

# CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

August 15, 2003

## CONTENTS

### Features

**Commentary**  
Software Aims  
to Boost  
Reimbursement 3

**Strategy**  
Health System  
Seeks to Improve  
Care by Developing  
Information  
Systems 10

**Interview**  
Proven Technologies  
Can Increase Efficiency,  
Expert Says 13

### Departments

**Editorial**  
Physicians Win  
Partial Victory,  
Continue to Fight 2

**Practice Management**  
Physician  
Capacity Declines,  
Report Says 6

## Care by Cardiologists Improves CHF Outcomes

**T**he mortality rate of patients with congestive heart failure who receive care from a cardiology clinic following hospital discharge is lower than the mortality rate of patients receiving follow-up care in a general medicine clinic, according to the results of a recent study.

The research was led by Eugene Oddone, MD, MHS, division chief of general internal medicine at Duke University Medical Center and director for the Center for Health Services Research in Primary Care at the Veterans Affairs Medical Center in Durham, N.C.

### Trends in Outcomes

Oddone and his colleagues pursued this research in an effort to improve disease management for patients with congestive heart failure. "We wanted to identify and understand the possible components of disease management programs for CHF," Oddone says. "By analyzing the VA database, we believed we could find trends in outcomes and identify quality parameters resulting from a given pattern of care. We were interested in whether certain kinds of clinic visit profiles or clinic visit provider mixes yielded improved outcomes for patients. Our hope is this analysis will help inform the optimal mix of general practitioner or specialist care for these high-risk patients."

Identifying optimal patterns of care for CHF is important because of the prevalence (almost 5 million

Americans have CHF) and cost (more than \$18 billion per year) of the disease.

Despite recent improvements in CHF therapy, Oddone finds that survival rates among these patients continue to be poor. "CHF is a severe disease, and in its later stages mortality is high," he says. "There have been definite improvements in survival over the last decade with better pharmacologic management of patients, more aggressive use of percutaneous transluminal coronary angioplasty (PTCA) and coronary artery bypass grafting (CABG) in appropriate patients, and the creation of disease management programs. Nevertheless, CHF is as deadly as diseases like AIDS and cancer."

Despite the severity of the condition, primary care physicians, not cardiologists, follow the care of most CHF patients. "This may largely be due to limited access to cardiology care," Oddone speculates. "Although access to cardiologists has improved over the last 10 years, it is still difficult for some patients to get this care."

### Voluminous Data

The research Oddone and his colleagues did was unusual because it used the national VA hospital database, which links outpatient and inpatient care and tracks outcomes. The database's patient treatment file contains demographic and discharge summary information for all inpatient stays in VA hospitals nation-

*(Continued on page 8)*

## Physicians Win Partial Victory, Continue to Fight

**B**y agreeing to settle with more than 600,000 physicians who had charged that insurers were incorrectly cutting their payments and interfering with recommended treatment for patients, Aetna Inc. took a significant step in the battle physicians have been waging against the most egregious elements of managed care. In late May, Aetna said it would seek the settlement to end litigation the physicians had started over the past few years. The physicians' case against other insurers goes on.

In the settlement offer, Aetna said it would revise its bill payment systems, establish a physician panel to offer advice on issues important to physicians, and pay \$20 million to establish a foundation to improve the quality of health care. Also, it said it would pay \$100 million to physicians (about \$147 per physician), adopt a clear definition of the term "medical necessity," commit to timely processing of clean claims, establish an independent appeals process to resolve physician billing disputes, and disclose factors that determine how physicians are paid.

These are significant steps and represent a victory for physicians in their fight against insurers. The lawsuits have been consolidated in the U.S. District Court in the Southern District of Florida, Miami Division.

Commenting on Aetna's proposal, AMA President-elect Donald Palmisano, MD, said: "By agreeing to the settlement, Aetna acknowledges that to mend the breach in its working relationship with physicians, it must implement a fundamental shift in how the company conducts business."

Tim Norbeck, executive director of the Connecticut State Medical Society, one of 19 medical societies that had sued Aetna and other insurers, told the *American Medical News*, "Aetna is the first and only insurer to step up and attempt to make this managed care system fair and equitable for physicians to navigate. This may not be perfect, but it is a tremendous step in the right direction."

Jack Lewin, CEO of the California Medical Association, another society involved in the case, said, "It's a very significant change in the relationship. I wouldn't call it a home run. But it's a very solid double."

Uwe Reinhardt, MD, a health care economist at Princeton University, said, "Doctors are like someone who has been through a boxing match. You stand there. You take punches. Your nose is bleeding. You've got a cut above the eye. But you're still standing. The other guy, the HMO, is down. You're hurting. But you won."

The sports metaphors ring true. Doctors are still standing after slugging it out with HMOs. HMOs are down, but not out. While doctors may have scored at least a partial victory, the fight continues.



