

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

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Communication Helps Cut Malpractice Claims

Physicians seeking to keep their medical malpractice insurance rates low are finding that one of the best ways to control malpractice costs is to do what automobile drivers and homeowners do: Avoid filing a claim whenever possible.

Among the reasons patients file claims are the physician's personality and the lack of thoroughness of the medical records, says Greg Scott, executive vice president of Millennium Insurance Co., a risk retention group in Doylestown, Pa. Millennium offers malpractice insurance to physicians in Pennsylvania.

Simply Speaking

"A doctor who is abrasive but an excellent clinician is more likely to get sued, simply because people don't like him," Scott explains. "Similarly, for a doctor who does not take the time to do a good informed-consent discussion before a procedure or to maintain thorough documentation, a lawsuit will be harder to defend."

Malpractice insurance rates typically are set according to territory, specialty, and claims history, all factors over which physicians have little control, says Wendy Levinson, MD, the vice chair of internal medicine at the University of Toronto Medical School. But communication style is one of the few factors related to malpractice costs that physicians can control, adds Levinson, who focuses her research on physicians' communication styles and their implications for practice.

"Malpractice insurers understand that communication style influences claims," Levinson explains. "In fact, most patient complaints stem from patients feeling that they were hurried or ignored by the physician." Recognizing the value of good patient-physician communication, Northwest Physicians Mutual, an insurer in Portland, Ore., offers premium reductions for doctors who receive communications training.

Another medical malpractice insurer that offers communication training to its insured physicians is Physicians' Reciprocal Insurers (PRI) of Manhasset, N.Y. The principal reason for the training is to support insured physicians in their practices, explains Marjorie Thomas, senior vice president for risk management and underwriting for PRI (at www.primedmal.com).

"Diagnosis and treatment rest in large part on communicating with a patient," Thomas says. "We believe (and the data support this belief) that a physician who is better able to communicate will find more adherence to treatment. The literature points to minimized instances of malpractice, and we believe it will help to decrease the number of malpractice cases." Regulations in New York allow insurers to offer a 5% premium credit to physicians who complete risk management education programs approved by the state Department of Insurance.

Research shows that physicians

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Studies Show the Effect of Wasted Time

Physicians waste about 55% of their time. That estimate comes from Greg N. Korneluk, chairman of the International Council for Quality Care Inc. (ICQC), a consulting firm in Boca Raton, Fla. In an eight-hour day, at a rate of \$3 to \$4 per minute, a physician would lose the equivalent of \$792 to \$1,056 of revenue each day, he says. Assuming that the average physician works 250 days each year, Korneluk's wasted-time calculations amount to about \$200,000 of lost revenue per year.

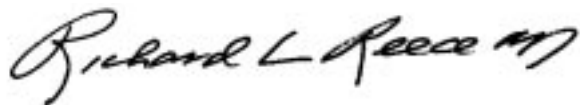
Time that is wasted and time that is not spent with patients can sharply limit cash flow and income. For busy physicians and harried staff, having enough time can mean the difference between barely getting by and being successful. With more time, physicians can see more patients, creating the potential to increase not only revenue, but also satisfaction for both patients and physicians as physicians apply their professional knowledge productively.

In time-and-motion studies involving physicians that ICQC has done, Korneluk has found that physicians spend too much time completing forms, looking for charts, and dictating or making notes. Physicians can save time by completing dictations while the patient is present, using electronic templates instead of dictation, or employing a dictation assistant to record encounters.

Korneluk is not the only one who argues that physicians waste time. Marshall O. Zaslove, MD, the author of *The Successful Physician: A Productivity Handbook for Practitioners* (Gaithersburg, Md.: Aspen Publishers Inc., 1998), says that the most significant time-wasting activities of physicians involve paperwork, interruptions, rework, unnecessary work, insufficient personal skill, clinical errors, missing or misplaced patient information, phone calls, useless meetings, friction with staff, time away from patients, and low energy.

Many experts believe physicians should do more at the point of care, which means getting everything done, including paperwork and note taking for billing, while the patient is in the office. The concepts behind point-of-care medicine that help save time include avoiding expensive rework of denied claims; automating patient flow and improving cash flow; documenting patient encounters while patients are present; and dispensing drugs, new disease information, and patient educational material during patient visits.

By increasing the amount of time they have to spend with patients and completing more work at the point of care, physicians will likely increase their productivity, reduce their overhead, and foster a more patient-friendly environment, consultants say.



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AHCs Need to Retool, Report Says

By Joseph Burns, Editor

Academic health centers need to rationalize their financial management, take advantage of new technologies in education, and demonstrate greater accountability for what they do, according to a report from The Commonwealth Fund in Washington, D.C. The fund (at www.cmwf.org) is a private foundation supporting independent research on health and social issues.

A task force that has been studying academic health centers (AHCs) over the past seven years recommends sweeping changes in clinical practice, research, and education at a time when such centers are critical to the nation's well-being, the fund says in a report issued in February. The task force was formed to examine the problems AHCs face in a changing health care environment, and specifically how AHCs can continue to pursue their social and academic missions of providing medical education, doing biomedical research, supplying specialized services, and providing indigent care.

Modernizing and Improving

The task force on AHCs says that some of the facilities are finding it difficult to survive in the complex and costly environment that predominates in health care today. The report, *Envisioning the Future of Academic Health Centers*, contains more than two dozen recommendations aimed at modernizing and improving AHCs.

"The missions of academic health centers are essential to maximizing public health in the United States," says David Blumenthal, MD. "But AHCs must be able to meet the evolving needs of the American people. They will have to learn quickly, act expeditiously, and face change head-on." Blumenthal, who is executive director of the task force, is also director of the Institute for Health Policy at Massachusetts General Hospital, which is affiliated with Partners HealthCare, a large health system in Boston.

Commenting on the report, Stephen C. Schoenbaum, MD, senior vice president of the Commonwealth Fund, says that AHCs have long been the leaders in providing education to the nation's health professionals, essential specialty care to citizens, research, and care for the underprivileged. "It is essential that they continue to focus on these missions, and have the financial security to be able to achieve them," he adds. "Since our nation's health and security depend on them, AHCs must be accountable to the American people for accomplishing these missions."

