

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

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When Sued, Physicians Struggle to Cope

A malpractice lawsuit is so painful and draining that few physicians are adequately prepared for the financial and emotional turmoil that typically follows. The best precautions any physician can take include having a paid-up insurance policy and knowing what to expect and where to turn for help, experts say.

The physician's reaction to a lawsuit depends on his or her personality, flexibility, and ability to handle adversity. A physician who is being sued sees the experience as if someone were accusing him or her of intending to do harm, explains Norman Straker, MD. "For many physicians being sued is a major affront to their identity as a person who is trying to help people and wants to do only good," he says. "Initially shocked and in disbelief, doctors who are being sued have an overwhelming sense that what is happening isn't fair, yet they have to adjust to this unpleasant reality." Straker, a clinical professor of psychiatry at Weill Medical College of Cornell University, treats physicians who have been sued.

Competency Questioned

For Don Kovalsky, MD, an orthopedic surgeon who's been sued several times, the most difficult aspect of this unpleasant experience is recognizing that he did not do anything wrong. The tendency at first is to take it personally, Kovalsky says. "But I quickly realized a suit is about people

attempting to make money," he adds.

Recognizing that orthopedic surgeons are sued often helped him to view a malpractice lawsuit as simply a part of doing business. "It's no reflection on my competency," he says. "I have to look at myself and know that I'm doing the right thing."

The first response among some physicians is denial. "You'd be surprised at the number of physicians who upon receiving the papers set them aside, thinking the problem will go away or take care of itself," says Helen Woodfall. "Being sued profoundly affects physicians—emotionally, professionally, and even physically. Reading 20 pages of allegations against them may lead them to feel personally affronted, and sometimes they may secretly worry that the allegations might be true." Woodfall is vice president of risk management at the Doctors Insurance Reciprocal (DIR), a malpractice insurer in Richmond, Va.

By the time doctors see Straker, they're afraid a lawsuit might put them out of business, ruin their lives, or jeopardize their families. "Some may be so anxious and preoccupied that they are unable to concentrate on their work, make decisions, or even sleep," Straker says. "Others become depressed or lose confidence in themselves, and are unable to function well. Getting the subpoena may be the most traumatic part of being sued, and sitting through a trial a few years later can bring the trauma back again."

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Has a Consumer-Directed Health Care System Arrived?

Many pundits are heralding the beginning of consumer-directed health care. They say that demanding consumers with a desire for choice and access to the best providers are using information from the Internet and other sources to shop for what they want rather than settle for what managed health plans tell them they can (and cannot) have.

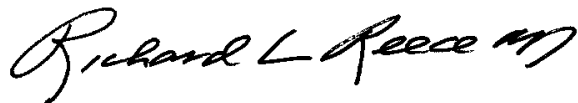
Other observers are not so sure that consumers will dominate the health system; they argue that few consumers have much leverage in such a vast system. Consider this true story: A cardiologist/lawyer recently developed mitral valve prolapse that required surgery. Since he had insurance coverage with the nation's largest health insurer, he went to a prestigious medical institution so that the world's top mitral valve surgeon could do the procedure. A few weeks later, he received a bill for nearly \$50,000, and insurance did not cover the cost. Being both a cardiologist and a lawyer, he sought to negotiate a reduction. But neither the insurer nor the institution budged. "So much for the power of the informed patient," he concluded.

This story offers two lessons for all of us: It shows that even the most informed consumers must follow the rules set by their insurers, and that going to the best doctors won't necessarily stop the insurer from sending the bill to the patient.

For physicians, the lesson is that consumer- or patient-driven health care might change little in the system we have now. After all, not many patients belong to consumer-driven plans, and those who do are likely to want what patients have always wanted from physicians: skilled medical professionals who are punctual, accessible, and responsive; and who listen carefully and make follow-up calls to inquire about their well-being.

Of course, there are some patients today who may want even more: They are shopping for physicians who will communicate with them by e-mail or provide online consultations for minor and nonemergency problems; they seek doctors who have Web sites that allow convenient office-visit scheduling, prescription refills, answers to frequently asked questions, and links to patient education sites; and they want physicians who use Internet-based sources to support clinical decisionmaking.

But most physicians practicing today are not prepared to meet these new health care consumer demands; for them, consumer-driven health care has not yet arrived. In other words, pleasing patients, retaining their loyalty, and having patients spread the word about the care they receive are likely to remain the bedrock of the patient-physician relationship for many years to come.



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Systems Need Closer Physician Ties

By Richard L. Reece, MD, editor in chief

Specialists have a prime opportunity to enhance their revenue by carving out niche services, potentially in partnership with hospitals, says Daniel K. Zismer, PhD, a management consultant to hospitals and health systems. At the same time, primary care physicians are well advised to join large integrated care systems, Zismer says.

Zismer consults on health care business strategies as a managing principal of Dorsey Health Strategies, a division of Dorsey & Whitney, a law firm in Minneapolis. Today, close physician-hospital relationships are important for primary care physicians, specialists, and health systems, he says.

"Health systems and physicians are at a crossroads," Zismer comments. "They will either move together or move apart. I think more hospital CEOs will lose their jobs over poor physician relations issues now than at any other time."

A Primary Cornerstone

The future of PCPs (including internists, family practitioners, and pediatricians) likely lies within larger organizations, Zismer believes. "The vast majority of PCPs will become part of larger integrated health systems, if they are not already," he says. "In the Twin Cities area, for example, most belong to one of several key health systems."

Minnesota is an anachronism in that 60% of the PCPs in the state are either employees or closely integrat-

ed with big health care systems. In other parts of the country, doctors, and particularly PCPs, tend to be in smaller groups. In Connecticut, about 70% of physicians are in groups of four doctors or fewer.

But these small groups need to change their business model if they are going to succeed over the long term. "Primary care is, per unit of service produced, the lowest paid part of the health care delivery model, yet it has the highest per-service-unit cost structure," Zismer points out. "In other words, PCPs have the highest overhead and the lowest fees. And they have the lowest potential to leverage their professional services. For example, a group of 10 or 20 cardiologists can add a variety of profitable ancillary services to their practice in the form of imaging and other services, whereas the ability of primary care physicians to leverage their professional fees with other services is relatively more limited."

