keep myself on sched-

***Hayward Zwerling, MD, FACP**, is the founder and president of ComChart Medical Software, a company in Lowell, Mass., that makes an electronic medical record program for physician offices. He also practices four days per week as a primary care physician and as a consultative endocrinologist.*

The electronic medical records program made it easy to document care and thus stay close to schedule by using a combination of voice dictation, template progress notes, and point-and-click notetaking.

ule, I obtained only those vital signs that were clinically necessary for each visit. If a patient had a urinary tract infection, for example, I might not ask the patient to step on the scale for a weight measurement.

Patient Education

During a typical office visit before becoming short staffed, I often did a fair amount of patient education and gave the patient medical literature relevant to the issue at hand. But this was not a typical time, and in order to stay on schedule, I would direct patients to my Web site and suggest that they could download the relevant patient handout materials.

If a patient needed more education than was available on the Web, I would recommend that the patient return during a subsequent visit to meet with me or my nurse practitioner. During this time, my nurse practitioner's day was mostly unaffected by the situation, since she has her own group of patients whom she sees.

Whenever possible, we would reschedule routine immunizations, such as those for tetanus and for pneumonia, for the next office visit, when I anticipated having a nurse. Since the nurse had scheduled radiologic studies for patients in the past, this task needed to be reassigned. My secretary scheduled the more important studies, such as chest x-rays for suspected pneumonia or stress tests, and the patients scheduled the routine studies, such as mammograms.

Fortunately, our electronic medical records program made it easy to document care and thus stay close to schedule by using a combination of voice dictation, template progress notes, and point-and-click notetaking. Thus, most progress notes were completed by the end of the office visit, and all notes were completed by the end of the day. In addition, our electronic medical records program allowed us to fax notes on consults directly from the computer in the examination room to the referring physician, thus permitting my secretary to direct her energies toward other endeavors, such as answering urgent telephone calls, checking in and checking out patients, and collecting copayments.

During the time without a nurse, the staff recognized that running a small office required professionalism and flexibility.

Normal Results

Previously, it had been our office policy to notify all patients about all test results, but not having a nurse forced a change in this policy. We revised our voice mail message to indicate that we would call patients only if their test results were abnormal.

In reality, we called a few patients, particularly those who were anxious about their results or who had critically important results, to report the lab findings. But most patients in the practice accepted this change in our policy.

One function that clearly suffered when we did not have a nurse was the restocking of supplies in our exam rooms. As a result, I would occasionally find that the exam room did not have a paper cup or stool guaiac cards; thus requiring that I leave the examination room. I also found that I was running late in my schedule. Although I usually run no more than 20 minutes behind schedule when we have a full staff, I was sometimes running 30 to 45 minutes behind schedule in the six weeks we spent without a nurse. Nevertheless, the patients were gracious and seemed to understand our situation because I had taken the time to explain the problem to them.

During the six-week interval that we were without a nurse, we carried a full patient load, and we believe it was possible only because of our investment in technology. But it was also possible because my staff responded to the situation with the utmost degree of professionalism. They understand that running a small office requires the staff to be flexible with respect to their assigned duties and responsibilities.

Over the six weeks, the processes in our office ran with relative ease but everyone seemed to be under considerably less stress once we had a new nurse on staff. And, computer innovations notwithstanding, we believe patients get better care when a nurse is involved.

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

Follow-up Care Cuts Mortality Rates

Patient outcomes following acute myocardial infarction may be influenced by the specialty of the physician providing ambulatory care, according to the results of a recent study. Specifically, researchers found that patients who were provided follow-up care by a cardiologist exhibited lower mortality rates three months after hospital discharge than patients who saw only an internist or a family practitioner.

The study was led by John Ayanian, MD, an internist at Brigham and Women's Hospital and an associate professor of medicine and health care policy at Harvard Medical School in Boston. The study was published in an article, "Specialty of Ambulatory Care Physicians and Mortality Among Elderly Patients After Myocardial Infarction," in the Nov. 21 issue of the *New England Journal of Medicine*.

The research shows that mortality rates were lower among the patients who saw a cardiologist in the first three months after discharge than they were among patients who did not see a cardiologist in that time.