Funding at Risk

The report cautions that future funding of AHCs is at risk. In addition to the pressures caused by rising health care costs and an increasing number of uninsured Americans, Medicare reforms that are being considered by

the Bush administration could negatively affect the income of AHCs, which rely heavily on Medicare for financial support.

To help AHCs continue to thrive despite proposed cuts in public health programs, the task force proposes the creation of a public trust fund to provide money specifically to support vital AHCs. Doing so would make the financing more accountable, predictable, and transparent, the report says.

In order to meet the country's projected health care needs, the functions that AHCs currently perform must increase over time, the task force says. Those functions include doing research, teaching clinical innovation, providing highly specialized care, and caring for the indigent. It is not necessary to increase the number of AHCs, the report says, as long as other organizations can perform those functions.

Geographic Needs

But in certain regions (particularly in the South and West), policy planners should foster growth in AHC capacity because these regions have experienced significant population increases and there is a currently a dearth of medical schools.

What's more, administrators at AHCs that have been operating for many years should think and act more strategically, according to the report. They should be more responsive to the needs of the communities

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"Academic health centers must be able to meet the evolving needs of the American people. They will have to learn quickly, act expeditiously, and face change head-on"

—David Blumenthal, MD, Institute for Health Policy

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they serve, and they should dramatically improve their internal accounting and financial management abilities. Also, they should develop the capabilities to measure performance and conduct quality improvement, the task force recommends.

In the future, most AHCs will specialize in certain missions; few will attempt proficiency in all areas of research, education, and clinical care, the report predicts. Rather, they will seek balance and diversification among the areas they pursue and chart their long-term agendas strategically. Interdisciplinary work will be the norm, especially in research.

Key Recommendations

The task force makes recommendations in the key areas of research, education, clinical services, and care for the indigent.

In the area of research, the task force urges AHCs to bring university-based research and innovation into the mainstream of American health care delivery. To do so, AHCs should become centers of research innovation by giving higher priority and recognition to new and traditionally under-supported areas of biomedical science.

They also should focus on translating the results of clinical research into everyday practice and nurture and manage their research relationships with industry in a manner that promotes the public interest, protects patient participants, and maintains academic values, the report says.

In addition to improving their research capabilities, the report says that AHCs should increase their focus on education. They should incorporate into their basic education curricula training in leadership,

team-building, continuous improvement, and the measurement of clinical performance. They also should be open to training new types of health professionals to meet changing health care needs.

The task force also recommends that AHCs develop the capability to educate students, residents, and clinicians online and remotely. AHCs also should incorporate simulation in all levels of experience, from students' first encounters with clinical care to continuing education and certification of master clinicians while providing leadership in training a culturally competent clinical and research work force.

In the area of clinical services, AHCs should develop relationships with other organizations (both academic and nonacademic) that will help them provide optimal care and ensure that trainees get the exposure to a wide variety of clinical settings that they will need to be successful in the workplace. The task force predicts that most AHCs will focus on providing high-technology and specialized services, although some will specialize in primary and community-based services. Regardless of their focus, the task force recommends that AHCs work to improve the safety, quality, and efficiency of the services they provide as part of a process that involves continual performance improvement.

Moreover, AHCs should act decisively to improve outcomes that fall below those obtained by peer institutions, or they should discontinue those clinical services, the report says. They also should become leaders in applying information technology to improve health care.

Care for the Indigent

One of the most important roles of AHCs is caring for the indigent, and the task force urges that these centers maintain their strong commitment to the care of the poor and underserved by ensuring that the quality and efficiency of care being provided to vulnerable populations are comparable to what is available to other populations. AHCs also should work with partners in local communities to serve the needs of poor and indigent patients and to adopt explicit programs to train staff at all levels to provide care that is culturally appropriate and responsive to the diverse needs of ethnically and racially varied populations.

Technology Pioneers

The report is the sixth and final one in a series of major reports that the task force has done on AHCs. In the first report, *Leveling the Playing Field*, the task force noted the effects of competitive health care markets on the organizational and financial underpinnings of AHCs. In other reports, the task force has examined the status of AHCs' research mission; the crucial role AHCs play in the development and delivery of highly specialized, technologically complex medical services; the contributions AHCs provide in delivering medical care to indigent and uninsured patients; and the problems and challenges AHCs face in educating the nation's health care work force.

To help ensure the survival of what it calls the vital missions of AHCs, the task force also makes public policy recommendations.

—More information on health care issues is on our Web site (see page 16).

It is essential that AHCs continue to focus on their missions, and have the financial security to be able to achieve them, says Stephen C. Schoenbaum, MD, of the Commonwealth Fund.

Why Physicians Hesitate to Use EMRs

By Hayward Zwerling, MD, FACP

About 5% of physicians are using an EMR (electronic medical record). Many observers consider this number to be startlingly small compared with the rate of adoption of smart technologies in other industries that have used electronic systems to achieve significant increases in productivity. High cost, a reduction in productivity, and concerns about moving from paper to electronic records are among the many reasons physicians give for their hesitation to make the transition to EMRs.

Other common reasons that physicians do not implement EMRs in their practices include a feeling of discomfort about having to depend on an EMR vendor for access to patients' medical records; a reluctance to take the time to learn about the different EMRs that are available, as well as the difficulty of finding time in a busy practice to learn how to use an EMR; a fear of having to type office notes rather than dictate or write them out in long hand; and a concern about being unable to move patient data from paper charts to an EMR.

These concerns are valid, so physicians should carefully consider the hurdles that may make adopting an EMR a significant challenge. Even so, the 5% of physicians who are using EMRs have found that this new technology has made it easier for them to do their job, despite the initial hurdles. After they did the work required to find and buy the right EMR for their practice, got it installed and running, and went

through the transition period when productivity decreases, they saw an increase in productivity and ease of use that is not possible without an EMR.

Lessons Learned

In my practice, we have been using the ComChart EMR since 1992, and the lessons we have learned are useful for other physicians.