The basic business model of a small private primary care practice may be professionally satisfying, but it does not hold a lot of promise for economic growth and development, Zismer comments. "Limited income potential has driven many solo practitioners to become part of larger systems," he says. "But the silver lining is that primary care practices provide important value to these systems, beyond just simply seeing patients. They are necessary for growing and retaining market share, and they serve as distri-

bution channels for care guidelines and epidemiologic strategies. Of course, certain physicians will always prefer to be in private practice. But there's a financial risk and potential downside to that choice."

Some experts believe that hospitals and health systems made a mistake when they integrated primary care into their operations, but Zismer disagrees. "Organized primary care is a significant component of any strategy," he says. "Despite the fact that hospitals think they lost money on primary care, these practices are the basis for and keystone of any larger scale health care strategy."

Specialty Revenue

While primary care may be the keystone of a large-scale strategy, specialists drive most of the revenue and profitability for hospitals. "In analyzing the revenue and profit structure of most large regional referral centers, it is clear that the majority of their profitability is driven by five major specialties—cardiovascular care, orthopedic and musculoskeletal care, neurovascular care, cancer care, and women's services," Zismer observes.

This situation, of course, confers significant financial leverage to the specialists. "The fact is, the economics favor the specialists," Zismer notes. "Specialists are currently in a position to draw services away from hospitals. As a result, hospitals and health care systems must either figure out how to partner effectively with

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"Primary care physicians have the highest overhead and the lowest fees. And they have the lowest potential to leverage their professional services."

—Daniel K. Zismer, Dorsey Health Strategies

(Continued from page 3)

specialists or face having their financial base decimated.”

Hospitals should actively seek to form joint ventures with specialists in order to retain their market share. “I am astonished that many members of hospital boards and health system leaders believe that because they have a particular revenue stream today, they will automatically retain that market or revenue stream in the future,” Zismer says. “Because of this attitude, when specialists approach hospitals with the opportunity for partnerships, often the hospital or health system responds by saying, ‘Why should I share my revenue stream with you?’ No other industry would view a revenue stream or market share as being owned in this way.”

Building Partnerships

In fact, some of the for-profit specialty companies have shown that it is relatively easy to organize a group of specialists and take revenue from a health system. “Frankly, I do not think this is the right direction for the industry,” Zismer comments. “Rather, health systems and physicians should try to integrate their businesses through effective partnerships.”

While these for-profit specialty companies have been extraordinarily destructive to hospital revenue, they have served a useful purpose in providing notice of the importance of specialty care to the typical health system, Zismer explains. “These companies have shown that it is not difficult to exploit a hospital’s revenue stream,” he says.

Furthermore, Zismer notes that a number of states place virtually no regulatory restrictions on the devel-

opment of health services through specialty hospitals, sophisticated ambulatory centers, and other similar organizations. “Those types of services will certainly continue to be targeted by the more entrepreneurial companies,” he notes.

In reaction, some hospitals are excluding from the medical staff entrepreneurial specialists who have developed and own external facilities. “This is an extreme reaction,” Zismer says. “Most physicians would rather, all things considered, be partners than competitors with the hospitals that they have been loyal to throughout their careers. But often they have been rebuffed by hospitals. As one medical group told me, ‘When we have tried to partner with the hospital, all we hear is ‘no’ from it.’”

Many hospital administrators and health system executives may believe that specialists want to develop specialty facilities out of greed. “From my experience, I have found that financial return is usually third or fourth on the list of physicians’ reasons for developing specialty care services,” Zismer states. “Right now, many health systems are strapped for cash. They have relatively little debt capacity and weak balance sheets. Consequently, they tell their specialists that they cannot purchase state-of-the-art equipment or produce state-of-the-art facilities for two or three years. A highly trained specialist can’t wait that long to have the hospital’s specialty services (including its physical facilities and capabilities) brought up to state-of-the-art level.”

For some specialists, three years may seem like a long time. “As a result, these specialists are seeking

alternative partners—not because of financial greed, but because they need to follow the advancements in their specialties,” Zismer says. “There are plenty of entrepreneurs ready to partner with these specialists.”

Accordingly, there is some urgency for hospitals to create these partnerships. “Hospitals cannot afford to look at opportunities linearly, which they typically do,” Zismer asserts. “They currently take one opportunity at a time. They may say to the orthopedists, ‘I know that you need new operating room facilities and new ambulatory and imaging centers, but we have to invest first in cardiovascular care and then in cancer care.’ The orthopedists will not wait for that. So there is a sense of urgency to move on all of these major specialty areas at the same time.”

Fundamental Problems

While some specialists may be wise not to wait for other parties to act and can establish viable practice models with relative ease, physicians in a variety of other settings may see change come to their practices more slowly. Changes that are occurring in many physicians’ practices will not necessarily revolutionize health care, Zismer notes.

“For example, information technology can provide excellent tools for physician practices and health systems,” he says. “But even electronic medical records are unlikely to revolutionize health care. These are simply tools.”

Similarly, defined contribution plans, which will give more health care purchasing power to consumers, may help alleviate some of the problems inherent in a system that relies on third-party reimbursement, but

“As consumerism grows, more dollars will be paid out of pocket for health care. Therefore, consumers’ demand for service, quality, and value will be directly proportional to the percentage of the total health care bill that comes out of their own pockets,” Zismer says.

they also are unlikely to revolutionize the system, Zisner adds.

"The problems in health care are still far more fundamental than could be addressed by either information systems or defined contribution plans," he says. "After all, we still have a system that consumes health care at a very high, and still accelerating, rate. Many services, even with defined contribution, are not paid for directly by the person who uses them. Furthermore, perhaps 35% of the services supplied do not provide a measurable benefit for the cost."

Creating Demand

Finally, our health care system still creates a significant amount of its own demand, Zisner continues. "The problems of the U.S. health care system are partly cultural," he says. "Americans demand high-end technologies, and the system delivers that consistently. The U.S. is the best country in the world for someone who needs a cataract operation, a hip replacement, a coronary bypass, an angioplasty, or any of these wonders of modern medicine. We have an insatiable appetite for such procedures because we have been acculturated to the fact that the user does not have to pay for them. As consumerism grows, however, more dollars will be paid out of pocket for health care. Therefore, consumers' demand for service, quality, and value will be directly proportional to the percentage of the total health care bill that comes out of their own pockets."