Increasing Quality

"In recent years, there has been increasing interest in the role of generalists and specialists caring for a range of conditions, but particularly for heart disease," says Ayanian. "A number of studies have looked at the impact of the type of physician providing care while patients are hospitalized for an acute myocardial infarction (AMI). But there has been little research about the impact of physician specialty with respect to ambulatory care after patients leave the hospital. We wanted to address that point because patients who have survived a heart attack clearly have chronic cardiovascular disease, and the quality of their ambulatory care may have a strong influence on their outcomes."

The quality of ambulatory care following an AMI is particularly important to ultimate patient outcomes because patients who have survived an AMI remain at high risk for cardiac complications (such as recurrent myocardial infarction or congestive heart failure), as well as noncardiac complications (such as depression) and the worsening of comorbid conditions (such as chronic lung or renal disease), says Ayanian.

"We wanted to look at the care AMI patients received in the first three months after discharge because that is a particularly critical period during which patients are most likely to experience complications or to be unstable," Ayanian explains.

The researchers analyzed data on 35,520 patients 65 years of age and older who were hospitalized for AMI in seven states during 1994 and 1995 and who survived for at least three months after hospital discharge.

Data Analysis

"These data were collected by the Medicare program's Cooperative Cardiovascular Project, a national project to assess the quality of care for patients covered by Medicare who were hospitalized for AMI," says Ayanian. The database provided detailed clinical information from medical records regarding patients' conditions at the time of admission to the hospital, complications that occurred while they were hospitalized, tests and procedures performed in the hospital, and medications provided at discharge.

Using a statistical technique called propensity score matching, the researchers adjusted for differences in demographic, clinical, and hospital characteristics. "The differences between the patients who saw cardiologists and those who saw only primary care physicians tended to be substantial," notes Ayanian. "AMI patients who saw cardiologists tended to be younger, male, and white and to have lower levels of comorbid illnesses relative to those who did not see a cardiologist. Each factor is, on its own, associated with better outcomes. But we wanted to examine the effect of specialty care independent of those demographic and clinical differences.

"Using the propensity score matching technique, we matched each patient who did not see a cardiologist with a patient who did, based on his or her estimated propensity to see a cardiologist given demographic and clinical variables," Ayanian continues. "Thus, we created a group of what we called matched patients who each had a so-called partner for comparison purposes, such that we could try to assess the independent effect of the type of physician who provided follow-up care."

Improved Outcomes

Analysis of the data revealed that each of approximately two thirds of the total patient sample (24,656 patients, or 69.4%) had seen a cardi-

(Continued on page 9)

(Continued from page 8)

ologist at least once in the three months after he or she left the hospital, while 10,864 patients saw only a primary care physician, such as an internist or a family practitioner. Among those patients who visited a cardiologist, about 14,000 were under the care of both a cardiologist and a primary care physician, and approximately 11,000 were treated by a cardiologist only.

"In round numbers, roughly one third saw only a primary care physician, one third saw only a cardiologist, and one third saw both a cardiologist and a primary care physician," Ayanian explains.

Examining Variables

The analysis revealed that mortality rates were lower among the patients who saw a cardiologist in the first three months after discharge. The two-year mortality rate in the unmatched cohort was 11.8% for the patients who saw a cardiologist, compared with 19.1% for those who saw only an internist or a family practitioner. The difference in mortality was reduced for the matched cohort (where the mortality rate was 14.6% for patients who saw a cardiologist and 18.3% for those who did not), but was still statistically significant.

"The characteristics of patients explained about half of the difference in mortality, as matching reduced the 7.3% differential to 3.7%," Ayanian explains. Ayanian notes that because this study was not done in a randomized trial, the researchers cannot draw a definitive conclusion that seeing a cardiologist was the cause of better outcomes. He adds that other variables not tested (such as patients' social support, medical care preferences, or supplemental insurance beyond Medicare) may also have had some influence. "Still, there is a strong association between better outcomes and cardiologist care," he says.

The findings suggest that access to cardiologist care should be encouraged for Medicare patients. "It is a concern that nearly one in three elderly patients who survive a heart attack are not seeing a cardiologist for ambulatory care," he says. "As the patients in our study were all fee-for-service patients within the Medicare program, we cannot attribute this finding to barriers related to managed care. Instead, it may be related to the geographic availability of cardiologists and the ability of patients or primary care physicians to seek out cardiology care when it would be most beneficial."

