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EDITORIAL

Studies Show EMRs Have Promise

Physicians have generally been reluctant to install electronic medical record systems in their office, in part because the cost is prohibitive. But some physicians are getting a significant return on their investment in an EMR.

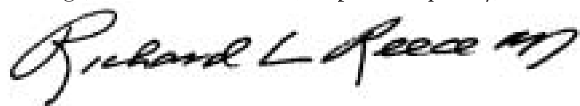
In the first year after it implemented an EMR, the Central Utah Multi-Specialty Clinic, in Provo, had significant savings and increased revenue. Even greater savings came over five years as a result of reducing administrative support staff and cutting dictation costs. CUMC also improved quality and patient care while increasing revenue as a result of improved coding compliance, according to "The Economic Effect of Implementing an EMR in an Outpatient Clinical Setting," an article in the winter issue of the *Journal of Healthcare Information Management*. CUMC, the largest independent multispecialty group in Utah, used the TouchWorks EMR from Allscripts Healthcare Solutions in Libertyville, Ill.

The authors of the article calculated that the practice saved $952,000 in the first year after EMR implementation and $8.2 million over five years. Included in these figures were the savings from having fewer full-time employees in the chart room, saving $61,692 in the first year and $376,634 after five years, and savings on transcriptions costs of $380,000 in the first year and $4.6 million after five years. The group also said that due to improved coding, income rose by $103,059 in the first year and would rise by almost $1.8 million after five years.

Mark Leavitt, MD, PhD, medical director and director of ambulatory care for the Healthcare Information and Management Systems Society, in Chicago, has said that he believes EMRs will spread rapidly in ambulatory care over the next few years for several reasons. Not only is the cost of hardware and software dropping, he says, it is now possible to connect the EMRs in physicians' offices with computers in hospitals and at insurance companies, making the physicians' EMRs more useful and cost-effective. What's more, Leavitt adds, physicians are becoming more computer literate and are thus more likely now to embrace technology than they were in the past.

Physicians are correct to ask about the return on investment they will get from such an expensive purchase, Leavitt says. He notes that physicians in both small and large offices can benefit: Physicians operating in a two- or three-physician office who are still dictating notes and having them transcribed will see a return, he says, while physicians in larger offices will see an even greater return. Leavitt, who once worked in a practice with 150 physicians and 50 medical record specialists, observes: "With the EMR, you don't need those 50 people."

The bottom line is: Transitioning to EMRs may be a costly investment, but—as CUMC has found—that investment provides the potential for significant savings, increased revenue, improved quality, and better patient care.



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Evidence Fosters Guideline Update

Prompted by significant technological advances and a growing body of evidence drawn from clinical trials, a revised guideline for the clinical application of echocardiography has been recently released. The American College of Cardiology (ACC) in Bethesda, Md., the American Heart Association (AHA) in Dallas, and the American Society of Echocardiography (ASE) in Raleigh, N.C., released the new guideline, which was published in the Sept. 3 issue of the *Journal of the American College of Cardiology* and in the Sept. 2 issue of *Circulation*. The new version revises the previous guideline, published in 1997.

"The main goal underlying the development of any guideline is to outline the proper and optimal use of a technique or treatment and designate the circumstances, if any, in which it should not be used based on expert opinion and the most recent and reliable evidence from the literature," says Melvin D. Cheitlin, MD. "The decision to update the echocardiography guideline was based on the fact that since the 1997 guideline was promulgated, there has been an enormous amount of new information in the field of pediatric cardiology and regarding the value of echocardiography, especially in diagnosing and risk stratifying patients with coronary artery disease, heart failure, and valve disease." Cheitlin is professor of medicine emeritus at the University of California, San Francisco, and chairman of the committee that revised the guidelines.

Extensive Revisions

As a result of this research, some of the tentative recommendations in the 1997 guideline are now more firmly supported by evidence. "Furthermore, technological advancement has meant that we have seen the development of special techniques that have improved imaging and therefore have enhanced the value of echocardiography as a diagnostic tool," Cheitlin points out.

The guideline committee reviewed more than 1,000 new research references over two years. Extensive revisions to the earlier guideline were made in numerous sections, including those on valve disease, ischemic heart disease, congestive heart failure, cardiomyopathy, assessment of left ventricular function, appropriate use of echocardiography as a screening tool, and echocardiography in pediatric cardiovascular patients and in critically ill patients.

Since the 1997 guideline was promulgated, there has been an enormous amount of new information in pediatric cardiology and on the value of echocardiography, especially in diagnosing and risk stratifying patients with coronary artery disease, heart failure, and valve disease, says Melvin Cheitlin, MD, of UCSF.

Diagnostic Value

Unquestionably, echocardiography is an important tool for cardiologists in managing patients, Cheitlin says. "Until echocardiography was developed, the diagnostic imaging tools that were used to look at heart and heart function were pretty basic," he observes. "X-rays and electrocardiograms became available in the beginning of the 1900s and, for many years, represented the two most common noninvasive methods for looking at cardiac anatomy, pathology, and function."

When two-dimensional echocardiography became available in the late 1960s, it became possible to look at the structure and anatomy of the heart to detect pathology that previously could not be seen.

"Next, the development of Doppler echocardiography meant that many of the functional properties of cardiac action could now be measured," Cheitlin says.

"Doppler echocardiography makes it possible to get pathologic, anatomic, and functional information," Cheitlin explains. "As a result, many patients—particularly those with valve disease or congenital heart disease—do not need to go through catheterization before surgery. Overall, echocardiography has probably been the most important advance in cardiology diagnosis in the last century because it provides anatomic, pathologic, and functional data; is noninvasive; and almost universally available."

In fact, echocardiography is useful in practically every disease problem that involves the heart, Cheitlin says. "The test is useful in people who have heart failure, because it can help define the function of the heart," he says. "Echocardiography can even help define the etiology of the heart failure. For example, it may

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reveal that aortic stenosis is the reason the patient has heart failure." Similarly, the test is helpful in the diagnosis and management of valve disease and all varieties of congenital heart disease.