The initial cost of the EMR soft-

ware and the requisite hardware can be significant. In fact, the hardware alone—a computer, a laser printer, network components, a modem, and other equipment for a practice of one-to-four physicians—could cost \$10,000 to \$25,000. However, many EMR companies can help physicians get a loan or may provide a lease-purchase option to help them acquire the necessary hardware.

An EMR system allowed one practice to reduce its staff, and the resulting cost savings has paid for all of the hardware and software since the practice abandoned paper charts almost two years ago.

The cost of the EMR software can range from several hundred dollars to hundreds of thousands of dollars. In addition, physicians must pay for training, upgrades, and a maintenance contract. Although vendors do not commonly discuss customized programming, some practices may need such additional work if they want to be able to include lab and radiology results electronically, and custom work costs extra.

Although these costs may seem formidable, they should be compared with the savings that are possible as a result of abandoning paper charts.

First, the office space allocated to rows of chart racks can be converted to productive office space. Second, staffing costs can be reduced, since the staff will spend no time looking for lost paper charts or repeatedly filing and refiling charts each day. With the traditional paper chart, someone has to pull and refile the chart for every office visit, progress note, lab or radiology result, phone call about an

illness, prescription refill, insurance question, and miscellaneous patient inquiry.

In my office of one physician and one nurse practitioner, the total number of paper charts that would have to be pulled and refilled each week is about 450 to 500. Based on this one statistic alone, I would need to hire at least an additional part-time or full-time employee if I used paper charts in my practice. The resulting cost savings has paid for all the EMR hardware and software since I abandoned paper charts almost two years ago.

Meeting Vendors

The purchase of an EMR will likely result in a long-term relationship between the physician and the EMR vendor. For this reason, it is essential that a physician trust the vendor to provide high-quality service and that the vendor have a record of providing reliable service. It is also important that it be clearly delineated, in writing, who is to be responsible for network

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Hardware Costs

The hardware alone for an EMR system could total more than \$9,000 in a practice with one-to-four physicians. Here's a breakdown:

- A computer to operate the EMR and distribute the data to client computers in various offices (\$800 to \$3,000)
- Client or terminal computers (\$400 to \$1,000 each)
- A laser printer (\$1,000 to \$4,000)
- A switch that enables computers and printers to communicate with each other (\$500)
- Network wiring (\$30 per computer or printer)
- A wireless network (such as Apple Computer's Airport for \$300), instead of a switch and network wiring
- A modem (\$300 or less)
- Backup hardware and software (\$500).

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problems and for EMR-related issues, and who to call when there is uncertainty about the source of a problem.

Because there is high turnover among EMR vendors, a physician should obtain a written guarantee that the vendor will provide, at no cost and upon request, a copy of the physician's medical records on a compact disk if the vendor is acquired by another company or becomes financially insolvent. Further, this copy of the medical records should be in a tab-delimited format and accompanied by a written explanation of what type of data are on the CD. Also, it is reasonable to ask the vendor—either quarterly or semi-annually—for a copy of such data.

The only alternative to reduce dependence on a vendor is to purchase an open-source EMR. An open-source EMR gives the user full access to the programming language, meaning physicians would be able to hire an independent software engineer to customize the EMR based on

the physicians' needs.

There are a couple of hundred EMR programs on the market, ranging from those that manage only patient prescriptions, to comprehensive EMRs designed to replace a solo practitioner's paper charts, to EMRs that can manage the charts of large physician groups. Therefore, before purchasing an EMR, it is essential that physicians define their needs precisely and invest the time to select the correct one for their office.

EMR Dropouts

Studies have shown that many physicians abandon their newly purchased EMRs within a year of purchase. Two causes for this high dropout rate are the failure of physicians to define their needs precisely and an unwillingness to invest the time necessary to learn about the capabilities of the EMR they have purchased. A good EMR is complicated software that physicians and their staff will use

innumerable times every day. Physicians who cannot invest the time to select the proper EMR system for their office and to learn how to use it should not purchase one.

Physicians sometimes abandon their newly purchased EMRs for another reason: Office productivity decreases when they first begin using the EMR. This decline in productivity is partly the result of the learning curve required to develop the skills necessary to use complicated software while concurrently running the practice. Another reason for the productivity decline is that the time-saving features of an EMR are useless during each patient's first or second office visit because the patient's chart is empty or incomplete until the physician or staff has filled in the patient data, problem list, medications, and other information. Another reason is that some of the data from the paper chart must be entered manually into the EMR.

When a practice begins using an EMR, entering the data will need to be done as part of the patient's first office visit. At the same time, the physician will need to listen to the patient and manage his or her medical problems. As a result, a drop in productivity will occur regardless of the EMR system selected. If a vendor says otherwise, physicians should reconsider their choice of vendor.

Making the Transition

To make the transition go as smoothly as possible, physicians should reduce the number of patients they see per hour during the first three or four months of using the new EMR. Based on my experience, I recommend that the number of office visits be reduced

A good EMR system is complicated software. Physicians who cannot invest the time to select the proper EMR system for their office should not purchase one, the writer says.

A drop in office productivity will occur regardless of the EMR system selected. If a vendor says otherwise, physicians should reconsider their choice of vendor.

by about 20% to 25%. What's more, physicians should spend time learning the EMR before going live with it, which can be done by creating and entering "dummy" patient data into the charts; ordering lab tests; and printing prescriptions, envelopes, and copies of the chart. Scheduling the patient visit, printing an encounter form, creating a dummy bill, and importing dummy lab results are other functions that should be tested.

In essence, physicians should try to use every feature of the program before using the EMR with real patients in order to avoid the dismaying discovery that they do not know how to use a particular function in the middle of a busy office schedule.

Eliminating Typing

Another issue related to ease of use involves typing. Many physicians fear that they will have to type their notes if they use an EMR. In my community, most physicians use a transcription service, and if the EMR is designed properly, a physician could continue to use an outside transcription service. But regardless of the EMR involved, physicians will need to do some typing.

An EMR that uses a voice recognition program, macros (a single key stroke or verbal command that can import long, prewritten notes), template notes, touch-screen technology, or handwriting recognition can help minimize the need for typing. Each of these options has advantages and disadvantages, and so physicians will want to choose their EMR carefully.