In fact, the absolute benefit of seeing a cardiologist in terms of improved survival was greatest among the types of patients who were least likely to see a cardiologist, the analysis revealed. "We divided patients into five groups according to their likelihood of seeing a cardiologist," Ayanian explains. "While there was some benefit to seeing a cardiologist in every group, it was in the group that was least likely to see a cardiologist (a group disproportionately composed of women, older patients, minority patients, and those with comorbid illnesses) that the mortality benefit appeared to be the greatest."

In addition, patients who saw a cardiologist after discharge were much more likely to be treated with additional cardiac procedures (such as angiography, angioplasty, and bypass graft surgery) during the three months after they left the hospital.

"We also surveyed a subset of the patients regarding their ambulatory care," Ayanian says. "We found that cardiologists' patients were more likely to have been referred for cardiac rehabilitation services and to have had exercise testing."

Somewhat surprisingly, cardiologists' patients were not more likely to have had either dietary or exercise counseling. Furthermore, the researchers did not find significant differences in the use of proven cardiac medications, such as aspirin, beta blockers, and cholesterol-lowering drugs. "There is significant room for improvement in the use of those effective drugs, regardless of the specialty of the physicians providing follow-up care," Ayanian observes.

Finally, patterns of ambulatory care are often established in the first three months after hospital discharge, according to the analysis. "Most of the patients who saw both a cardiologist and an internist in those first three months continued to do so over the next 15 months," Ayanian notes. "However, more of their care shifted from the cardiologist in the first three months to the primary care physicians during the next 15 months, a trend that is likely to be appropriate as patients become more stable."

> **"It is a concern that nearly one in three elderly patients who survive a heart attack are not seeing a cardiologist for ambulatory care."**
> ***—John Ayanian, MD, Harvard Medical School***

Collaborative Care

Interestingly, the researchers found that mortality rates were lowest for patients who received care from both a cardiologist and an internist or a family practitioner. "When we compared the mortality for the patients who saw cardiologists to the mortality of those who also saw a primary care physician, we found a small but significant mortality benefit (about 1%) to having care provided by both

(Continued on page 12)

(Continued from page 1)

levels of coverage as a condition for licensure.

Insurance Required

An overwhelming majority of doctors carry liability insurance for protection of their assets and because coverage is required to participate in health plans or to obtain hospital privileges. Out of fear of losing significant portions of their physicians, hospitals and health plans are easing policies to allow physicians to go without insurance. "Increasingly, hospitals have no alternative but to allow physicians to use their facilities regardless of their insurance status," says Curtis Rooney, JD, senior associate director and counsel of the American Hospital Association, in Washington, D.C. "Otherwise, hospitals would not be able to provide adequate services."

Numbers of bare doctors are difficult to track because there is no central repository for reporting data. Florida doctors are required to record their insurance status every two years when they renew their licenses. By last fall, the Florida Board of Medicine listed only 5% of the state's 48,000 physicians as bare, considered grossly underreported because of the lag in reporting time.

A clearer picture arises from a November survey of 1,600 practicing physicians in three Florida counties that have the most expensive rates, near the cities of Miami, Fort Lauderdale, and West Palm Beach. Among respondents, 5% went bare in 2001, 16% in 2002, and 52% were considering going bare this year, according to the survey commissioned by Floridians for Quality Affordable Healthcare. Three county medical societies and a regional hospital association support FQAH. Most of those surveyed had been sued at least once. Among respondents, 100% of the neurology and vascular surgeons had been sued, 94% of the general surgeons, and 89% of the radiologists. The only physicians who reported that they had not been sued were allergists.

Some physicians are altering practice patterns by eliminating risky procedures (such as vaginal birth after caesarean section), obstetrics, emergency room call, nursing home consultations, and reading mammograms.

Self-insuring is a risky game of livelihood roulette that is not for the faint of heart. Doctors must find experts and pay legal fees, settlements, and judgments out of their personal bank accounts. In some states, bare doctors who can't afford to pay at least part of a judgment can lose their licenses. At the same time, an underlying benefit of having no insurance means doctors don't have to succumb to insurance company clauses that force them to settle claims quickly regardless of guilt or innocence.