Another issue important to physicians involves the treatment of patients with chronic illness. About 80% of health care spending in the United States goes to treat patients with these conditions. "For example, heart disease is a chronic disease," Zisner says. "Yet we tend to approach it in the health care industry as an unforeseen acute problem. Many chronic diseases, such as obesity, diabetes, and arthritis, are predictable and manageable by self-intervention to a

Market Moves to Define Quality

One issue that is particularly important to physicians involves the quality of care patients receive. Even so, there seems to be little that physicians can do to shape the discussion about how to improve quality, says Daniel K. Zisner, PhD, a health care management consultant.

"The general marketplace is going to define quality before the U.S. health system can generate a definition," Zisner says. "Considering the information that is now available on the Internet, the public will be defining and reporting on quality. Consumerism is accelerating at a quick pace, and consumers are becoming far more sophisticated when they seek care. They want to know about mortality rates, morbidity rates, procedure volume, and cost data. These data will become more available and easily accessible to them."

Some organizations, such as the Buyers Healthcare Action Group in Minneapolis and the Leapfrog Group, in Washington D.C., have begun to show that employers are serious about finding ways to improve health care quality. "Initially as the buyer coalitions came together, they thought that they were going to round up covered lives and drive them from one health system to another, based on price and quality," Zisner says. "But in most mature markets health plan enrollees will not tolerate being herded to providers. In the final analysis, most health plans are still selling choice under variations of fee-for-service plans. I would expect more, not less, quality reporting to become available directly to consumers. Likewise, more quality-focused advocacy organizations will form. They will become more prescriptive regarding health services delivery."

For example, some of the initiatives of the Leapfrog Group include promoting the use of intensivists in intensive care units, developing computerized prescription order entry in hospitals, and fostering the use of high-volume hospitals over low-volume facilities. "Hospitals are paying a lot of attention to those three issues," Zisner notes. "My hat is off to the Leapfrog Group because it has been willing to identify certain key initiatives and push those agendas. It has been very effective at simply picking three important initiatives and moving forward with them. Hospitals and health systems are notoriously poor at sorting out major priorities like this."

—DJN

significant degree. Yet incentives are aligned for health systems to be in the business of offering episodic acute interventions. Another attribute of American culture is that the medical system is so effective that I can just let myself go, and when I get right up to the edge before I go over, somebody will retrieve me and I'll be saved. Then, I can go back to my old habits again."

Health care executives will do little to intervene on the health care cost problem, Zisner concludes.

"The health care cost problem is undoubtedly driven more by personal health behavior and the behavior of society in general than it is by provider behavior," he notes. "If we just got everybody to wear seatbelts, exercise, eat well, and not shoot each other, the national health care bill would go down precipitously."

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

Changes Make IT More Accessible

The cost and complexity of information technology can be prohibitive for many small physician practices. But over the past two years, information technology companies have developed Internet-based systems and creative financing to make IT more accessible and affordable even for practices of one and two physicians, according to a report by the First Consulting Group in Long Beach, Calif. The report, for the California HealthCare Foundation in Oakland, aims to help physicians find systems to meet their needs.

“Web-based technology and widespread access to the Internet allow vendors to offer remotely hosted applications that simplify the task of managing the technology,” says the report. “The advent of mobile computing devices enables a better fit with the work style of physicians, without huge costs for equipment and wiring.” For a remotely hosted system, a practice would have a monthly or annual subscription, meaning it would not need to pay a hefty price to purchase a system for its own office. A practice would access a remotely hosted application via the Internet.

Improving Quality

For the report, *Achieving Tangible IT Benefits in Small Physician Practices*, researchers interviewed physicians and staff at more than two dozen small physician practices. They also interviewed vendors of information systems and leaders from several national professional organizations. The report is available online (at www.chcf.org).

The researchers concluded that changes in technology allow physicians to enhance the quality of care they deliver through certain applications, such as electronic medical records that provide up-to-date drug information. Mobile computing devices and wireless technology allow physicians to bring technology to the point of care without running wires throughout their offices.

What’s more, financing options from information systems vendors can help to make new systems more affordable than they have been in the past. Some vendors offer modular products that allow a practice to expand slowly by adding one system at a time.

Another development contributing to the availability of information systems for small practices is that vendors are employing generally accepted technology standards in product designs, allowing users to integrate different systems and move data from one system to another more easily than was possible in the past, the report says.

The report provides seven case studies of small practices that have been using information systems to improve efficiency and enhance care quality. “Though few of the interviewed practices undertook a formal return-on-investment analysis, physicians and practice staff all shared abundant evidence of the benefits they achieved for their practice and their patients,” the report says. “Every story articulated some measure of success in addressing the problem the practice set out to solve.”

For example, an orthopedist in a

three-physician practice in San Diego uses an automated appointment reminder system that frees up time for support staff. It cost about \$5,500. A physician in a two-physician allergy and immunology practice in West Chester, Pa., uses an electronic drug reference program that he downloaded from the Internet to a handheld device he already owned. The data help him avoid medical errors. A solo practitioner in Pacerville, Calif., spent \$3,000 on an electronic prescription writer that provides drug contraindication alerts and dosing information.

Common Themes

As a result of the interviews, the researchers identified four common themes in small practices that had implemented information systems. First, a specific problem was targeted. “While not every practice chose the same challenges to address, they all chose something, and the scope, complexity, and type of problem the practice tackled shaped the characteristics of their solution,” says the report.

Second, small practices tended to purchase IT that could address multiple problems. Even single-function products that are easy to implement can solve different types of problems, such as locating medical records, the report says.

Third, physicians were generally the principal catalyst for implementing a system. “A highly motivated, technology-savvy physician drove a definitive process for introducing IT to the practice to solve challenges,” the report says.

Financing options from information systems vendors can help to make new systems more affordable than they were in the past.

Fourth, the practices achieved real benefits in terms of solving the problem it sought to address, in part because the information system was fairly sophisticated.

Multiple Benefits

The physicians found that the new information systems offered several benefits. As a result of the systems, the physicians and staff in the small practices needed less time to locate and assemble patient information, they documented care more thoroughly, they had more reliable and available details about patient care, they found that up-to-date drug information was easier to obtain than it had been in the past, and they could generate prescriptions more efficiently. Moreover, physicians found that workflow improved overall because they had a reduction in paperwork and were more productive.