When making the transition from a paper medical record to an EMR, it may seem instinctual to copy the entire paper chart into the new EMR.

But old mammograms, chest x-rays, EKGs, progress notes, and lab results are rarely needed if more recent data are on file. Therefore, it is unnecessary to incorporate every piece of medical data into the new EMR. I found that my time could be used more efficiently by dictating a summary note of relevant past normal and abnormal test results as part of a patient's first EMR note. During the first office visit, you should also begin to fill in the patient's EMR flow sheet with data from the patient's paper chart.

Moving Data

After I started using an EMR, I kept my patients' old charts on site for two to three years. After about six months of using the EMR, I rarely needed their old paper records. After using the EMR for two to three years, I moved the paper charts out of my office. The only paper records I keep are patients' old EKGs, although I could scan them and put them into my EMR.

I also keep notes from consulting physicians on site for about two years. Rather than retyping the entire note into an EMR, my nurse practitioner dictates a two-to-three sentence summary of it for the EMR. Using this method, I minimize transcription costs while ensuring that my EMR has all the relevant information of my patients' consult letters. It is extremely rare that I need to review the original content of a consultant's letter. Another option is to scan these notes into an EMR and store them as an image or convert the image into text with an optical character recognition program.

Fortunately, my laboratory and radiology vendors return their results to me electronically. If an EMR is

designed properly, the EMR can file these data automatically, making them accessible for searches and analyses. Although this auto-filing feature will save time, it is a feature that physicians should begin using only after they have mastered the basics of the EMR.

A final point: When using an EMR system, it is particularly important to implement an automated backup process from the first day of use. Obviously, no physician wants to lose all of the practice's patient records to a hardware or software glitch. What's more, a well-designed backup program can help ensure that the EMR is more tamper-proof than the traditional paper record, an important feature in today's litigious environment.

Looking Ahead

Although converting from a paper medical record to an EMR presents all physicians with new problems, the long-term financial benefits alone justify making the transition. Unfortunately, this transition cannot be carried out successfully without the investments in time and effort required to make it work. Physicians who are just beginning their practice should make the transition now, before they get too busy.

My experience and published data have shown that a well-designed EMR will help physicians not only improve the quality of care they deliver by helping them meet various guidelines, but will also provide them with the ability to demonstrate to third-party payers that the quality of care they provide exceeds that of other physicians.

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

Data Foster Guideline Compliance

An initiative sponsored by the Duke University Medical Center in Durham, N.C., encourages cardiologists and other physicians to follow published guidelines for high-risk cardiac patients.

Called CRUSADE (for “can rapid risk stratification of unstable angina patients suppress adverse outcomes with early implementation of the American College of Cardiology/American Heart Association Guidelines”), the initiative involves data on 100,000 patients at 600 hospitals nationwide. Conducted by the Duke Clinical Research Institute and begun in 2001, the project measures clinician adherence to guidelines for the care of patients who arrive at the emergency department with chest pain and other symptoms that place them at high risk of acute myocardial infarction or death.

Medication Monitoring

For the initiative, researchers examine the early instigation of proven treatments and other recommendations at discharge, such as aspirin, other medications, smoking cessation, cardiac rehabilitation, and dietary counseling for appropriate populations.

So far, data collected on 35,000 patients at 400 institutions show a significant gap between guideline recommendations and clinical practice. The goal of the initiative is to educate and influence physician practice so that physicians and other providers adhere to guidelines more frequently. “Recent investigations have shown that a large gap exists between what the evidence gathered during clinical trials indicates ought to occur and what actual-

ly occurs in clinical practice,” says cardiologist Eric Peterson, MD. Peterson is an associate professor of medicine at Duke University Medical Center and a principal investigator for CRUSADE.

The evidence, which has been considerable and largely uncontroversial, has been formulated into guidelines by the ACC in Bethesda, Md., and the AHA in Dallas. “The mission of CRUSADE is to highlight the guidelines such that clinical practice approaches best practice,” Peterson explains.

“Adhering to guidelines is typically associated with better outcomes,” says E. Magnus Ohman, MD, chief of cardiology at the University of North Carolina (UNC) Medical Center in Chapel Hill, an institution that is implementing CRUSADE. “We hope that just by bringing the guidelines to clinicians’ attention, we will elevate quality of care nationwide.”

The early and aggressive treatment of patients with potentially serious chest pain may save thousands of lives each year, Peterson notes. “To improve outcomes, physicians must identify high-risk patients quickly and begin appropriate therapy early in their hospital stay,” he says. “Such care often involves emergency medicine physicians, who may not be aware of the most up-to-date findings in the field of cardiology. Thus, one goal of CRUSADE is to involve emergency medicine physicians and cardiologists in a collaborative effort to educate both groups of physicians about the guidelines.”

Several factors underlie the gap between guideline recommendations and actual adherence. “Maintaining

a familiarity with clinical evidence and associated guidelines is a challenge for clinicians in practice, especially in cardiology, where advancements in the specialty occur relatively rapidly,” Peterson explains. “CRUSADE helps spread knowledge about the best care for patients with chest pain among clinicians who are in a position to provide that care.”

Closing the Gap

A survey last year by researchers at the Duke Clinical Research Institute revealed that only 45% of cardiologists and 15% of emergency medicine physicians at the institution had reviewed the latest ACC/AHA guidelines for treating patients with non-ST segment elevation acute coronary syndromes.

Also, many clinicians do not have data that they could use to compare their own practice patterns with guideline recommendations. “Even if they are knowledgeable about guideline recommendations, many physicians do not really know whether their actual practice mirrors those recommendations,” Peterson observes. “We all think that we deliver the best quality care. Only in light of evidence and feedback about our actual practices do we realize that there is room for improvement.”

Such gaps in care occur even in the most respected institutions. “When we started tracking practice patterns at Duke, we found instances where we could have improved with regard to guideline adherence,” Peterson says. “Of 400 CRUSADE institutions that have provided data to date, each one had room for improvement.