Guideline Update

The guideline update includes changes in the recommendations for the use of echocardiography during stress or exercise testing. "We now have much more evidence demonstrating the sensitivity, specificity, and accuracy of stress echocardiography in detecting myocardial ischemia, evaluating ischemic heart disease, and determining the presence of viable myocardium after myocardial infarct," Cheitlin says. "At the time the 1997 guidelines were promulgated, the medical community had more experience with myocardial perfusion than with echocardiography in these areas. Numerous nuclear myocardial perfusion studies showed the value of that procedure, while the amount of evidence supporting echocardiography was not as great at the time. Now, because the strength of evidence is much greater, stress echocardiography was moved up to a Class I level." (See sidebar.)

Another major area addressed in the guideline update is the use of echocardiography when evaluating patients with heart failure, especially regarding diastolic function of the heart. "Systolic dysfunction has always been considered a hallmark of heart failure," Cheitlin explains. "But in the last 15 years, we have recognized that the major problem of many patients with heart failure concerns the heart's ability to relax (diastolic function) rather than contract (systolic function). Echocardiography has been proven to be very useful in identifying diastolic dysfunction."

Also new in the update is a section concerning the use of intraoperative transesophageal echocardiography (TEE). "The earlier guideline for the use of TEE during surgery was promulgated by the American Society of Anesthesiologists and the Society of Cardiovascular Anesthesiologists," Cheitlin says. "With their permission and with a member of both societies, Daniel M. Thys, MD, on our guideline committee, we received permission to include an update on the usefulness of intraoperative TEE."

The update also covers the appropriate use of echocardiography as a screening tool. "Using echocardiography as a screening tool is appropriate in patients who may not have a manifest problem but whose close relations have a known condition that has a genetic foundation," states Cheitlin.

One example of such a condition is Marfan's disease, a hereditary condition of the connective tissue, complications of which are aneurysms of the aorta and myxomatous mitral valves. "If a member of a family has Marfan's disease, then screening close relatives to look for changes in their aorta or in their mitral valves might be helpful in detecting the disease," Cheitlin states.

Another condition for which screening might be helpful is hypertrophic cardiomyopathy. "Individuals may have this disease, be completely asymptomatic, and then die suddenly while playing sports," Cheitlin says. "When cardiologists have patients with hypertrophic cardiomyopathy, it is recommended that the first-degree relatives be screened for the disease, including the use of echocardiography."

While echocardiography is a valued diagnostic tool for all heart patients who might otherwise need an invasive procedure to facilitate diagnosis, it is especially useful for patients who are elderly or critically ill, because an invasive procedure can be much more dangerous for these patients. "Elderly and critically ill patients have a slightly higher complication rate from invasive procedures, but obviously getting the information noninvasively is better than having to do an invasive procedure on anyone," notes Cheitlin.

Caution Against Overuse

The guideline is designed to help define the indications and conditions in which echocardiography should be used. But just as important, emphasizes Cheitlin, is knowing when not to use it. "As a noninvasive technique that poses no danger to patients, echocardiography obviously can be used inappropriately at any time and as many times as a physician wishes it to be used," he says. "The problem is that it can be overused."

Overuse of echocardiography is associated with two main problems: high cost and poor quality of care. "As with all diagnostic tests, echocardiography does cost money," Cheitlin says. "Medical resources used for echocardiography cannot be used to pursue other options for care. Consequently, using the technique

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System Indicates Degree of Usefulness

The intent of the ACC/AHA/ASE 2003 Guideline Update for the Clinical Application of Echocardiography is to define broadly how the technique can be useful, while pointing out where it is not useful or even harmful, says Melvin Cheitlin, MD, the chairman of the guideline committee.

The update outlines the indications for echocardiography use in three categories:

- Class I: Conditions for which there is evidence and/or general agreement that a given procedure or treatment is useful and effective.
- Class II: Conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment. Class IIa is designated when the weight of evidence or opinion is weighted in favor of usefulness/efficacy, while Class IIb is designated when usefulness/efficacy is less well established by evidence or opinion.
- Class III: Conditions for which there is evidence and/or general agreement that the procedure or treatment is useful/effective and in some cases may be harmful. A designation of Class III indicates a contraindication to the use of the test.

As noted in the guideline update, the classification of the clinical usefulness of a diagnostic test such as echocardiography is much more difficult than classifying the usefulness of a therapeutic intervention, because a diagnostic test can never have such a direct effect on patient outcomes. Nevertheless, the classification system used in the echocardiography guidelines follows that used in other ACC/AHA guidelines, and is generally considered to be an acceptable scale for evaluating usefulness and effectiveness.

"The guidelines were designed to broadly assess the usefulness and effectiveness of echocardiography as indicated by studies and the agreement of experts in each clinical area covered," Cheitlin says. "Still, every individual patient is different. No guideline can take every specific individual circumstance into account. Cardiologists consider all individual circumstances when treating a patient. Therefore, there may be instances when some clinical action is taken outside of the guidelines for good reason."

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when it is not medically necessary is, quite simply, a waste of health care resources."

Second, echocardiography can show details of anatomy and reveal findings that could lead to inappropriate diagnostic tests and even unnecessary therapy. "Cardiologists must be aware that echocardiography may reveal findings that they might not be able to interpret or that might be easily misinterpreted," Cheitlin cautions. "As a result, a physician can start a patient down a road of diagnosis that can lead to more tests and even invasive procedures that are completely unnecessary. If that happens, the patient can ultimately be harmed."