Defense Costs

"Even though 70% of all medical malpractice actions brought against physicians result in no indemnity payment to the plaintiff or his or her attorney, they are, nonetheless, costly to defend," Lawrence Smarr said last year when testifying before the U.S. House of Representatives. Smarr is president of the Physician Insurers Association of America, in Rockville, Md. The average legal cost to defend a meritless claim last year was $23,000. For doctors who went through trial and got a favorable verdict, the cost averaged $86,000, according to the PIAA's Data Sharing Project.

More upsetting than financial expenses are the time required and the emotional burden created by these actions. "Even if a medical malpractice insurer is involved, lawsuits take a lot of time from doctors and they take a toll emotionally," says Christopher Nuland, JD, an attorney in Jacksonville, Fla., who represents nine Florida specialty societies. "It affects the way physicians live, the way they practice, and their faith in their profession. It's incredibly demoralizing."

Going bare has spawned a cottage industry of financial planners who specialize in directing physicians in how they can legally hide assets by shifting bank funds to offshore trusts or putting money under the names of family members. And, self-insured physicians sometimes declare bankruptcy, which can help them to avoid paying judgments.

Many attorneys on both sides of the issue believe bare physicians who protect their assets may be litigation-proof and less prone to being sued. Going without insurance discourages lawsuits by lowering the physician's financial profile, says Howard Rosen, JD, CPA, a law professor at the University of Miami. "If an attorney knows a doctor has a great asset-protection plan, he realizes he won't get paid and won't assume the risk and costs of litigating the case," he explains.

To prevent lawsuits from ever getting to the filing stage, insured and bare doctors are taking measures to reduce their exposure. One step involves referring patients who might be litigious or may have had a bad outcome to doctors associated with

public hospitals where the ability to collect on a lawsuit might be limited under law. Physicians are advised to check their state laws for the extent of protection under these laws.

Patients who are obese, suicidal, asthmatic, diabetic, or insured through Medicaid, and women who have premature babies are among those being banished from some practices. Moreover, physicians are altering practice patterns by eliminating risky procedures (such as vaginal birth after caesarean section), obstetrics, emergency room call, nursing home consultations, and reading mammograms.

Being Selective

"Now we're more selective about patients and procedures," says Eisermann, the Miami fertility specialist. "We are much more aggressive in using screening techniques for genetic illness, doing more genetic testing than may be required."

The result of such increased caution is that patients in several states (including Mississippi, Nevada, Pennsylvania, and West Virginia) are having trouble finding physicians to provide care. In these states, trauma centers, rural health clinics, and maternity wards have closed, and physicians in obstetrics and neurology, among other specialities, are moving elsewhere or not taking new patients.

"If your child falls off the bleachers in a football game and sustains a head injury in Charleston, you have to transport that child to Pittsburgh, which is 50 miles away, or to Morgantown, W. Va., which is 75 miles away," explains Evan Jenkins, executive director of the West Virginia State Medical Association.

The issue involving access to care will not abate as long as incentives to reduce care persist. As just one example, several insurers offer discounts to obstetricians in Las Vegas who limit the number of babies they deliver annually to 125, half the usual number. Other insurers reduce premiums for radiologists if they do not read mammograms.

Some physicians who are unable to afford malpractice insurance or are reluctant to go bare and fear a malpractice suit are simply closing their practices. In 2000, *Baltimore* magazine named Gina Sager, MD, 42, one of the top breast surgeons in the region. Yet, even with the $25,000 deductible her insurer required, her premiums were unaffordable. She could not go bare since Baltimore hospitals require physicians to carry medical malpractice insurance. Johns Hopkins, for instance, requires obstetricians and neurosurgeons to have malpractice insurance policies with a limit of $3 million per occurrence and $5 million per year; physicians in other specialties are required to have policy limits of $1 million and $3 million.

Last May, after four lawsuits she attributes to bad outcomes not medical mistakes, Sager closed her practice. "I realized I didn't have to do anything wrong to be sued again," she says.