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One goal is to involve emergency medicine physicians and cardiologists in a collaborative effort to educate both groups about the guidelines.

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—Eric Peterson, MD, Duke University Medical Center

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CRUSADE provides physicians with ongoing feedback regarding how their care practices compare to those of their peers within the hospital and in other similar hospitals, and to best practice guideline adherence.”

Improved Outcomes

CRUSADE results counter some of the typical arguments physicians have had against national care guidelines, including the charge that the results of clinical trials cannot be generalized to apply to real practice. “Projects like CRUSADE, which show therapeutic results in real-life clinical practice to be similar to results of clinical trials, go a long way toward countering that argument,” Peterson contends.

Furthermore, some physicians have argued that guidelines are little more than cookbook medicine, saying they need to treat the patient in the office, not follow some national guideline, Peterson notes. “But the fact that patient outcomes are correlated to how closely physicians follow the ACC/AHA guidelines is a strong message that the guidelines are more than cookbook medicine,” he says. “They actually result in better care.”

Finally, the results to date also support the idea that quality can be evaluated with a few process measures. “Physicians may believe that a few measures may not represent the true care quality they deliver to a given patient,” says Peterson. “But the strong correlation between these particular measures and patient outcomes indicates that we can understand which institutions will exhibit the best outcomes if we just look at how well they adhere to the national guidelines.”

As a result, the CRUSADE analysis supports the idea of performance measurement and shows that such measurement can be effective when it is fully supported by physicians and other providers, Peterson explains.

“CRUSADE is a voluntary effort,” Peterson says. “All the participating hospitals have volunteered to submit data and are working internally to improve their quality of care based on the data analyses. Through this effort, the physicians are voluntarily assessing practice patterns and helping to develop systems to improve hospital care for patients who present with a potential heart attack.”

Proven Therapies

For CRUSADE, participants gather data on patients who are admitted with unstable angina or non-ST segment elevation myocardial infarction. Patients who have ST segment elevation myocardial infarction or who are candidates for immediate thrombolytic therapy or primary angioplasty are excluded.

The data are collected using a four-page case report form that outlines various measures of patients’ presenting features and risk factors, the treatments they receive at the hospital, and the treatments they receive or are recommended at discharge. Data on outcomes that occur during the hospital stay include mortality, recurrent heart attack, heart failure, or other problems (such as kidney disease or bleeding).

“The most salient finding of the analysis of CRUSADE data is that there is a significant and continuing gap between what the guidelines have recommended and what occurs in actual practice,” Peterson says.

The researchers also found that the gap between recommendations and actual practice is wider when it involves using newer therapies (such as IIb3 inhibitors or clopidogrel) than it is with more established therapies (such as aspirin or beta blockers).

“Finally, the analysis revealed a strong correlation between hospitals that practice evidence-based care (meaning they adhered most closely to the guidelines) and hospitals with lower overall mortality rates,” says Peterson. “Stated another way, evidence-based practice translates into better outcomes for cardiac patients.”

Analysis of a composite measure including all guideline recommendations revealed that hospitals at which care decisions were consistent with guideline recommendations only 65% of the time or less had an in-hospital mortality rate for patients who were eligible for therapy of approximately 6%. “In comparison, hospitals that were the most adherent to the guidelines (were consistent 80% of the time or more with guideline recommendations) had a mortality rate of only 3.6%,” Peterson says. “This represents almost 40% lower mortality at hospitals that implemented evidence-based care.”

Better implementation of the guidelines would yield better quality of care as well as more cost-effective care. “We noticed an interesting phenomenon: Patients at hospitals that practiced evidence-based care experienced better outcomes and shorter lengths of stay,” Peterson says. “For example, one of the recent ACC/AHA recommendations is that high-risk patients should receive a more aggressive interventional strategy, such as early catheterization and revascularization if neces-

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who adopt good communication strategies with their patients are less likely to be sued for malpractice, even in the event of an adverse outcome.

In 1993, Levinson and colleagues conducted research on the communication patterns of surgeons and primary care doctors. The researchers audiotaped 10 patient visits with each of 125 physicians. Among the physicians under study, half had experienced at least two malpractice claims against them, while the other half had never had a malpractice claim.

"When the tapes were analyzed, we

through their total experience with the doctor," she says. "If patients feel that the doctor listened, truly cared, and gave his or her best, then if things go wrong these patients will be much more forgiving and will not necessarily seek retribution through the malpractice litigation system.

"Doctors tend to overlook the real importance of quality communication from the perspective of patients," Levinson continues. "We have many interactions every day with many different patients. But what is routine to the physician is not

decision to proceed," she notes.

Physicians who bypass the consent discussion are taking an unnecessary risk. The risk grows greater when the consent form is replete with jargon. "Plaintiff's attorneys love to stand in front of juries and read a complicated consent form, and imply that a patient could not understand what he or she was agreeing to," Baker observes.

Physicians might consider an additional line on the form that says, "I have read and understood this form," Baker suggests. "A patient who has signed this additional statement has a

Patients who believe the doctor listened, cared, and gave his or her best will be more forgiving if things go wrong, researchers say.

found that physicians exhibited distinctly different communication patterns depending on their claims history," Levinson says. "The PCPs who had not been sued were more likely to facilitate patient talking, to orient the patients on what would happen in the process of medical care, and to obtain more information from their patients. In addition, their visits were approximately three minutes longer."

Learning to Listen

In more recent research, Levinson collaborated with colleagues at Harvard University to analyze the audiotapes with a method called filtered speech, in which voice tones, but not content, are heard. "In that analysis, we found that the surgeons who had a dominant voice tone were much more likely to be sued," Levinson notes. "The PCPs who had a warm and interested voice tone were less likely to be sued."

One conclusion from this research is that it is important for doctors to recognize that patients do not simply judge them on technical competence, Levinson explains. "Rather, they judge the quality of their care

routine to a patient, who perceives the power and importance of the interaction to be much greater. Physicians should recognize how meaningful these interactions are to their patients."