The report categorized new information products as financially, clinically, or patient focused. Many practices already have some form of information system to support their financial practice management functions, says the report, but new options are emerging. Physicians are using handheld devices, for example, to capture information about charges and coding, and therefore they are gathering more accurate and thorough information about each patient visit.

Clinically focused IT systems include electronic medical records. In the past, EMR systems were expensive and provided a wide range of integrated clinical and decision support tools. Today, simpler, more affordable EMRs are available that support such basic functions as pre-

scription writing, problem list management, and note writing. Capabilities previously found only in complete EMR programs (such as drug reference materials and prescription writing) can now be purchased as standalone software for handheld devices, at a lower cost.

“While these products may not achieve the breadth of measurable benefits that a full EMR can, some small physician practices have found benefits in their use,” the report says.

Small physician practices may want to employ tools that help manage patient flow and meet their patients’ expectations, the report says. Telephone management systems for small practices can help triage and direct incoming telephone calls. Some companies offer products that remind patients of upcoming visits or tests they may need and facilitate communication via the Internet between patients and physicians.

“Patient-focused products actually reap financial savings for small physician practices when they perform routine administrative tasks that would otherwise require support staff time,” the report says.

Looking Ahead

Practices choosing between single-function and more comprehensive systems should consider their capacity for investing in IT and any resulting disruption or change in workflow, the report says. Also, physicians should try to anticipate their needs for the future. It may not be necessary to integrate all of a practice’s different information tools, and usually a practice may find that little training is needed to use the system.

Integrating technology becomes more important as more discrete systems are employed, particularly to avoid duplication of data entry. As a result, planning for IT is important, according to the report.

“The significance of technology integration is that without proper planning, a small physician practice could potentially employ a number of discrete, unintegrated IT tools that do not communicate with each other or with outside entities,” it says. When a single electronic source for patient information is employed throughout the practice, even when its various components are purchased over time, rework is reduced and the administrative benefits increase, the report explains.

With the ability to deliver more affordable tools to small physician practices, many IT vendors that originally targeted large providers are now targeting physicians who work in solo or small physician practices, the report concludes. According to the AMA, about 58% of U.S. physicians are in practices of four or fewer doctors. “Many [vendors] have reconfigured their products and pricing models, and new vendors have emerged specifically targeting this practice setting,” the report says. “As a result, the options for the small physician practice have markedly expanded in the past few years. Not only have several more affordable multifunction EMR products come onto the market, but there are numerous single-function products available that are relatively inexpensive.”

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More practice strategies are available on our Web site (see page 16).

Patient-focused products actually reap financial savings for small physician practices when those products perform routine administrative tasks that would otherwise require support staff time, the report says.

Some CV Drugs Linked to ADEs

Since many cardiology patients require medical therapy to manage their conditions, cardiologists are concerned about adverse drug events. ADEs are a major cause of serious injury and death, as indicated in numerous studies. While some ADEs result from adverse drug reactions, others result from medical error and are therefore preventable.

An article in the Nov. 15 *Annals of Internal Medicine* summarizes a retrospective malpractice claims analysis of preventable ADEs. "Our goal was to use malpractice claims as a different method to analyze the frequency of ADEs that are associated with errors and are therefore preventable," says Jeffrey M. Rothschild, MD, MPH, a lead author of the study. Rothschild is also an internal medicine physician at Brigham and Women's Hospital in Boston.

High-Cost Cases

Among the other findings, the analysis revealed that the classes of medications most frequently involved in adverse events were cardiovascular drugs, anticoagulants, antibiotics, antipsychotics, and antidepressants. ADEs were deemed preventable in three fourths of the cases.

About half of the ADEs were life-threatening or fatal; regardless of outcome, the costs of defending ADE-related malpractice claims were significant, as much as tens or even hundreds of thousands of dollars per claim. Furthermore, most of the events involved system-related deficiencies that could be corrected with information technology systems or

other prevention efforts.

Most of the studies done on ADEs are either retrospective or prospective clinical studies and chart reviews performed in various health care settings. "While malpractice claims represent only a very small proportion of all adverse events, they do reveal information that cannot be found by doing chart reviews," Rothschild says. "Thus, by examining malpractice claims, we learned more about the circumstances surrounding the adverse events than we would learn just through chart reviews."

Such information can highlight the underlying system failures that lead to adverse events, and thus pinpoint necessary prevention strategies. Researchers analyzed information in malpractice claims that included case abstracts, defense expert opinions, statements from health care personnel involved in the case, relevant clinical records, depositions, and communications between the defendant, the insurer's attorneys, and claims representatives.

Study Methodology

The study methodology involved a review of malpractice claims records at the Controlled Risk Insurance Co., a malpractice insurer in Cambridge, Mass. CRICO covers 8,300 physicians, 23 hospitals, and 430 other provider organizations in Massachusetts and New Hampshire. The company covers more than 25% of the physicians in Massachusetts.

The researchers analyzed medication-related malpractice claims filed between January 1990 and December

1999. "We used an electronic screen to pull out claims related to medications, and then we selected those that were related to an ADE," Rothschild explains. "We then examined the face sheets that accompany these claims. These sheets summarize information related to the claim, including the nature of the claim, the medication involved, the circumstances surrounding the alleged ADE, and the outcome."

Two physicians with expertise in judging ADEs reviewed the claims information and evaluated the presence of an ADE and whether it was preventable. Event-related variables included the presence of an ADE, the location of the event, the medication class, the medical personnel involved, and the specialty and experience level of the physicians involved.

ADEs were rated according to several different scales as follows:

- Preventability: definitely preventable, probably preventable, probably not preventable, or definitely not preventable
 - Severity: significant, serious, life-threatening, or fatal
 - Deviation from accepted practice norm: no negligence, negligence, or unable to determine negligence.
- "Deviation from accepted practice norm basically amounted to a judgment by the physician reviewers," Rothschild explains. "There are so many medications and variations in specific circumstances surrounding ADEs that it is difficult to establish a single definition of a deviation to explain every situation."