Doctors who do not want to go bare are dealing with a huge increase in rates by working harder, spending less time with each patient, reducing overhead, cutting staff, forgoing office renovations, and putting off capital improvement purchases. When possible, they are reducing premiums by cutting coverage to as low as $250,000 per occurrence and $750,000 per year. Though low rates may seem appealing, such limits may leave a physician underinsured. The median jury award in medical malpractice claims was $1 million in 2000, according to Jury Verdict Research, in Horsham, Pa.

Target Practice

Conversely, some physicians fear large policy limits make them a target for aggressive litigators. "Do high coverage limits encourage lawsuits? It's 50-50," says Cliff Rapp, vice president, risk management, FPIC, Jacksonville, Fla., one of that state's largest physician insurers.

Those physicians who simply cannot find affordable insurance and who are not close to retirement may have few options but to go bare. But critics say it's irresponsible for physicians to go without insurance. "Imagine if all automobile owners were allowed to drive without insurance," says Jonathan Schochor, a Baltimore plaintiff attorney who is past president of the Maryland Trial Lawyers Association.

Attorneys fear that if significant numbers of asset-protected doctors go bare, plaintiffs would be unable to collect judgments and lawyers working on a contingency-fee basis will go unpaid. "Lawyers may have killed the golden goose," Florida attorney Nuland says. "Why do you think so many trial attorneys are trying to get doctors to form self-insurance trusts? It's the only guaranteed way to obtain funds from a judgment."

Patient advocacy groups, such as Public Citizen in Washington, D.C., have aligned themselves with plaintiffs' attorneys. "There is no medical malpractice insurance crisis," Joan Claybrook, president of Public Citizen, said at a press conference last fall in Fort Lauderdale, Fla. "Rather there is excessive doctor malpractice and an insurance industry profits crisis."

While parties on both sides argue over the issues, some patients may be suffering the worst fallout from the crisis. A patient who is legitimately injured by the medical mistake of a bare doctor who is asset-protected may not be able to have his or her medical expenses reimbursed. "When a truly deserving patient is issued a judgment, it could become increasingly likely the patient will not be able to collect the full amount of the award," Nuland says.

—Reported and written by Maureen Glabman, in Miami. More information on physician practice strategies is available on our Web site *(see page 16).*

Experts See Value in Study

After analyzing the data reported in an article, "Specialty of Ambulatory Care Physicians and Mortality Among Elderly Patients After Myocardial Infarction" in the Nov. 21 issue of NEJM, experts at the Rand Corp., in Arlington, Va., say translating these findings into action will result in improved quality of care.

The Rand experts, Nicole Lurie, MD, and Melinda Beeuwkes Buntin, PhD, acknowledge that collaboration between specialists and primary care physicians can improve care and that systemwide coordination of care is an essential requirement for improving the quality of care. Some patients referred to specialists fail to keep their appointments, they say. Collaboration helps to prevent this problem. "Systemic solutions—those that fundamentally alter the process of care, for example, by tracking individual patients from the beginning to the end of the episode of care—can address this problem," they explain.

When researchers identify disparities in health care, the findings reflect deficiencies in quality, Lurie and Buntin say. "The findings of Ayanian, et al., suggest that targeting quality-enhancing initiatives to increase ambulatory specialty or collaborative care in groups that are otherwise less likely to receive these services would bring the largest absolute reductions in mortality," they write in an editorial in NEJM. "Their results also suggest that universal application of these techniques would reduce disparities in cardiovascular outcomes that are associated with personal characteristics. This study confirms once again that changes in health care delivery systems are needed to optimize health outcomes."

(Continued from page 9)

types of physicians relative to just cardiologists alone," Ayanian says. "This suggests that the optimal outcomes for elderly patients, who often have both significant heart disease and multiple additional medical conditions, can be achieved by collaborative care from both a cardiologist and a primary care physician."

Such collaborative care can be cost effective as well, Ayanian believes. "As a practicing internist, I believe that specialists and generalists bring complementary skills to patient care," he states. "By working together and communicating well in coordinating patient care, collaborative care can definitely be cost effective if appropriate and integrated treatment strategies are pursued." If patients are seeing several physicians who are not communicating and coordinating their recommendations and treatments, redundant conflicting services might substantially raise costs without benefiting the patient, he adds.