Informed Consent

One important area for physicians seeking to reduce the likelihood of claims is informed consent. "In reality, what happens between doctors and patients during an informed-consent discussion is quite different from what lawyers would hold up as the standard," says Levinson, noting that informed decisionmaking is much more casual in practice.

The consent discussion should include the nature of the procedure being considered and the risks, benefits, and alternatives (including the alternative of doing nothing), says Susan Keane Baker, a practice management consultant in New Canaan, Conn. Baker is the author of *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients* (San Francisco: Jossey-Bass, 1998). "The competent adult patient should fully realize that it is his or her

more difficult challenge in proving lack of informed consent. However, no matter how simple the form and no matter how many safety nets are created by the form, consent requires a discussion, not just a signature on a form."

Physicians can adopt several communication strategies that will help reduce the likelihood of malpractice claims. "Discussions with patients are important, but with so many patients to see and so little time, physicians can sometimes rush them," says Baker. "The amount of new information that can be absorbed by an individual at any one time varies from person to person."

Risk Reduction

To reinforce what has been said, Baker suggests that physicians consider writing down the steps a patient should take or tape record discussions with patients (with the patient's permission) so that the patient can listen to the conversation later.

In addition, physicians should advise patients to call if their problem worsens or if they are not satisfied with their progress. "Physicians would do well to recognize that a red

Insurer Promotes Education

Given that medical malpractice insurers have so much to gain from preventing claims, many offer consultation and education programs for insured physicians. Physicians' Reciprocal Insurers, in Manhasset, N.Y., for example, says its risk management and education programs are aimed at preventing malpractice suits. As a result of its claims experience, it lists numerous correctable risk factors that form the basis of its effort to teach physicians how to reduce their chances of being sued. The risk management services include the following:

- An in-office consultation for the physician, office administrators, and staff
- Educational seminars
- Results of practice surveys designed to keep physicians abreast of liability issues and developments
- Telephone consultations that allow physicians to consult with risk management and legal experts.

flag is waving whenever a patient returns with the same acute problem," Baker continues. "Physicians shouldn't allow their earlier findings or assumptions to rule their thoughts and actions. Above all, they should demonstrate, by sincere listening, that they are as concerned as the patient is. When in doubt about a patient's prognosis, they should obtain or encourage the patient to obtain a second opinion. A defense lawyer once told me, 'Two wrong opinions are a lot easier to defend than one.'"

Finally, physicians should retain any evidence that the patient considered the physician-patient relationship to be positive or beneficial. "Physicians should make it a practice to include in the chart any correspondence from the patient, especially a note of gratitude or a statement of improved health," Baker says. "That kind of information can demonstrate to a patient's attorney that the physician wasn't, as the patient may have claimed, 'Always a terrible doctor.'"

Adverse Events

Even if an adverse event occurs, the physician can reduce the likelihood of a claim. "The most important risk management strategy that physicians

can use to reduce the likelihood of a claim following an adverse event is to take care of the patient's medical needs first and keep those needs at the focus of every discussion," Baker counsels. "The patient's needs must be the center of every message."

Every patient has three options in a relationship with a physician: exit, voice a concern, or express loyalty. "Exit may feel more comfortable for a patient and a physician, but may result in litigation," Baker notes. "Voicing a concern may mean emotional meetings and difficult questions, but indicates that the patient wants the relationship to continue. The patient is more likely to express loyalty when the physician shows ongoing concern." The last two options can be time-consuming for the physician, but simply being present and listening to a patient can make a significant difference in handling an adverse outcome, she adds.

In the first discussion after an adverse event, physicians should prepare the patient for bad news. To start the discussion by saying, "I'm afraid I have information that isn't good," prepares the patient and shows that the physician is not trying to avoid the topic, Baker explains. Then, the physician can clearly state

the adverse event that occurred.

"To prepare for a postevent meeting, a physician might examine every statement he or she intends to make, and then ask 'why' five times after each statement," Baker says. Taking time before a meeting to go over the conversation will help the physician to identify any gaps in information. "The rehearsal aspect will help the physician appear more confident and authentic during the meeting," Baker says. When physicians don't anticipate a question and struggle to find an answer, they can appear evasive to a patient or family members. Answers to the 'five whys' help ensure that most of the questions that will come up have been thought through."

Avoiding Speculation

Unfortunately, a physician may not have an answer to every question after an adverse event. "In that instance, the physician should discuss what he or she knows to be true and avoid speculating about the rest," Baker advises. "The physician might write down the questions to which there are no answers and talk with the patient or family about the next steps to take to find the answers."

In summary, Baker relates how one surgeon handled adverse events: "A surgeon told me that one of his standard operating procedures when a patient died (whether or not the death was expected) was to say to family members, 'You may have a question later on today, tomorrow, or years from now. If that happens, call me. I will always be happy to hear from you.' For him, this has been an effective way to assure the family of an ongoing relationship. And he would rather hear a question directly from a family member than from a friend of the family who just happens to be a lawyer."

—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).

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sary. Similar to what the randomized trials have shown, the CRUSADE data reveal that institutions that implement these programs also shorten their length of stay."

Most of the therapies recommended by the guidelines have been evaluated individually through clinical trials and were found to be cost effective.

"UNC has contributed data to CRUSADE for a full year," Ohman says. "After six months of data collection, we reviewed our CRUSADE report, identified several areas for improvement, and used the educational tools to implement improvement efforts." Two areas identified for improvement efforts are patient time to EKG and the in-hospital prescription of medications.

Implications for Cardiologists

"The first and most important message to cardiologists is that all of us need to look very closely at our own practice patterns and try to identify areas for and methods of improvement," Peterson says. "These measures matter. Unquestionably, there is a high correlation between adherence to national evidence-based care practices and patient outcomes."

Patients at hospitals that practiced evidence-based care experienced better outcomes and had shorter lengths of stay.

Ohman agrees, adding that physicians tend not to review their own practice patterns regularly. "The CRUSADE program allows us to do that and to pinpoint breakdowns in the system of care that need to change," he says.