The reasons underlying these

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Anticoagulants and such cardiovascular drugs as anti-arrhythmics and antihypertensives were among those that resulted in most of the preventable ADEs that occurred in the outpatient setting.

“Antibiotics can cause significant side effects that are not always predictable. In contrast, 90% of the events associated with cardiovascular drugs were preventable.”

— Jeffrey Rothschild, MD, MPH, Brigham and Women’s Hospital

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events, specifically human performance and system failures, were analyzed to understand more fully the possible causes of ADEs. This analysis allowed the reviewers to determine the potential of preventing the ADE with an intervention in the system, such as computerized physician order entry or clinical pharmacist participation in patient rounds.

Important Findings

The physician reviewers determined that 129 out of 2,040 claims filed (6.3%) involved an ADE. Of these, 94 ADEs (73%) were rated as preventable. Preventable ADEs were evenly divided between the inpatient and outpatient settings. About one third were life-threatening, and 16% were fatal. Just over half of the cases (53%) were deemed negligent, while 21% were judged not negligent, and negligence could not be determined in the remaining cases.

The most common medications that resulted in ADEs were antibiotics, antidepressants, antipsychotics, cardiovascular drugs, and anticoagulants. Anticoagulants and such cardiovascular drugs as anti-arrhythmics and antihypertensives were among those that resulted in most of the preventable ADEs that occurred in the outpatient setting. Approximately 15% of both preventable and non-preventable ADEs were attributable to internal medicine subspecialists, including cardiologists.

“The fact that these drug classes were most commonly involved in ADEs is partly because they are among the most commonly prescribed medications,” Rothschild believes. “And, of course, certain

medications are more risky. For example, anticoagulants are a particularly risky medication, since when things go wrong with these drugs, the potential for significant harm is often much greater than it is for other medications. In the claims analysis, we found several cases of avoidable life-threatening hemorrhage in patients who were given anticoagulants.”

While cardiovascular drugs were the third most common drug class associated with malpractice claims, the ADEs associated with these drugs were mostly preventable, Rothschild points out. “Many of the ADEs associated with other medications were balanced between preventable and non-preventable errors,” he observes. “For example, antibiotics can cause significant side effects that are simply due to the fact that adverse reactions to these drugs, such as anaphylaxis, are not always predictable. In contrast, 90% of the events associated with cardiovascular drugs were preventable.”

Identifying Deficiencies

The most common human factor deficiencies that occurred were related to communication problems, including communication among members of the same team or different teams and communication gaps that occurred during patient hand-offs, Rothschild says. “For instance, information on the medications prescribed at discharge was not relayed to the outpatient consulting physician, who then made further modifications, or medication changes were made by a physician in the outpatient setting with no follow-up as to drug levels or laboratory results for known side effects,” he explains.

Other system failures included situations judged by the reviewers to involve inadequate supervision or inadequately trained staff. “We saw either junior physicians or unsupervised physicians using medications in a potentially dangerous fashion,” Rothschild explains. “In addition, there were several situations in which consultants were not appropriately used. We noted several examples in which there were what might be called substitute physicians, such as float nurses, who were not familiar with the hospital’s systems and were unaware of some of the policies and processes in a hospital setting.”

The researchers also determined that deficient automation or technology design was a factor in some cases. “One example was an outpatient whose intravenous pump was misprogrammed, causing the patient to receive a several-day dose of narcotics all at once, resulting in fatal respiratory failure,” Rothschild explains. “That type of error is probably related to the design of the pump or unfamiliarity with that particular pump, which made it difficult for the home care nurse to program it properly.”

Many deficiencies can be both performance-related and system-related. “Certainly, there can be some performance issues involved in a preventable ADE,” notes Rothschild. “If a physician orders a drug with a high risk for side effects, he or she should know to follow up with laboratory tests, for example. But the system to facilitate such checks may be complex, and the reality of follow-up can be difficult for a physician who has so many patients and must remember the specifics of a wide variety of medications.”

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Private therapy is one avenue of assistance. Many malpractice insurers offer support services for clients. In Colorado, the COPIC Insurance Co., a malpractice insurer in Denver, stages a mock trial twice a year. The number of participants in each session is limited to 20 physicians and their spouses. Attorneys and actors show the workings of a typical courtroom proceeding; the audience acts as a jury. About six times a year, COPIC's "Lawsuit Stress Support Session," held at locations throughout Colorado, offers an evening program featuring a video, trained facilitators, and an open discussion.

Similarly, DIR identified a need for clients to be able to discuss their lawsuit experience. "One of the first things a physician being sued is told is to talk to no one other than defense counsel," says Woodfall, a former RN who counsels doctors in her company's physician support program. "Shutting them down is problematic because it corks this now-infused bottle.

"A doctor is a fish out of water when sued," Woodfall continues. "Medical schools teach nothing about risk management. We give them an outlet: a chance to talk about the whole process."

Talk Therapy

To increase a client's knowledge of the legal process and to ease the damage to his or her self-confidence, DIR delivers a "Suit Case" of informative and educational materials to any physician who is sued. Woodfall also provides phone numbers of someone the physician defendant can call as needed, a referral to a doctor who has

First Steps to Take

For physicians who are being sued, insurance experts advise that the first step they should take is to call their insurance company. They should ask if the company offers a support program and should then seek recommendations from colleagues and malpractice experts for the names of therapists. And, finally, experts advise physicians who have been sued not take any legal action personally; suits are simply an onerous part of doing business, they say. —CM

volunteered to work with physicians seeking support, or a physician in his or her own specialty (who may also have been sued).

"The program provides physicians being sued with an opportunity to open up to someone on their defense team," Woodfall explains. "Clients enjoy talking to a health care person, who understands both medicine and the legal process."

In individual meetings with physicians who have been sued, she encourages doctors to describe the situation, patient, medical incident, their own perspective, reactions, and experience of the malpractice suit.

Similarly, Straker believes that his job involves helping physicians who have been sued to understand that the suit is not a personal attack on them but usually an attempt to win a settlement. He helps doctors accept "that we live in an adversarial society," he adds.

A physician who is anxious or depressed as a result of a suit can become incapable of working. But with a few weeks of therapy and possibly medication, that physician can be helped to return to practice, Straker says. "The goal is to fight back psychologically and not to give in," he explains.