For example, an echocardiogram can reveal a patent foramen ovale, a small opening connecting the two upper chambers of the heart, which is caused when the normal opening in the atrial septum in the fetus fails to close after birth. This condition is present in 10% to 20% of humans, but has no clinical significance in a vast majority of those individuals, says Cheitlin. "If a cardiologist finds patent foramen ovali in a patient who has never had any symptoms of the condition, acting on that finding—such as performing an operation to close the connection, or putting in a device to close the connection—is the wrong thing to do," he notes.

Certainly, because of the cost and quality considerations, widespread screening is the wrong use for echocardiography. "For example, it is not useful or cost-effective to perform echocardiography on every person who is going to play competitive sports, with a view toward reducing mortality from hypertrophic cardiomyopathy," Cheitlin says. "This possibility was studied in several large series in the literature and revealed no one with whom competitive sports were contraindicated. We would have to screen thousands of people before picking up one case of hypertrophic cardiomyopathy."

In closing, Cheitlin explains that using the technique when there is no real reason to do so—meaning the individual has no complaints, there are no physical findings, and the test is simply used as a screening tool fishing for trouble—would waste resources. "As with any diagnostic test, echocardiography should be used only when there is a real indication for its use or there is a question about the heart's function, anatomy, or pathology that needs an answer," he adds.

—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).

Act May Help Rural Doctors Succeed

One little-noticed provision in the Medicare Prescription Drug Improvement and Modernization Act calls for health savings accounts. Some observers believe that HSAs could make practicing in rural settings more rewarding for physicians.

HSAs are tax-free accounts designed to help individuals, spouses, and dependents pay for qualified health expenses. An individual covered by a high-deductible health plan could make a tax-deductible contribution to an HSA and then use the funds in the HSA to pay for out-of-pocket medical expenses, such as prescription drugs and physician office visits. HSAs are designed to help more American families get the health care they need at a price they can afford, the government says.

Primary Threats

The HSA provisions in the new Medicare act may be a welcome remedy to primary care physicians, who believe the primary care system in the United States needs to be overhauled. "The family doctor is going to die out if we do not change the reimbursement mechanism in the health care system," says Donald Copeland, MD. "Family physicians provide important, basic primary care. For example, pediatricians do a lot of primary care for children, and many internists provide this type of care for adults. In rural regions of the country, where there may not be other doctors or subspecialists, it is the family doctor who forms the framework for care in these communities." Copeland, a primary care physician who once practiced in rural North Carolina, now works for the state's health department in Lincolnton.

Jonathan Showstack, PhD, a professor of medicine and health policy at the University of California at San Francisco, agrees with Copeland's assessment of the problem. "If we don't reconstruct the way primary care is provided in this country, we will inevitably face a costly medical, financial, and human crisis," he says. "Primary care is a core component of nearly all modern health care systems in the world, except in the United States." Last year, Showstack was the lead author of a research report in *The Annals of Internal Medicine*, which calls for a national effort to reform primary care to encompass care for an aging, diverse, and chronically ill population.

Quality Component

Primary care is a vital component of high-quality health care, the report says. Its strengths derive from its continuous relationship with patients, its broad perspective, and its flexibility and adaptability, according to the report. Yet, there are new and substantial threats to primary care.

While patients value primary care, a number of organizational and financial pressures make it difficult for physicians to deliver such care, says Steven A. Schroeder, MD, UCSF distinguished professor of health and health care and a co-author of the report. As a result, patients are increasingly dissatisfied with their relationships with primary care physicians, says Schroeder and other researchers who worked on the report. Access to primary care services is becoming much more difficult, even for those with insurance, and PCPs are finding it more difficult to respond to patients' needs for accessible, comprehensive care, they say.

Managed Care Criticized

Managed care systems damaged the relationship between patients and PCPs by making gatekeepers of many primary care doctors, thus tarnishing their image among patients, Showstack explains. "Primary care providers are viewed by many patients as barriers to specialized care, rather than as trusted partners and advocates who guide patients through their care," he says.

Moreover, primary care has failed to attract new physicians as medical specialties have, the researchers say. "Primary care must be able to justify its place in a system where specialist physicians, nurses, and other providers are increasingly providing principal care and where patients often choose to go to nontraditional settings for

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—Jonathan Showstack, PhD, University of California at San Francisco

HSAs: How They Work

Health savings accounts are a significant improvement over previous savings accounts, the federal government says. Medical savings accounts, for example, were limited to employees of small businesses and the self-employed, and compared with HSAs they required health insurance policies with much higher deductibles.

HSAs are available to any individual under age 65 who is covered by a high-deductible health insurance plan. The annual deductible must be at least $1,000 for individual coverage, and at least $2,000 for family coverage. Individuals with existing MSAs can roll the amounts into a new HSA. Contributions to HSAs by individuals are deductible, even if the taxpayer does not itemize, according to the U.S. Department of the Treasury.

For self-only policies, a qualified health plan must have an annual minimum deductible of $1,000 and a $5,000 cap on out-of-pocket expenses. For family policies, a qualified health plan must have an annual minimum deductible of $2,000 and a $10,000 cap on out-of-pocket expenses.

Preventive care services, as well as coverage for accidents, disability, dental care, vision care, and long-term care, are not subject to the deductible, the government says.

Individual owners of HSAs may contribute as much as 100% of the health plan deductible up to a maximum annual contribution of $2,600 for self-only policies and $5,150 for family policies.

Contributions, which may be made by individuals, family members, and employers, are tax deductible, even if the account beneficiary does not itemize deductions on his or her Form 1040, the government says. Employer contributions are made on a pretax basis and are not taxable to the employee. What's more, employers can offer HSAs through a cafeteria plan. Investment earnings accrue tax-free.

HSAs allow individuals to take distributions that are tax-free if the distribution is used to pay for qualified medical expenses, the government says. Qualified expenses include prescription drugs, certain long-term care services, long-term care insurance, medical services, medical products, over-the-counter drugs, and health insurance premiums if the HSA owner is unemployed.