Furthermore, cardiologists should foster the development of systems of care to ensure that evidence-based care is delivered in a systematic and standardized manner at their own

institutions, Peterson says. "It is hard to implement guidelines in a standard fashion for every patient," he says. "The more a formal system can help physicians provide standardized care, the better." Such systems might include care pathways, standardized order forms, reminder checklists, or electronic systems.

"Hospitals that constantly examine their practices and implement changes are going to be known as hospitals that care about their patients," Ohman contends. "Hospitals that do not do this are probably going to find that physicians will demand change."

Since many patients with chest pain are treated first in the emergency department, cardiologists and emergency medicine physicians must work together to ensure optimal care, Peterson notes. "In many institutions, that relationship is somewhat dysfunctional," he says. "Different cardiologists have different regimens and practices that they want put in place for patients in the emergency departments. This variation makes it confusing for emergency medicine doctors. Furthermore, there is a certain reluctance on the part of the cardiology profession to allow emer-

gency medicine physicians to initiate appropriate care, and yet there is a long delay before the cardiologist will see the patient. These are challenges that must be overcome."

In general, patients stay longer in emergency departments today than they did in the past mainly because of bed shortages, says Ohman. "Therefore, collaboration between cardiologists and emergency department physicians has become more

important because more cardiac care is being delivered in the emergency department now compared with 10 years ago," he adds.

CRUSADE has helped to foster increased collaboration between emergency medicine physicians and cardiologists, Peterson points out. "We found that simply getting these physicians together to discuss these challenges went a long way toward actually resolving them," he observes. "The physicians saw that improving care for patients with chest pain had to be collaborative and involve the development of standards of care."

Patients Take Notice

It is likely that payers and patients will notice such improvements. "There is a strong movement afoot, spurred partly by interest on the part of payers, to base contracting decisions on quality measures," Peterson notes. "Even the Medicare program has looked into the concept that hospitals that deliver high-quality care ought to be rewarded in some fashion. Whether providers are for or against this concept, it is becoming a reality in the health care industry."

Still, Peterson notes that quality improvements in particular institutions are not likely to change referral patterns over the short term, and across-the-board improvements in quality are needed over the long term. "People having a heart attack are not able to choose which hospital to go to; they just end up at the closest one, regardless of quality," he notes. "Efforts to improve care across all hospitals are needed. Instead of trying to create a few stellar hospitals for heart care, a worthy goal would be to ensure that all hospitals provide better quality care."

—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).

Physicians May Need New Strategies as Reimbursement Falls, Expert Says



Nathan Kaufman is senior vice president for health care strategy at Superior Consultant Co. in San Diego. He consults with health care clients on various projects, including negotiating with payers on behalf of hospitals and physicians, structuring joint ventures, and resolving disputes between doctors and hospitals. Editor in chief Richard L. Reece, MD, discussed the market for physician services with Kaufman.

Q: Would you begin by telling us how many physicians around the country are suffering financially and why this is happening?

A: Yes. Physicians nationwide are not happy, and the reason is that their business model is under severe stress. The malpractice insurance crisis, which has been in the news quite a bit lately, is just one component of that stress.

In general, the mathematical equation that generates professional income is becoming more difficult to solve. In an average practice, expenses are rising by 6% annually while net revenue per patient is increasing by just 3%. The only way that most physicians are addressing this problem is by seeing more patients. However, there is a limit

to the number of patients physicians are able to see, and when they reach that limit their professional income begins to fall.

Medicare rates were cut by 5.4% in 2001, and regardless of what happens to rates this year, the prospects do not look good for the immediate future if physicians do not change their business strategy.

Q: How can physicians change their business strategy to achieve financial success?

A: The bottom line is that medicine is a free-market business, and in a free-market business, the business owners must focus their attention on revenue, expenses, and pricing. If they don't do this, they will go out of business. There are physicians around the country who are paying attention to the dollars, and they are making a fairly good living.

The first thing physicians need to do is to recognize that ultimately increasing patient volume is not going to solve their problems. That is, by seeing more patients they are not necessarily going to improve their income, especially given the state of Medicare reimbursement.

Rather, the most important line item that physicians need to focus on is collected revenue per patient visit. Physicians need to negotiate more strongly with payers so that they can achieve better reimbursement per visit. What's more, they should stop

participating with some payers whose reimbursement rates are too low. In these cases, if the patients want to see the physician, they are going to have to pay more out of pocket to do so.

Q: Do you think patients will be willing to pay more out of pocket to see a particular physician?

A: Yes, in fact, they already are. Nationwide, we are facing a physician shortage in many specialties, and many physician practices have long waiting lists. The basic rule of economics is supply and demand. If the supply is insufficient to meet the demand (which is the case in many specialties), then prices should go up. However, the reimbursement of physician services has actually gone down over the last few years. While physicians cannot affect Medicare pricing—other than by ceasing to treat Medicare patients—they can influence the terms of the contracts they negotiate with commercial payers.

If a physician group that has a high-quality practice and a solid reputation decides to drop some of its poorer paying contracts, the physicians in that group will usually see significant improvements in both their profitability and their lifestyle. The reason is that the patients they do see are generating more revenue per visit. And because the physicians may not be seeing as many patients as they

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“To be successful, a primary care physician must be picky when it comes to the contracts he or she is willing to accept, keep overhead really low, see at least three to four patients an hour, and collect the copayments up front.”

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once did, they have a little more free time. In most markets, including California and other places, we have seen good physicians increase their income by refusing to participate in contracts that are not financially viable for them.

Q: *Are many physicians successful in negotiating reasonable contract terms?*

A: No. Unfortunately, physicians typically are busy focusing on patient care and seeing more patients in order to boost their revenue. Because they have little experience in negotiating contracts, they tend to sign most contracts that come across their desks. As a result, their income is suffering even though they are working harder.

One strategy that I recommend is for physicians to create a spreadsheet that profiles their payers by volume and percentage discount. Then, they should use the data from that spreadsheet to consider terminating contracts with payers that provide low volume and that receive high discounts.