In the mid-1990s, one of Kovalsky's worker's compensation patients developed an infection two months after knee surgery and informed the surgeon that he'd be suing. "It's nothing personal," the patient said. "It's just against your insurance company." Surprised to learn the patient wanted to keep seeing him, Kovalsky continued to treat the patient. "Finally his lawyer told him not to see me anymore because it would weaken his case," the surgeon says. "That was the only time I went to court."

A Winning Record

In the trial, Kovalsky prevailed, as happens in most cases. Among cases that reach a jury, 81% were decided in the physician's favor from 1985 through 2001, according to the Physician Insurers Association of America (PIAA). That's because many plaintiffs, like Kovalsky's patient, have weak claims. "About 75% of cases I review are nonmeritorious," reports Woodfall. "We're often defending a physician whose care we believe was appropriate."

Even with favorable odds in a lawsuit, a physician still needs to overcome several hurdles. "It's hard to get

"Initially shocked and in disbelief, doctors who are being sued have an overwhelming sense that it isn't fair, yet they have to adjust to this unpleasant reality."

—Norman Straker, MD, Weill Medical College

AMA Says 18 States in Crisis

The U.S. court system has evolved into a lawsuit lottery, in which select patients and their lawyers get astronomical awards, and many patients suffer access-to-care problems because of it, AMA President Yank D. Coble Jr., MD, said in March. Malpractice reform is the AMA's top priority.

AMA President-elect Donald J. Palmisano, MD, told Congress in February that many physicians have been hit with medical liability premium increases of 25% to 400% in the past year, and that the average jury award is currently \$3.5 million.

The ill effects of the medical liability system have put six more states in crisis, according to a new AMA analysis released in February: Arkansas, Connecticut, Illinois, Kentucky, Missouri, and North Carolina. Last year, the AMA said 12 states were facing a medical malpractice crisis: Florida, Georgia, Mississippi, New Jersey, Nevada, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. In all 18 of these states, the malpractice insurance system is adversely affecting patient care, the AMA says.

a doctor to understand the legal standards, how they apply, and the way the legal system works," notes Paul Keane, a partner in Martin Magnuson McCarthy & Kenny in Boston. Keane defends 30 to 40 malpractice cases at any given time.

For physicians, a lawsuit brings upheaval. "These very busy professionals, working long hours, must suddenly take time to meet with lawyers and give a deposition, with the opposing attorney attacking them, questioning their competency and their integrity," Keane says. "In addition, when both the insurer and his or her attorney have told the physician not to talk to anyone about the case, the physician defendant can easily feel isolated, which increases the stress."

In about 25% of cases, Woodfall will find that a physician did make a mistake. "That may not mean an error in

what the physician did, but sometimes a doctor may forget to document what was done, making it very difficult for us to defend," Woodfall says. "Also, a physician can be pulled into a suit when a hospital or a nurse didn't report back in a timely manner, and a patient sues," she explains.

If a case is defensible, the physician typically will want to defend it, Keane says. Medical malpractice insurers prefer not to settle cases on a nuisance-type basis; that is, settling the case simply to end the ordeal, he notes. "They'd rather pay me \$20,000 to defend the case than spend \$10,000 to settle, at least in Massachusetts, because this strategy helps to screen out frivolous claims," he explains.

But in New York, insurers often would rather settle a case to avoid costly litigation fees, Straker says. "That feels like an admission of guilt to the

doctors, and is very hard for them to accept," he adds. "I have to help them realize it's a business decision, and part of the way the system works."

Physicians in certain specialties incur more malpractice suits than those in other specialties. Physicians in obstetrics, radiology, orthopedics, and surgery are frequent targets of lawsuits, Keane says. PIAA found the most common conditions in lawsuits are breast cancer, neurologically impaired newborns, pregnancy, and acute myocardial infarction.

Emerging Victorious

If a case goes to trial and ends in a finding for the defendant physician, "the doctor who prevails feels elated by the outcome," says Keane. "The case may have involved an allegation that a delay in diagnosing a cancer contributed to the death of the patient. However confident the doctor is that he or she did the right thing, that doctor has had two or three years to reflect on the attacks by the plaintiff's attorney and the accusations of responsibility for the death of the patient. This is a heavy burden to carry, and the defense verdict can extinguish any lingering doubts about whether the doctor acted appropriately and in the patient's best interest." However, the attorney acknowledges, "A victory is often bittersweet."

Reflecting on his case, Kovalsky agrees. "Even when you win, you lose. You're exonerated, but you don't get anything for it."

—Reported and written by Carol Milano, in New York. More information on physician practice strategies is available on our Web site (see page 16).

"When both the insurer and the attorney have told the physician not to talk to anyone about the case, the physician can easily feel isolated, which increases the stress."

—Paul Keane, Esq.

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Strategies to resolve such system deficiencies exist, Rothschild adds. "For example, computerized physician order entry can reduce ADEs due to drug-drug interactions," he offers. "Reminder systems can be created to notify physicians electronically to follow up with a patient taking certain

"A high proportion of physicians have gone through the experience of being defendants in a malpractice claim and can attest to the fact that such claims can cause emotional concerns and can even affect the way they practice," Rothschild says. "A claim that results in a trial causes a

For patients who are put on medications that require subsequent tests for drug levels, renal fractions, electrolytes, or clotting studies, Rothschild recommends the development of a system or mechanism that ensures clinicians order these tests and follow up with patients. "Cardiologists should understand the potential for adverse events associated with the cardiovascular drugs and anticoagulants that they prescribe, and ensure that appropriate monitoring of patients occurs," he says.

The analysis revealed that the mean cost of a preventable inpatient ADE was \$376,500 per claim.

medications or requiring certain laboratory test results. Such system approaches can overcome the human performance failures, which are natural in a health care setting characterized by complexity and high volume."

Malpractice Costs

One reason cardiologists and other physicians are interested in reducing ADEs is malpractice costs. Malpractice suits are costly to defend, and malpractice insurance rates are higher for physicians with a history of claims.

"Drug-related errors are extremely expensive," Rothschild states. "Just defending these claims is costly, even if the claim results in a favorable verdict for the defendant physician. Clearly, we are facing a malpractice crisis across the country. Our analysis covered 129 cases over a 10-year period, but those 129 cases cost the malpractice carrier in excess of \$19 million."