Distributions made for any other purpose are subject to income tax and a 10% penalty, the government says. The 10% penalty is waived in the case of death or disability. If the individual who owns the HSA dies, ownership can be transferred to a spouse tax-free.

In an effort to make health care more affordable to more of the 43.6 million uninsured Americans, the House Republicans introduced a bill in March that would allow those who participate in HSAs to fully deduct the health insurance premiums from their taxes. The bill would cost an estimated $24 billion over 10 years. —JB

their care," Showstack says.

For these and other reasons, Copeland believes HSAs may help to reestablish the doctor-patient relationship damaged by the intrusiveness of managed care, especially in rural areas. Farmers and employees who work for small business owners do not usually have access to employer-sponsored health plans offered through large companies, Copeland notes. But if groups of small business owners, such as chambers of commerce, can offer a major medical policy with a high deductible to members, then HSAs will allow individuals and families to cover costs below the deductible amount, he explains.

Changes Revealed

The Medicare act made many significant changes, but two were designed to help physicians in rural settings. One provision eliminated the 1.6% cut in Medicare fees that was scheduled to go into effect on Jan. 1. Even better is that physicians who were scheduled to get a cut of 4.5% in Medicare payments this year and next will instead receive a 1.5% increase in 2004 and 2005. By eliminating the cuts, physicians in rural areas will be paid at about the national average rate, observers say. Although an increase is better than a cut, Copeland says the increase is not enough: "In general, the increase does not add up to a whole lot," he notes. "Medicare is already about half of what it ought to be."

That may be so, but another way the act aims to help attract physicians to rural and underserved areas is by giving physicians a 5% bonus for providing care in these regions. The Centers for Medicare & Medicaid will calculate the ratios of primary care and specialty care physicians to Medicare beneficiaries in each county, and physicians providing care to beneficiaries in counties that fall in the bottom 20% of these ratios will qualify for the bonus, according to published reports. To qualify for the bonus, physicians will not necessarily need to locate their practice to those counties in order to provide

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7 Primary Care Principles

The researchers at the University of California at San Francisco who conducted the research for a report in *The Annals of Internal Medicine* last year identified seven principles that can be used for the reconstruction of primary care and the health care system. In the report, the researchers called for a national effort to reform primary care to care for an aging, diverse, and chronically ill population as follows:

1. Health care must be organized to serve the needs of patients. Much of the current organization of medical care is structured to accommodate incentives in the reimbursement system and the preferences of providers, often with patients' needs included only as an afterthought.
2. The goal of primary care systems should be to deliver the highest quality care as documented by measurable outcomes. The definition of quality should be based on definable outcomes. Doing so will require research to establish appropriate indicators of primary care quality and to identify, collect, and evaluate relevant information.
3. Information and information systems are the backbone of the primary care process. Today's health care information systems were designed primarily in response to administrative needs, and reimbursement was at the top of the list. These systems rarely collect information that allows providers to manage a patient's needs over time or to assess the effects of care on patient health. Specifically, medical records should remain with the patient and be interactive for patients and providers alike.
4. Current health care systems must be reconstructed. The American health care system is a complex and fragmented set of providers, facilities, and services that have been created based on requirements for reimbursement and the needs of providers. The system should be participant controlled, outcomes oriented, structured to address the needs of the population, and focused on the ongoing relationship between a patient and primary care provider.
5. The health care financing system must support excellent primary care practice. At a minimum, such changes must include adequate reimbursement for primary care services such as performing a history and physical, counseling patients about their health, and being an advocate to guide patients through the health system.
6. Primary care education must be revitalized so that there is an emphasis on new delivery models and training in sites that deliver excellent primary care. Clinical training should occur in settings that provide high quality, continuous, patient-centered, outcomes-oriented, team-based care.
7. The value of primary care practice must be continually improved, documented, and communicated. There must be a concerted, national effort to redesign, implement, and evaluate new forms of primary care delivery.

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services, rather they can simply hold a clinic in a qualifying county for two afternoons per week, for example.

Regaining Control

Many managed care plans have a gatekeeper provision, which infringes on the doctor-patient relationship, Copeland believes. "We've got to get back to the personal physician who treats each individual, and that's where HSAs will help," he says.

When a patient is using his or her own money to pay for health care, as a patient would with an HSA, the patient can choose the best doctor. "That way, we can get the managed care people out of the picture," Copeland argues. "If patients can control their dollar, they can then decide if their physician is charging an adequate amount for the services they provide. If they don't like it, they can find another doctor." What's more, when patients pay for health care out of their own pockets, physicians benefit because receiving cash payments lowers their overhead. "You need to have one person to collect the payment," Copeland says, "not six people who are there to argue with insurance companies."

Cash Benefits

Another benefit of patients paying with cash is that physicians seeking to establish their practices can do so without first having to negotiate contracts with managed care companies, Copeland adds. "Today, in order to get established, a doctor has to have a certain number of contracts," Copeland explains, "and many don't know how to do that. With HSAs, a doctor can put a shingle up and get started."

Eliminating the middleman in this way forces patients and physicians to communicate, Copeland believes. "It will reestablish the doctor-patient relationship," he says. "That's the main thing. Doctors will communicate with their patients because if they don't, those patients will go elsewhere."

—Reported and written by editor Joseph Burns. More information on physician practice strategies is available on our Web site (see page 16).

Will New Rules Improve the System?

By Richard L. Reece, MD

Consumer-driven health care and health savings accounts (HSAs) are market-driven solutions to some of the problems inherent in the current health system. With consumer-directed plans and HSAs, informed consumers use their own money and choose hospitals, health plans, and physicians based on quality and value. In theory, these two strategies will help to control costs and allow consumers more choice as well. But not everyone agrees with the theorists.

Critics contend that these two programs will attract disproportionate numbers of healthy and wealthy individuals, and by doing so will fragment the risk pool and drive up health care costs for the sick and the poor. Proponents say these programs will help to improve health care quality and control costs. HSAs were added to the Medicare Prescription Drug Improvement and Modernization Act of 2003 in an effort to gain support for the legislation among conservatives in Congress, according to *The New York Times*.