Q: *Some observers believe the future will be more difficult for primary care physicians than it will be for specialists, such as orthopedic surgeons, neurosurgeons, and heart surgeons. What is your opinion?*

A: Primary care physicians have the highest overhead and the lowest revenue per patient visit. Therefore, primary care physicians especially must focus on the pricing in contracts. They should not simply accept the prices offered by payers. Suppose, for example, that Medicare represents 50% of a primary care practices' business; those primary

care physicians should strive to get at least 1.5 to 2 times Medicare reimbursement from a payer that accounts for only 10% of the group's business. That's my rule of thumb.

Again, if the group is recognized as a quality provider and it has high patient demand, one of the ways it may have to achieve that increase in price is by telling its patients, 'Your health plan is unwilling to pay us a fair wage, so we are now not participating in that plan. You can still come to see us but you will have to pay retail rates and ask the health plan to reimburse you.' This step is uncomfortable, but necessary.

The second strategy is to focus on efficiency. Particularly in primary care (such as pediatrics, internal medicine, and family practice), it is essential that the physician see at least three patients an hour. In order to reach this target, the office must run at an incredibly efficient pace. What's more, patients must understand that they are coming in to address a particular problem and that the doctors will not be able to sit and chat.

The third strategy is to ensure that the practice is collecting up front whatever copayments are due. In most physician practices, that \$10 or \$15 copayment will cost more to collect after the patient leaves the office than the actual value of the copayment itself.

In summary, to be successful, a primary care physician must be picky when it comes to the contracts he or she is willing to accept, keep overhead really low, see at least three to four patients an hour, and collect all patient copayments up front.

Q: *Is there any benefit to physicians in promoting ancillary services?*

A: Actually, one of the few areas of relief for some specialists is to own ancillary services, such as surgery centers or imaging services. Owning one of these facilities will help, but many specialties do not have the critical mass to own the ancillaries that they use. Therefore, this option is closed to them.

Q: *Is there any possible relief in the deployment of information systems and related technologies?*

A: No. I do not think that physicians can count on information technology to make a real positive difference in their bottom line. In theory, it can; but in practice I don't think that information technologies will significantly improve the financial situation of physicians in the short term.

Q: *What will be the impact of the Health Insurance Portability and Accountability Act of 1996?*

A: HIPAA is an unfunded mandate. Not only did Medicare cut physician compensation per patient visit, but the act also requires them to spend a whole lot more money keeping their patients' information private. That puts even more stress on the physicians' business model.

Q: *It has been well documented that we are experiencing a shortage of specialists, particularly those who treat Medicare patients. Is it possible that this shortage could create a political crisis?*

A: Yes. In fact, some observers are hoping for a political crisis in Medicare because until there is a crisis, the government is not going to

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“Some observers are hoping for a political crisis in Medicare because until there is a crisis, the government is not going to focus on the fact that Medicare needs to pay physicians more per patient visit.”

focus on the fact that Medicare needs to pay physicians more per patient visit. The only way the government is going to get that message is for more Medicare enrollees to have trouble finding physicians. The leverage that will result in political change lies with Medicare recipients rather than with doctors.

Q: *Some physicians have created subscription services for medical care. How are these working?*

A: Subscription services are emerging to meet patient demand for physicians. Patients pay an annual subscription fee in exchange for access to a physician, who limits his or her practice to subscribers and provides exceptional service and access in return.

The success of such activities is market specific; for example, this model has succeeded in Florida, Boston, Seattle, and Southern California. Even so, this model is kind of a fringe activity that will work for just a few physicians. A fairly high-income population is needed to support the model. But as more physicians will be dropping out of the Medicare program and, by definition, if patients want to see those physicians, they're going to have to pay higher rates.

Currently, the delivery system is being held together by physicians who are accepting low market rates for treating patients. When physicians realize that the demand for their services is in excess of supply, we will see a change in physician behavior.

As I said earlier, the bottom line is that medicine is still a free-market business. If physicians cannot pay their rent, they will go out of business. There is no entity or system to

bail them out. If certain physicians can find a niche or a business model in which they can succeed in this free-market delivery system, more power to them.

Q: *Recently, we wrote about a gastroenterologist who changed his practice in order to focus on colonoscopies. That's his niche. Is this the type of activity that can help physicians become successful?*

A: Yes. That gastroenterologist probably owns his own colonoscopy center, and that business generates about a 40% profit margin. So that gastroenterologist is an entrepreneurial physician who has found a profitable niche in the market and is exploiting that niche. His patients are getting good care, and he is being rewarded for that.

Q: *There is a movement toward specialist-owned specialty hospitals that perform only heart surgery or orthopedic surgery, for example. Is this a successful strategy physicians might pursue?*

A: The performance of these hospitals has actually been spotty. Some of them have done well; some of them have done poorly. Currently, there is a backlash from the general hospitals against these physician-owned hospitals. Let me give you a few examples.

There was recently a case in Louisiana in which a hospital said to the local payer, 'If you include a certain specialist-owned surgery center in your network, then our hospital charges to you, the payer, will go up.' The surgery center took the general hospital to court, and basically the ruling of the Louisiana appellate court was that it is fine for the general hospital to use its leverage to encourage payers to exclude the

specialty hospital from the network.

In Ohio, when a group of orthopedic surgeons was building an orthopedic surgical hospital, the competing general hospital considered terminating the orthopedic surgeons' privileges. The state legislature in Ohio is considering a conflict-of-interest law prohibiting physician ownership of hospitals.

So this is a strategy that is not a sure thing and can lead to a lot of conflict. Specialists may practice more efficiently in specialty hospitals, but local politics and economics may not favor the strategy.

Q: *Can partnerships between hospitals and physicians, particularly specialty physicians, alleviate some of this financial distress?*

A: Yes. For example, many hospitals are willing to participate in a joint venture with local physicians in creating endoscopy, imaging, or surgery centers. Here's another example: Some specialists are now getting paid for services that they once provided for free to the hospital, such as coverage in the emergency department. So there is some incremental income that can come from working with the hospital. But it will not always be easy for physicians to work with their local hospital because anything the hospital pays the physicians is going to represent an expense on its books, and, after all, hospitals are trying to maintain their profitability as well. Still, many hospitals have reasonable CEOs, and physicians can work with them to develop creative strategies that yield positive results for both.

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