"Because our study population consisted of elderly patients, many had significant noncardiac conditions in addition to their cardiac conditions that would influence their quality of life and their survival," Ayanian points out. "Some cardiologists are interested in providing general primary care for their patients as well as cardiac care. However, many cardiologists prefer to focus on the care of cardiac conditions. If they are not also prepared to manage other conditions (such as diabetes, chronic lung disease, and renal disease), then it is most appropriate to collaborate with primary care physicians in delivering that care."

As a result, cardiologists seeking to improve the care of AMI patients might try to find opportunities to pursue collaborative relationships with general practitioners for these patients. "Cardiologists can examine patterns of care in their own local areas and determine whether there are patients or primary care physicians who don't have good access to cardiologists providing ambulatory care," Ayanian says. "By developing strong collaborative relationships with primary care physicians, cardiologists can increase their referrals and enhance quality of care as well."

Appropriate Therapy

In addition, more primary care physicians should discuss with their heart attack patients whether these patients would benefit from seeing a cardiologist. "Most heart attack survivors would be willing to see a cardiologist if their primary care physician recommended it," Ayanian says. "In general, both cardiologists and primary care physicians can work to build collaborative relationships, and the best way to do that is by jointly caring for patients over time. Then, both physicians and patients would become more comfortable with those collaborative arrangements."

Similarly, both cardiologists and general practitioners should try to improve the use of appropriate medication therapy and counseling. "Better systems are needed to help physicians monitor whether their patients are getting appropriate medications and counseling," Ayanian observes. "Some health care organizations have information systems that provide reminders and reports—and sometimes incentives—to physicians to help them ensure that their patients are getting high-quality care based on the best available evidence."

—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).

Consumer-Driven Focus, Chronic Care, IT Will Be Key to Success

***Brooks O'Neil** is a senior principal at Triple Tree, an investment bank in Minneapolis. He worked for 15 years in the health care practice of U.S. Bancorp Piper Jaffrey, an investment banking firm in Minneapolis. He is the author of the report,* A Prescription for Health Care, *which Triple Tree published last fall. Editor in chief Richard L. Reece, MD, discussed with O'Neil the four themes he believes will transform health care over the next 10 years.*

Q: *How do you see health care evolving over the next decade?*

A: The health care delivery system in this country faces major issues. The largest one is that quality of care needs to be improved dramatically. There are also issues related to the ever-escalating cost of care and access to care for the 40 million Americans without health insurance.

The environment is ripe for change because employers are frustrated with the health care costs they are being asked to bear. At the same time, consumers are increasingly frustrated with the cost of care, the limited access to care, and the quality of care.

We identified four themes that will play a major role in transforming health care over the next 10 years. The first theme is the concept of consumer-driven health care. We expect a transformation of the insurance landscape from an employer- and a government-driven system to one that is oriented toward the consumer, who will gain control over purchasing decisions and dollars.

The second theme involves customized care centers. We believe there will be a major change in the way providers are organized to deliver acute care. We expect the development of focused units that are customer friendly and deliver care for specific conditions, such as cancer, heart disease, orthopedic ailments, and kidney failure.

The third theme is chronic care management. This concept has been talked about for a long time, but given the aging of the population and the rising cost of care, consumers, employers, and insurers will all become willing and able to buy services to treat chronically ill patients much more effectively.

Fourth, the glue that holds the first three themes together is information technology. Health care spending for IT will be increasingly oriented toward outsourcing. Rather than buying computers and software and hiring people to run these systems, health care constituencies will hire firms to handle an entire IT function in specific areas, such as billing, transcription, and medical records.

These forces will begin to manifest themselves in the market independently. Employers, for example, are considering the concept of consumer-driven health insurance programs. We think the big explosion in enrollment in such plans will occur next year, but we will begin to see a clear movement in that direction this year. As that theme begins to take hold in the marketplace, it will begin to drive changes on the provider side, such as the development of customized care centers and chronic care management programs. It will also force providers, insurers, consumers, and employers to reconsider the way they manage health care information and to invest in IT systems that will make them more efficient and effective.