Starting a Revolt

Those who support HSAs believe they will help foster a consumer revolution in health care, according to U.S. Rep. Paul D. Ryan (R-Wis.). Ryan contends that HSAs will get people shopping for health care using their own money, unlike the situation now, when many people don't care about treatment costs because their insurance is paying for it.

Writing in *The Wall Street Journal*, Martin Feldstein, a professor of economics at Harvard University, says, "The health savings accounts may well be the most important piece of legislation of 2003. The new tax and insurance rules have the potential to transform health care finances, bringing costs under control and making health care reflect what patients and their doctors really want."

Among those who oppose these programs is a group of doctors in Chicago called Physicians for a National Health Program. PNHP is a nonprofit organization of physicians, medical students, and other health care professionals that supports a national single-payer health insurance program for all Americans. When it learned of the HSA provisions in the Medicare bill, it told its members to seek to repeal the act.

PNHP co-founder Quentin Young, MD, an internist in private practice in Chicago, says the HSA provision will attract the wealthy and healthy into what he calls tax-free schemes. "HSAs will seriously undermine the insurance risk pool for all of us," he argues. "Risk-pooling is the source of strength, prudence, and effectiveness of national health insurance. The enemies of universal coverage understand this and thus have inserted this poison pill into Medicare 'reform.' "

The HSA provisions in the Medicare act allow any individual with a high-deductible health plan to set aside income on a pretax basis to pay for health insurance and related health costs, such as prescription and over-the-counter medications. Any individual under age 65 can establish an HSA if he or she has a health plan with a minimum deductible of $1,000. For family coverage, the minimum deductible is $2,000.

It is too early to know whether and what effect HSAs and consumer-driven health plans will have on the health system, since unambiguous evidence of the effects of government programs takes decades to accumulate.

Early Stages

In fact, consumer-directed plans and HSAs are still rudimentary and have yet to be tested in rigorous trials against HMOs, PPOs, or fee-for-service models of care. PNHP believes that if HSAs are used in large numbers nationwide, changing to any other system of care (such a single-payer system) would be almost impossible because too many Americans would already be enrolled in a working health insurance program. Critics of the current employer-sponsored health system believe it has failed because more than 43 million Americans cannot afford health insurance of any kind. In March, a group of Republicans in the U.S. House of Representatives introduced a bill to allow individuals who participate in HSAs to deduct health insurance premiums from their taxes, according to *CongressDaily*. Eric Cantor (R-Va.)

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"The new tax and insurance rules have the potential to transform health care finances, bringing costs under control and making health care reflect what patients and their doctors really want."

—Martin Feldstein, Harvard University

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and Sam Johnson (R-Texas) said their bill would cost an estimated $24 billion over 10 years and would help to make health insurance more affordable for the uninsured.

"HSAs are going to be very powerful," predicts John Goodman, president of the conservative National Center for Policy Analysis, in Dallas. "The HSA is by far the most flexible health savings account widely available to people. And insurance companies and insurance agents report that there is significant interest in it."

Meanwhile, physicians should explain these options to patients, Goodman believes. "Physicians should play an educational role," he comments. "Doctors should be agents of the patient, helping patients make medical as well as economic decisions. That's a new role for doctors.

"When insurance companies pay the bills, the patient is never sure what the price is going to be," Goodman continues. "But in the market for cosmetic surgery, where insurers do not pay the bills, the patients know about price upfront. In the 1990s, the real price of cosmetic surgery went down, while health care costs generally were rising. Something similar is going to happen in other areas of medicine."

Health care costs will not come down if the widely held belief among paternalistic health policy makers is true that consumers aren't smart enough to make their own health care decisions. Fortunately, others believe consumers are smart enough to affect the market positively.

"Consumers are very smart, and they will make better decisions than those who would act for them would make," comments Regina Herzlinger, a business professor at Harvard and author of *Consumer-Driven Health Care* (Jossey Bass, San Francisco, 2004). "I would say nobody at the top is smart enough to know everything that goes on at the market level."

The Business Perspective

Some skeptics are concerned about the risks involved in turning from government control and managed care regulations to letting consumers control health care inflation, which is now running 6.5 times the general rate of inflation and 4.5 times the rate of increase in workers' annual salaries. Herzlinger addresses these concerns by predicting that consumer-driven health care will ultimately correct health care inflation.

"The reason is quite simple," she argues. "Consumer-driven care will bring about prudent consumer spending and increased productivity. Why do you think health care inflation is so high while the rest of the economy has such a low inflation rate? The answer is higher productivity in the nonhealth care sector. We must bring higher productivity to the health care sector, and that will come from the bottom up, from consumers acting in their own best interest and providers responding."

Even if consumers succeed in bringing costs down, some critics suggest that they might end up establishing a consumer-supplier relationship that results in depersonalizing medicine. "On the contrary," Herzlinger contends. "Consumer-driven health care will personalize, deepen, and enrich the relationship. Focused factories will help the relationship too. In focused factories, teams of physicians and other health care professionals specialize in treating patients with one disease, thereby enhancing quality, value, and productivity. And the decentralization of medicine into facilities outside centralized hospitals will help attract consumers as well." In her 1997 book, *Market-Driven Health Care* (Addison-Wesley: Reading, Mass.), Herzlinger explained why focused factories would grow in popularity.

For physicians, too, a consumer-driven market will be advantageous, Herzlinger believes. "Doctors will be the sources of virtually all the productivity gains in response to their patients' needs in consumer-driven health care," she explains. "Right now, doctors have become too dependent on insurers. In a consumer-driven system, doctors would have to operate on the basis of fixed fees that they themselves set. In any industry, there has to be a high level of trust between the supplier and consumer of services. Fixed, predictable fees will help enforce that trust. Also doctors are going to have to be more accountable for their performance. The system has to more transparent, with a freer flow of information. Consumer-driven health care will strengthen rather than weaken the doctor-patient relationship."