The analysis revealed that the mean cost of a preventable inpatient ADE was \$376,500 per claim. The mean cost of a nonpreventable inpatient ADE, a preventable outpatient ADE, and a nonpreventable outpatient ADE ranged from \$64,700 to \$74,200.

In addition, Rothschild notes that malpractice litigation involves not only a dollar cost, but also a significant professional and emotional cost to the defendant physician, who can become, in effect, a second victim.

loss of practice time, may affect a physician's reputation, and may affect the future malpractice premiums for that physician."

While ADEs are certainly expensive in terms of malpractice costs, they result in high direct and indirect health care costs as well. "ADEs extend length of stay, result in more tests and medical care, and cause morbidity and potential mortality, which involve a certain cost to the patient," Rothschild points out. "Other factors, such as the cost of lost work by patients who are harmed by an ADE, must be considered as well." Cost-effectiveness studies of ADE prevention strategies, such as computerized order entry with decision support, are ongoing, although they may not include a malpractice component, he adds.

Reducing ADEs

The study analysis offers several lessons for cardiologists and other physicians. "Clearly, one important message is to ensure good communication between specialists and primary care physicians, in both inpatient and outpatient settings," Rothschild says. "Furthermore, hand-off of patients among colleagues should involve thorough background information. For example, a cardiology group that has different coverage on weekends or holidays has a potential Achilles' heel associated with patient hand-offs that should be reviewed."

Cardiologists also might want to lobby for new technologies that could help prevent ADEs. Using certain systems can help prevent a large portion of these events, notes Rothschild, adding that the analysis revealed that an order entry system was judged likely to have prevented 40% of inpatient preventable ADEs and 36% of all outpatient ADEs in the study. "Similarly, having a pharmacist participate on rounds, especially in the hospital's intensive care unit, is another proven strategy that reduces inpatient ADEs, he points out. On-site clinical pharmacists were judged to have had the potential to prevent 64% of all inpatient ADEs found in the chart review.

Building redundancies into the system can further decrease the frequency of ADEs. "For example, verbal orders should have a call-back mechanism so that the pharmacist or nurse restates the orders that the physician placed to verify that the drug requested matches the physician's intent," Rothschild explains.

"Overall, a variety of methods have been shown to be of value, and clearly they could have prevented many of the events that we reviewed in this study," he concludes. "Cardiologists and other physicians, and their patients, will all benefit from the adoption of such strategies." —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).

E-mail, Web Help Physicians Improve Communications With Patients



Steve Malik is CEO of Medfusion Inc., a health care information company in Research Triangle Park, N.C. Founded by Malik in 1996, Medfusion helps physicians improve efficiency and revenue through secure, Internet-based patient communication. Such communication allows physicians to renew prescriptions, take a medical history, send appointment reminders, report lab results, create a virtual medical record, and provide educational material to patients; it also allows patients to pay bills online. Editor in chief Richard L. Reece, MD, discussed with Malik how the Internet is helping to improve physician-patient communication.

Q: To begin, let's address physician skepticism about new technology. Physicians are skeptical partly because these systems can be expensive and partly because of their concern about security and protecting patients' privacy.

A: I have learned that physicians are indeed skeptical about new technology, and the concerns you mention are impediments to their willingness to adopt technology.

New technology, however, should accommodate physicians without being a burden to them, financially or in terms of time. The best systems allow physicians to try new applications to

determine if they feel comfortable using those applications and to see if the technology helps them accomplish their goals. In this way, they can access the technology without having to make a major investment.

For example, the transaction rate for reporting a laboratory result via a Web-based system is 35 cents; mailing the result costs 37 cents plus the cost of the envelope, the stationery, and the staff labor to send the letter. Therefore, most groups adopting systems that allow patients to get laboratory results online find that doing so is cost-effective.

Many companies are trying to implement technology features that do not require the physician to do anything differently in the examination room. They offer incremental EMR-type solutions, so that physicians are in a good position to take the technology a step further. For instance, taking the patient history was once a big challenge in implementing EMRs. Today, to the extent that patients can answer a set of prepared questions, these systems can help to reduce the data entry that a clinician must do at the point of care.

Although many physicians resist change, by taking incremental steps to reach a certain comfort level, they will slowly build up to a more effective utilization of other technologies. In addition, return on investment is easier to achieve by taking incremental steps. If physicians do not see a strong

return on investment for each step of the process, they will not continue.

Successful information technology solutions in health care will have a number of characteristics. They will not represent a financial impediment to initial adoption. If physicians have to go through administrators or other partners to obtain a significant amount of funding for an information system, it is unlikely that the system will make it onto the priority list because of so many other pressing business expenses. Second, successful solutions will not tether the clinician to the computer. Third, useful systems should enhance patient flow and cash flow. Fourth, these systems should be flexible enough that physicians are not constrained by using them and have to function differently than they are used to functioning. And fifth, these solutions will be a natural extension of the physicians' workflow.

Q: Are more physicians becoming interested in communicating with patients via the Internet than they were in the past?

A: Yes. In the past, physicians expressed concerns about security, receiving compensation for additional work, and setting patient expectations regarding appropriate communication. Now that those issues can be resolved with Internet products specifically designed to allow doctors to communicate with patients—as opposed to communicat-

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Successful IT solutions in health care will not represent a financial impediment to initial adoption or tether the clinician to the computer, Malik says.

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ing via e-mail alone—the trend toward greater physician adoption is very strong. In fact, patients are pushing doctors to provide such services and are willing to pay for the convenience.

Q: *What are the benefits to physicians of communicating with patients online?*

A: By providing a secure way to communicate with patients, many low-acuity, nonemergent care requests can be handled online in much less time than would otherwise be needed for both the doctor and the patient. Patients want increased access to their doctors, and this technology allows for much faster resolution for those issues. The overhead to respond to even a minor issue in the office is expensive, while online responses take relatively little time.

The results from our patient surveys are outstanding: More than 90% of patients indicated that the advice and treatment offered online were the same as or better than they would have received in the office.

Q: *Will physicians who offer this service be able to win new patients as a result?*

A: Industry studies have estimated that two thirds of patients with Internet access would switch to a physician or another provider who offered Internet communication as part of his or her services. In certain pockets of the country, practices are beginning to leverage this interest to win new patients.