Q: *Do you think there's enough critical mass and investment among consumer-driven health plans to make this a reality?*

A: The common perception in the marketplace today is that there is not. A fair case can be made that there are not enough alternative plans available. There is not enough capital or management, and there has not been enough time devoted to experimenting with various alternative consumer-driven plans. But because of the overall landscape (meaning 12% to 15% health care inflation this year) the likelihood that consumer-driven health plans

(Continued on page 14)

"We expect a transformation of the insurance landscape from an employer- and a government-driven system to one that is oriented toward the consumer, who will gain control over purchasing decisions and dollars."

(Continued from page 13)

will grow over the next couple of years is very high. There will be dramatic pressure on the traditional insurers and on new consumer-driven players to offer meaningful alternatives to employers. Over time, the government programs, Medicare and Medicaid, will offer consumer-driven programs as well.

Q: *What adjustments has the Internal Revenue Service made in how we account for health reimbursements that are conducive to consumer-driven plans?*

A: The IRS action on this issue is a significant development. There is an historical quirk in the way employers buy health insurance: They are allowed to buy health benefits on a pretax basis. That is the primary reason that health insurance is largely employer-driven today. Last year, the Treasury Department dramatically expanded the potential of health reimbursement accounts (HRAs) by allowing employers to contribute money to those accounts and consumers to spend that money on a pretax basis.

Furthermore, these accounts were made portable and transferable. Historically, flexible spending accounts have been structured as "use it or lose it" accounts, which dramatically limited the amount of money anyone was willing to contribute to them. In its decision last year, the Treasury Department allowed rollovers, so money not spent this year can be retained in the same account to be spent later, and if an employee leaves a company, he or she can keep the account.

These are major provisions that will allow for a dramatic expansion in the amount of money contributed to these accounts and hence their effect on the marketplace.

We have heard that some major health insurers are at least considering offering a consumer-driven alternative. When some companies make this offering, others will follow. In the next two or three years, we will see a major expansion in the number of consumers that have dollars to spend directly on their health care.

Q: *Are these developments helpful to the 40 million Americans who are uninsured?*

A: It is very helpful for them. Employers, large or small, will be able to offer an insurance plan to their employees that is much more affordable than the plans currently being offered. The structure that may be most appealing to a large number of people is a plan that offers low-cost catastrophic coverage, along with an HRA that individuals will use to pay for basic care expenses. Employees can contribute a modest amount to these accounts on a pretax basis, allowing them to take advantage of the pretax spending opportunity that the government is providing.

Q: *What effect will consumer-driven plans have on physicians?*

A: Historically, the health delivery system has been very inwardly focused. In other words, often the prevailing mindset was that the system was there to serve doctors, and doctors were there to serve hospitals, and all of the support and ancillary services were there to support the doctors and the hospital. But the demands of the marketplace will force a shift in focus, so that physicians will need to understand what consumers want rather than focusing on some other constituent.

Q: *What do consumers want from their doctors?*

A: Consumers want what they want in most other markets. They want access to quality care, convenience, service, affordability, communication, and information.

Delivering what consumers want means physicians and other providers are going to need to focus on having locations and hours that are convenient and staffing that allows more effective and efficient management of patients. Long waiting times will not be tolerated. Consumers will self-monitor the quality of care, and they will hold providers accountable if they're not getting high-quality medicine. Some might argue that consumers are not capable of self-monitoring, but I see evidence all over the health care system that consumers are arming themselves with more information, much of it provided over the Internet, and that allows them to quickly become savvy consumers of health care.

Q: *How can physicians succeed in this new environment?*

A: Considering transformations that have occurred in other industries over the last 20 or 30 years, most notably in the retail sector, it is likely that the days of a highly independent, small, locally focused physician or provider organization are numbered. Rather, the winning providers will be part of sophisticated organizations that have effective management and that can access capital. In fact, access to capital is going to be one of the most important competitive variables over time.

Over the long term, chain operators that have a sophisticated business model that they can execute in a high-quality, cost-effective fashion will come to dominate health care, just as such operators dominate the

"The demands of the marketplace will force a shift in focus, so that physicians will need to understand what consumers want rather than focusing on some other constituent."

Many doctors do not realize that paper claims processing is rapidly going to become obsolete, not only at the level of Medicare and Medicaid, but for all health plans too.

retail landscape.