—Reported and written by Editor in chief Richard L. Reece, MD. More information on physician practice strategies is available on our Web site (see page 16).

"In the market for cosmetic surgery, where insurers do not pay the bills, the patients know about price upfront. In the 1990s, the real price of cosmetic surgery went down, while health care costs generally were rising. Something similar is going to happen in other areas of medicine." ***—John Goodman, National Center for Policy Analysis***

Strategies Needed to Retain Physicians

By *Joseph M. Mack, MPA*

Many physicians, dissatisfied with the practice of medicine, are seeking new ways to make a living in health care or in other fields. But when physicians leave the practice of medicine, particularly as patients age and require more services, all sectors of the health care system suffer.

In fact, this exodus of doctors from the medical profession puts physician groups and other health care organizations that want to retain doctors in a difficult dilemma: how to keep as many physicians satisfied and productive in the organization while also containing the cost of delivering care. While this dilemma may be difficult to address, there are strategies to help these organizations keep physicians on staff.

Misused Information

In today's information society, data are increasingly being used as a club against physicians. Gathering data and creating *information* that physicians can use to improve their practices qualitatively and economically will improve the environment in which physicians work. If this strategy is pursued as a collaborative effort with hospitals and insurance companies, it has more likelihood of success.

Moreover, implementing various technologies—such as Internet-based application service provider (ASP) solutions to gather data that improve the clinical and financial performance of various health care organizations—will improve efficiencies, decrease administrative costs, free up physician time, and improve the overall quality of life for physicians. The key is not how much data an organization has that physicians must review, but rather how to transform information to improve efficiencies and optimize qualitative economical performance.

As reported in the January *Group Practice Journal*, "Enhanced information in the hands of the right personnel, at the right time improves efficiency and creates additional capital for medical groups to fund their strategic and operational priorities."

ASPs can provide information that improves efficiencies so that physicians can spend more time practicing medicine.

The article, "ASP Solutions Empower Process Improvement to Unlock and Increase Medical Group Capital," explains that ASP vendors manage the hardware and software used to store data and manage information. As a result, medical groups need not replace their systems or buy new ones. ASP implementation fees average $3,000 to $5,000 per month, or about 1.5 to 2.0 full-time-equivalent staff per year, including implementation, support staff, and training, the article says.

Information systems like these can provide decision support and improve efficiencies so that physicians spend more time practicing medicine and less time seeking ways to comply with various and competing regulations from state and federal governments and private organizations. What's more, delivering the right information at the right time to the right parties improves processes throughout the health care delivery system.

Empowering Physicians

Hospitals, HMOs, and medical groups can use Internet-based ASP solutions to generate information from multiple sources. That information can then be used to provide reports that empower physicians with the data and tools they need to improve qualitative outcomes, administrative efficiencies, and economic performance.

For this strategy to work, physicians must partner with these organizations in producing and analyzing information, since it is physicians who write the orders and prescriptions that drive health care resource consumption. Physician organizations should utilize resources such as ASPs to gather the information that they deem critical in accomplishing their two most important objectives: improving quality and increasing capital. Responding to each new request for reports from various external constituencies exacerbates the workload on physicians while creating inefficiencies and frustration.

By focusing on what is critical to their own survival, physicians can achieve their missions and respond appropriately, since they will have already compiled information for use within their own practices.

Moreover, hospitals, HMOS, and other organizations external to physician practices need to recognize that physicians must first meet their own objectives. Then, these organizations should facilitate the use of decision-support tools, such as Internet-based

(Continued on page 12)

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ASPs, which would thereby assist physicians in gathering data from disparate sources.

Taken together, these efforts should improve the efficiency of administrative and operational tasks, as well as improve communication, free up physician time to practice medicine, and generate revenue. All of these efforts should help to stabilize or increase physician income. Only through collaborative use of information with physicians will the projected trend of more mature physicians retiring be minimized.

In fact, a recent survey showed that compared with older physicians, younger physicians have a more corporate mentality to the practice of medicine, viewing themselves more as "9 to 5" employees. Unfortunately, the health delivery system can ill afford to lose those older physicians. Because of their experience with the art of medicine, older physicians are often more efficient in delivering care than their younger counterparts are. Consequently, the loss of more seasoned professionals negatively affects the mentoring occurring between older and younger physicians.

Capital Needs

One of the most pressing issues affecting physicians relates to capital. They need funding to make improvements in processes, technology, operations, and income generation. As physicians learn more about how to deliver care and as more technology becomes available, many physicians are interested in upgrading the equipment and processes in their offices that help them deliver quality care. In particular, they are seeking access to computer technology they can use at the point of care. For many businesses, access to capital, particularly cash from operations and not from loans, can solve many problems, and physician practices are no different than most businesses in a slow—but rebounding—economy.

Among the benefits of physicians using ASP solutions is increased capital. Improved capital will enable them to save money for retirement, if they so choose or to continue to practice the art of medicine in the altruistic way, which is the reason that physicians enter medicine.

The Consumer's Role

Today, as many health plans and employers support efforts to make consumers more sophisticated users of the health care system, payers, employers, and patients are demanding that physicians prove the value of their services and provide data on the quality and cost of providing care. Increasing numbers of patients now present at doctors' office with printouts from Web sites that describe their symptoms, or offer other information on their self-diagnoses and treatment plans. These patients then want physicians to perform the treatment, regardless of its efficacy or cost.

This rise in consumerism also has led to many Internet-based companies and other organizations to rank physicians and other providers. These organizations use proprietary algorithms to enable them to compare physicians across service areas, and allegedly to put the data on a level playing field. Unfortunately, there are no standards for creating the algorithms; consequently, these rankings are often invalid, meaning consumers should not rely on them when selecting or evaluating physicians.