Here in Raleigh, for instance, patients typically have a two-week wait to see a physician. Therefore, being able to provide them with a response fairly quickly to questions related to low-acuity conditions can have a lot of value in growing a practice. Several groups here are starting

to get comfortable with that concept. The key is that there must be enough flexibility in the solution for each doctor to communicate with patients in a way in which he or she feels comfortable.

Q: *What are some typical topics that patients want to cover with physicians via the Internet?*

A: Patients express interest in many functions: scheduling a visit, asking physicians simple questions about care, and getting laboratory test results, appointment reminders, or prescription renewals, among others.

Scheduling is problematic, however. Currently, the majority of our clients have patients request an appointment rather than actually make their own appointment online. While it isn't like booking your airline flight online, for example, there are still significant advantages to eliminating the phone traffic involved in making an appointment.

Q: *What are the issues involved in providing medical advice over the Internet?*

A: Numerous issues must be addressed, such as patient privacy, legal liability, and the capture of physician revenue. The best systems address all of these issues by, for example, requiring patients who want to receive medical advice online to have a pre-existing relationship with the doctor and to have approved a detailed waiver statement.

In addition, all patients requesting care must have their identification authenticated using online credit card processing technology. These systems handle various options for payment, including patient self-payment and insurance billing if online services are covered by a patient's health plan. When Medicare and Medicaid billing issues are involved,

the patient must approve the appropriate releases.

Of course, e-mail should never be used to communicate a patient's personal health information because of the lack of security inherent in e-mail systems. E-mail should be used only to notify patients that a secure message is available if they log onto their physician's Web site.

Ultimately, the physicians are responsible for the advice they provide online, just as they would be responsible for the advice they give in the office. But some of the best companies have taken steps to ensure that these Web-based communication systems support the doctors in this process with optimal concern for patient privacy and the ability to bill for the doctor's time.

Q: *What are some of the technical requirements of Internet-based physician-patient communication?*

A: Typically, it is easy for a physician to set up an online communication system and start using it. But before doing so, physicians should ensure that the technical requirements from their end are minimal. What's more, they should also be sure that the vendor appropriately provides and maintains the needed technology, including ensuring patient privacy, as required under the Health Insurance Portability and Accountability Act (HIPAA).

For example, some Internet companies and consultants will provide the infrastructure to facilitate secure communications. The best companies in the field of providing patient-physician communication online maintain a security and privacy officer and comply with HIPAA regulations, as well as run security audits to make sure the sys-

“The best systems will address the issues of patient privacy, legal liability, and the capture of physician revenue.”

“To the extent that patients can answer a set of prepared questions, these systems can help to reduce the data entry that a clinician must do at the point of care.”

tem is tamper proof so that the patients' and physicians' information is secure.

Physicians should also make sure their Internet providers have an errors and omissions insurance policy so that they are protected against any liability issues arising out of their commitment to meeting patient privacy requirements.

In other words, physicians will want to contract only with companies that commit in their contract to meeting the legal requirements that allow physicians to provide patient care and not have to worry about the privacy, security, and technology infrastructure issues. Then, physicians need to notify patients of their privacy policy and ask patients to give consent to communicate in this manner.

Q: *How can physicians ensure that Internet-based communications are cost-effective?*

A: These systems can be cost-effective if the physicians clearly communicate to patients what they can expect from such communication. One way to do so is for physician practices to have their own Web site in which they can fully explain what patients can and can't do when communicating with them online.

Some companies are integrating patient interviewing software onto physicians' Web sites. These programs allow physicians to collect detailed histories from patients prior to making treatment decisions, thereby eliminating some of the potential back and forth of additional questions and answers that can make the treatment decision process iterative and complicated.

For administrative issues, such as

appointment requests, some software allows all of the pertinent intake data to be captured so that the appropriate person can respond, increasing staff efficiency. Some systems allow groups to designate who gets which type of inquiry from patients; in other words, the system gives the responding staff person a choice of response options as he or she reads the patient request, which can speed up the processing of these transactions.

Q: *What features of an Internet-based communication system should physicians look for when assessing the various companies offering such systems?*

A: A doctor can subscribe to any number of Web sites offering various services, but a coordinated approach that fits his or her existing workflow is critical. I encourage doctors to look for systems that they can integrate into their existing practice management and EMR systems. I also encourage physicians to focus on ease of use and on getting a defined return on their investment from these systems.

Patients should be able to use the physician's Web site to register and provide a history prior to coming into the office. This step saves the physician time, reduces transcription costs, and creates excellent documentation to support billing.

Recognizing that physicians do not want additional administrative burdens or costs and are skeptical about the benefits of new technology, some of the best companies in this field will offer a guarantee of sorts, meaning that physicians can develop a demonstration site until they are satisfied that it will meet their needs, and they should not have to pay any-

thing until they are ready to put up a live site that patients can use.

Q: *How can physicians advertise that this is a service they offer?*

A: One effective way to advertise this new Web feature is to use a telephone-based appointment reminder system. In this way, the practice's office staff can alert patients to the functions of the Web site when they are speaking with patients to confirm appointments. This approach offers a peripheral benefit of reducing patient no-shows, and lets the office staff prompt patients to register on the Web and provide all health history information. By working these new types of communication systems into the practice's existing office protocols, patients become aware of the services as a by-product of seeing their doctor instead of requiring a special effort on their part.

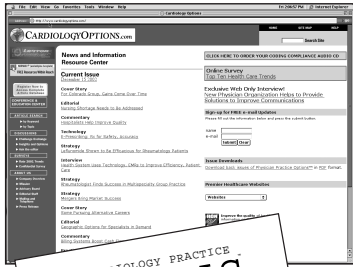
For instance, one online function that has been wildly successful allows patients to pay their bills via the physician's Web site. This is a great way to reduce receivables and educate patients about online offerings.

Q: *Do you think that physicians who offer this type of service will be more likely to win and retain patients?*

A: Yes, Internet communication attracts specifically the type of patients most practices want. Clearly, the convenience offered by these solutions appeals to everyone. Our evidence indicates that Internet users are better paying and tend to be more involved in their treatment protocols and are therefore more compliant with physicians' orders.

—Edited 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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