The best examples in the hospital market are HCA, in Nashville, and Tenet Healthcare, in Santa Barbara, Calif. Despite the recent problems Tenet has experienced, the for-profit chain operators continue to prosper in the hospital market. The players that succeed in this market will streamline their functions and not try to provide all services to all people in a community. They will focus on high-quality acute-care services in the most important surgical areas. The core activities of hospitals are the specialty areas that generate the most revenue, and those areas include cardiovascular, cancer, and musculoskeletal care.

Several years ago the concept of a dedicated heart hospital was highly controversial. Today, in Minneapolis, all of the major hospitals in the market (and they are all nonprofit systems) are building dedicated heart centers. The concept of a dedicated heart center has become mainstream. Similarly, we will begin to see more dedicated orthopedic hospitals. Also, diagnostic imaging and surgery centers and cancer and dialysis centers are all areas that are ripe for consolidation and rationalization.

If physicians are going to prosper in this environment, they will need to find ways to participate in the economics and the care management around these core service areas.

Q: *The majority of doctors are involved in primary care. Will primary care physicians be left out because they do not provide specialty services?*

A: They will not be eliminated in the health care system, but they are, for sure, at the lower end of the food chain. Hence, the revenue and profit potential for PCPs is going to be modest at best. In the future health care environment, the most important thing for them is to get into an efficient delivery model that can provide superior service on a cost-effective basis. Again, factors such as location and hours of service will be vitally important. Primary care is the area of health that will see the first impact of the consumer-driven initiative because it is the first area where consumers will be paying directly for care.

Q: *Is there a critical role for information technology in the survival of PCPs?*

A: Absolutely. IT can streamline the business of health care. Physicians can use IT effectively to gather and process data. We will still have a highly fragmented delivery system in which cooperation and coordination among independent physicians and other providers will be the key to service delivery.

One reason I believe in chain operators is that it is much easier to organize and coordinate activity within a single organization. However, regardless of whether physicians are in a chain or are independent providers, one key to success will be managing information effectively.

On the business side, the information relates to activities such as billing, processing, scheduling, and procuring supplies. On the clinical side, patients will demand electronic access to medical records.

Q: *Will the Health Insurance Portability and Accountability Act present an opportunity for doctors?*

A: Yes. I'm not a believer in the status quo in health care. There is a growing realization that the industry is facing significant issues of quality, cost, and access. The doctors who embrace initiatives that have the potential to improve quality, reduce cost, and improve access will be the winners in the long term. The physicians who use IT intelligently, and do so primarily through outsourced providers, will be able to use it to their advantage.

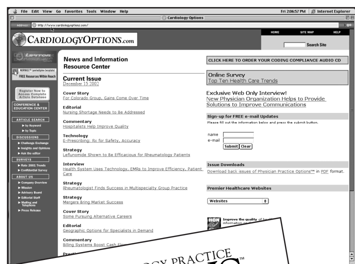
The number one opportunity for doctors is in billing and collections. It is absolutely critical to bill and process accounts receivable electronically. Small independent groups of doctors who are using small billing and collection companies will not be able to compete with the groups using larger, more sophisticated billing companies that use the most advanced information systems to streamline the process.

Many doctors do not realize that paper claims processing is rapidly going to become obsolete, not only at the level of Medicare and Medicaid, but for all health plans too. It's like any other innovation that has occurred in the 20th century. At the outset, an investment is required to take advantage of the innovation, but ultimately a tremendous improvement will result. When people first had an opportunity to buy a car, it was much more expensive than a horse, but ultimately they figured out that they could get from point A to point B a lot more quickly. The IT revolution in health care will have the same impact.

—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



CARDIOLOGY PRACTICE OPTIONS™

Improving Patient Care Through Increased Practice Efficiency

January 15, 2003

Group Recruits Carefully to Boost Efficiency

CONTENTS

Features

Commentary: What Happens If Cost Control Fails? 3

Strategy: ACC Promotes Use of Guidelines 8

Interview: Consultant Offers Advice for Raising Physician Productivity 13

Departments

Editorial: Increased Efficiency Improves Patient Care 2

Practice Management: Privacy Rules Made Simple 6

Our FREE online resource includes:

- Strategies and tactics to build your practice
- A complete database searchable by keyword, subject, or issue
- 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 **973-682-9077.**

Name: ______________________

E-mail: ______________________

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

March 15, 2003

Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

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