Yet consumers, employers, payers, and hospitals are using these rankings, which makes the practice of medicine less rewarding than it once was. At the same time, physicians are facing increased requirements for compliance with various policies and procedures, forcing them to work more hours, yet they are getting paid less than they were in the past.

One way physicians can improve the satisfaction they get from practicing medicine is to take control of the information they have in their own practices to illustrate the value of their diagnoses, treatment, and experience. They can do so by using relatively low-cost Internet-based ASP systems. These systems enable physicians to gather and compile information quickly and easily, allowing them to tell their story if an external organization uses the same information in a skewed manner against them.

Hospital Strategies

For hospitals seeking to retain physicians, one of the first steps they can take is to improve the ingress and egress of physicians. In fact, the ease in which physicians can enter and practice within the hospital is vitally important given their increasingly busy outpatient practices. For example, a central location would be ideal for all physicians seeking access to patient charts, dictation, and reports. Also, hospitals should assist physicians with compliance issues demanded of them by the government and private payers.

When providing information to physicians, hospitals should do so in a collaborative, rather than punitive, manner. As hospital margins have declined, many hospitals present information as evidence of untoward practice or treatment patterns. Moreover, much of the data used are oriented either financially or clinically. Hospitals need to blend both, while at the same time recognizing that the best quality medicine

Hospitals, HMOs, and medical groups can use Internet-based ASP solutions to generate information from multiple sources.

is the most cost-effective overall. And, there needs to be increased collaboration among physicians and hospitals in the capture, use, and reporting of information that affects physicians.

Hospitals are one of the most central points for capturing data, yet good information is difficult to access. For example, a hospital where I once served as a vice president had four servers on which 65 different computer programs were housed. Each program captured specific information, yet none of the programs integrated their data with each other. The result was that we had to manually gather data to produce useful information.

Therefore, hospitals could benefit from the use of Internet-based ASP solutions that pull data from disparate systems and compile and report information that is useful, illuminating, and collaborative. Information such as how physicians can improve the qualitative outcomes of their practice would emerge and increase physician perception that hospitals are working with them, and not against them.

Health Plan Steps

For health plans, there are a number of steps they can take to improve relations with physicians. First and foremost, they should increase the efficiency of their claims-payment processes. Much of the drain on the time physicians and their staff spend each day can be attributed to having to match the payments received from payers to what was billed. Then, when discrepancies are uncovered or there is a question about a payment, a staff member or the physician must seek an explanation from the health plan's claims department, which can be a time-consuming and frustrating way to spend time that could be devoted to patient care.

Also, health plans can work with physicians to collaborate on information that is necessary and reasonable to improve performance. Currently, many payers have different and conflicting requirements for compliance with preadmissions, second opinions, concurrent review, and various other issues for which physicians must submit data. All these actions, exacerbated when physicians participate in several health plans at once, increase the administrative burden that physicians face in participating in managed care.

Health plans should follow the lead of organizations such as the California Association of Physician Groups in Los Angeles (at www.capg.org). CAPG lobbies and negotiates with employers and HMOs in California on behalf of their member physician organizations to identify a few critical programs for which data are required to be submitted. Representing more than 122 medical groups, independent practice associations, and other physician organizations in California, CAPG assists its physician members in developing ways to approach and implement the data requests. By doing so, physicians do not feel as if health plans are singling out one from the others nor are they being divided and conquered as many physicians believe.

Fostering Collaboration

As with hospitals, health plans should collaborate with their affiliated and employed physicians to develop the information necessary to illustrate the efficacy and quality of care that physicians provide to health plan members. Studies by the Kaiser Family Foundation in Menlo Park, Calif., show that patients seek care largely based on word of mouth, and principally through assessing which physician delivers the highest quality care.

Yet much of the current health plan marketing information is directed toward employers and consumers and includes only the plans' in-network physicians and hospitals. Instead, health plans could form partnerships with the physicians and hospitals in their networks that exemplify the highest quality and most cost-effective providers. Moreover, they do little or no work with physicians or hospitals that are not among the high scorers on their rating systems to provide them with remedial assistance to improve their scores. The information is often used punitively during contract negotiations or when terminating a provider's contract.

Health plans and insurance companies would do well to include physicians in their marketing, and to improve any qualitative insufficiencies they or the public perceive. Doing so would empower the physicians with the information necessary to begin once again to perceive that their efforts are consistent with their altruistic reasons for entering medicine in the first place. Most physicians did not enter medicine for business reasons. Collaborative efforts to capture and use the information necessary to improve their qualitative and economic outcomes will go a long way toward improving their perceptions of insurance companies.

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

CAPG helps physician organizations respond to data requests so that physicians do not feel as if health plans are singling out one from the others or that they are being divided and conquered.

Report Offers Lessons in Technology

Physicians have always been proponents of clinical innovation, but many have been reluctant to adopt new information technology in their offices, according to a new report from VHA Inc. Understanding the barriers to increased use of information systems in physicians' offices and the strategies that institutions can use to foster more use of technology is important for all health care organizations, the report says.

The report, *Physician Adoption of Information Technology,* focuses on the strategies that hospitals and health systems have used to foster wider use of information systems among physicians, and the lessons learned can benefit physician organizations as well. The report shows that hospitals have found information technology systems can improve clinical outcomes, reduce costs, and increase efficiencies, but physicians have been slow to adopt new technology.

VHA Inc. is a health care cooperative in Irving, Texas, that represents some 2,200 health care organization including 1,400 community hospitals. The hospitals have relationships with 25,000 physician practices and other nonacute facilities. It works to help member nonprofit health care organizations nationwide improve operational and clinical performance.

Collaboration Required

"There is little doubt that information technology has the potential to be a powerful tool in improving patient care," the report says. "For these tools to fulfill their potential in practice, however, clinicians must embrace them; they cannot be imposed. Health care organizations must collaborate with physicians to identify solutions that enhance the care processes of the institution and the work processes of the doctors."

In other words, hospitals or any organization attempting to introduce information systems to physicians in clinical practice need to show the value of such systems and have physicians work closely with administrators in introducing these systems into practice, says Richard Howe, PhD, the vice president of information technology consulting at VHA. Most physicians already understand that electronic medical records and other IT tools improve health care quality, he says. But, he adds, physicians are swayed by the myth that using IT tools takes more of their time; in reality, he says, these systems do not take more time.

Saving Time

For example, while writing a single prescription on paper takes as much time as writing one electronic prescription, a computerized prescription order entry (CPOE) system can save significant time if a physician needs to write 10 prescriptions for the same patient, he says. What's more, if a pharmacist cannot read a physician's handwriting and calls to ask for an explanation, the interruption can be time consuming for the physician, the pharmacist, and the patient. With an electronic prescription, pharmacists have fewer questions.

But simply generating fewer questions may not be sufficient reason for physicians to adopt CPOE systems. Since most physicians work in hospitals as independent contractors and are not employees, they may not have a vested interest in increasing the efficiency of the hospital or health system, the report says.

"While organizations may lament the physicians' commitment to technology that they hope will improve patient safety and clinical outcomes, the fact is that physicians have nothing to sell but their time," the report says. "To the extent that new programs are less efficient than current ones, the savings accrued by the hospital will be at the expense of reductions in income for the medical staff. Beyond this, the learning curve for physicians is often substantial and to the extent programs are updated frequently, doctors must trade patient care time or time with their families in order to maintain their proficiency. Unlike continuing medical education of professional topics, computer learning generally does not earn CME credits. The upshot of these concerns is that organizations should understand the importance of the efficiency and economic issues physicians will legitimately raise in the process of adopting new technology."

Information technology affects physicians' efforts in four main areas, the report says: workflow, payment, productivity, and liability. Experts believe that EMRs and CPOE systems can address each of these concerns positively. It is the responsibility of group administrators and health care system executives to make it

"Health care organizations must collaborate with physicians to identify solutions that enhance the care processes of the institution and the work processes of the doctors," the report says.

clear that information systems actually solve more problems than they cause, the report shows.

At the Ochsner Clinic Foundation in New Orleans, Chief Information Officer Lynn Witherspoon, MD, used a team of clinical nurses to spend time following and observing many of the clinic's physicians to understand and document their workflow, the report says. This information was then used to design appropriate, customized clinical applications.

At Abington Memorial Hospital in Abington, Pa., Alison Ferren, chief information officer, and Keith Sweigard, MD, chief of internal medicine, believed that when introducing new technology, they needed to address workflow and convenience for physicians. "You absolutely have to have speed within the systems, the right networking, the right screen presentations, content, and reliability," they said in the report. "This had to be workflow neutral with a key on patient safety."

Abington sent members of its physician advisory group to the physician staff and hospital departments to learn the workflow and what was needed to make CPOE work. Ferren and Sweigard recognized that most physicians did not use wireless devices and would need a technology-supported process that could accommodate physicians in different locations, such as while physicians were sitting, standing, using phones, and at computers. "These requirements also meant that enough devices needed to be available at peak times to meet the workload and workflow needs of the physicians and nurses," they say.

Improving Results

Information systems also are helping to increase revenue for physicians by ensuring that physicians use the proper supporting information when entering a diagnosis, explains Howe. "In terms of payment, one factor that has been a problem is that if you don't have the coding right for a particular ambulatory diagnosis, then the payers will downgrade the payment," he says. "The new ambulatory systems calculate the best diagnosis and the best billing codes that would go with that diagnosis. They also alert physicians that there may be another diagnosis, sign, or symptom they may need to enter in order to support that diagnosis."

EMRs also are helping physicians to reduce the number of support staff needed in back-office operations for such tasks as transcribing notes and tracking and following up on insurance payments, Howe explains. "With electronic filing of claims in an EMR system, you do not need to increase your billing staff or have all those denials that require follow-up on the back end," he comments. "I have seen physicians who had four or five billing staff go to an EMR system and then cut their billing staff in half. That's a big return on investment. When you get the diagnostic justification that supports the best billing codes, then the physicians are actually increasing revenue."

CPOE and EMR systems also are helping physicians to document the steps of care more carefully. By doing so, they may be affording themselves some protection against malpractice claims because electronic records may document care steps more thoroughly than a paper chart can, Howe says. In fact, some electronic systems prompt physicians to provide the requisite support.

"One thing an electronic system can do is ask all the questions that are needed to support each order," Howe says. "That can be good news because you're asking physicians to support the order from a clinical diagnosis point of view." With a paper chart, Howe explains, physicians aren't forced to give that information; they just write the order. Many times the reason for the order isn't put down, which means the hospital doesn't get paid or it has to chase the physician down to get the information. "For certain orders, does it take more time to put a reason code in?" Howe asks. "Yes. But will they get calls at the end of the day? No."

What's more, once the proper reasons are in the documentation, the physician and the hospital may have the documentation needed to support a malpractice defense, if needed.

The report makes clear that all organizations need to collaborate with physicians in explaining and demonstrating the value of information systems in clinical practice. "It is worth noting the wide range of organizations working on the problem, and the wide range of strategies they have employed," the report says. "Perhaps the most reassuring insight is the way organizations across the country are working aggressively to overcome barriers and their willingness to share what they have learned."

—Reported and written by Joseph Burns, editor. More information on physician practice strategies is available on our Web site *(see page 16)*.

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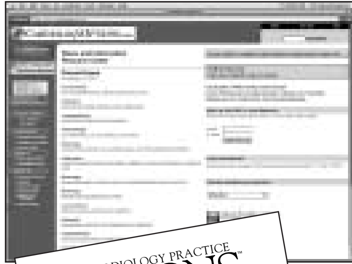

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