Richard L. Reece, MD

Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: [Rreece@premierhealthcare.com](mailto:Rreece@premierhealthcare.com)

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

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

### Publisher

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

### Editor

Joseph Burns  
508/495-0246  
[editor@premierhealthcare.com](mailto:editor@premierhealthcare.com)

Neil Baum, MD

Urologist  
New Orleans

Daniel Beckham

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

Thomas M. Gorey, JD

President and CEO  
Policy Planning Associates  
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA

Executive Vice President  
Premier, Inc. and  
Premier Practice Management  
San Diego

Harold B. Kaiser, MD

Allergy & Asthma Specialists, P.A.  
Minneapolis

Nathan Kaufman

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

Paul H. Keckley

President and CEO  
webEBM  
Nashville, Tenn.

Peter R. Kongstvedt, MD

Partner  
Cap Gemini Ernst & Young  
Vienna, Va.

Richard Liliedahl, MD

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

John W. McDaniel

President and CEO  
Physician Management Group  
Tuscaloosa, Ala.

Lee Newcomer, MD

Executive Vice President  
Vivius Inc.  
St. Louis Park, Minn.

James G. Nuckolls, MD

Medical Director  
Carilion Healthcare Corp.  
Roanoke, Va.

Bernard Rineberg, MD

Physician Consultant  
BAR Health Strategies  
New Brunswick, N.J.

Jacque Sokolov, MD

Chairman  
Sokolov Schwab Bennett  
Los Angeles

# Software Aims to Boost Reimbursement

By Richard L. Reece, MD, editor in chief

**F**or many physicians, operating a medical practice today can be financially treacherous because insurers often fail to pay bills in full. Most insurers use sophisticated software to cut reimbursement levels, and the rules these programs follow are often unknown to physicians.

One way physicians can increase their gross receipts is to verify that insurers' payments are accurate, but doing so is complicated and costly. Some companies offer reimbursement validation software that examines whether a practice has been accurately and fully reimbursed for services rendered, says John McDaniel, chief executive officer of Physician Management Group, consultants in Tuscaloosa, Ala.

## Finding Errors

Some consultants, including PMG, conduct quarterly or semiannual audits of income from payers to verify that insurers are paying in full, McDaniel says. To catch errors, consultants examine bills at random and then compare the bills with what an insurer actually pays. A few years ago, PMG examined the receipts of a solo practice and found that it had suffered a number of discrepancies over 12 months totaling \$12,000. In this case, finding one error led to the discovery of a series of errors. Unfortunately, many practices do not perform manual audits, McDaniel says.

Some practices use software to examine CPT codes for accuracy and

help physicians determine whether they are under- or overcoding when they bill payers, says McDaniel. But few companies offer software that analyzes practice records and compares what a practice receives to what it bills.

"In most audits, it's a hit-and-miss situation," says McDaniel. "The use of computer software to conduct reimbursement validation on a regular basis could be extremely valuable. Payers make mistakes in reimbursements all the time."

Bill cutting by insurers is a major reason to consider reimbursement validation software, McDaniel says. "Reimbursement validation is the kind of thing physicians tend not to do on their own," he says. "It's the kind of thing doctors should do, but need help in getting done."

## Verification Needed

Terry Rajendran, president and CEO of Nobelus Inc. ([www.nobelus.com](http://www.nobelus.com)), a company in Colorado Springs, Colo., that makes reimbursement validation software, agrees with McDaniel. "Verifying payments by insurers is harder than you would think," she says. "To begin with, even a careful review of the contract won't give you enough information to calculate your payment accurately, and such factors as modifiers and places of service will not be addressed at all."

Complicating such calculations still further, most contracts explicitly allow bundling or downcoding, and

most practice management tools cannot track or measure how often bundling or downcoding occurs or the effect of these processes on costs.

While suing an insurer is one way to proceed, it's also time-consuming and costly, Rajendran comments. "It's a start but it is an expensive way to recover a dollar," she says.

To be certain they are getting every dollar owed to them, practices first need to measure and monitor payment compliance daily so they can recover lost dollars as quickly and efficiently as possible, and second, to write a more thorough contract to protect their interests, Rajendran says. "Insurers understand the importance of such contracts and it shows in the way they are written," she adds. "The insurer's interests are well protected at the physician's expense."

A good example of such built-in protection is the arbitration clause. Over the past few years, insurers have been adding clauses into physician contracts that require physicians to settle any disputes through arbitration. Today, insurers are seeing benefits from using such language in contracts. For example, the insurer charged in a \$200 million lawsuit by physicians has been removing those physicians from the suit who have signed a contract that requires arbitration in any disputes, thus preventing these physicians from participating in a class action.

"But arbitration can work in the physicians' favor if they have the

*(Continued on page 4)*

**The fee schedule is only the starting point for calculating payments accurately, and without taking into account the many factors that affect payment, the results are erroneous and misleading, says Terry Rajendran of Nobelus.**

## Physicians See Progress in Underpayment Cases

**P**hysicians have long contended that insurers underpay. At issue is a practice called bill cutting or the use of software by insurers that automatically cuts reimbursement to physicians. The AMA contends that automatic bill cutting improperly deprives doctors of hundreds of millions of dollars in fees each year. Nearly 90% of all physicians report insurers do some sort of automatic bill cutting, the AMA says.

Class action suits filed through state medical associations are pending against most of the nation's large health insurers, including UnitedHealth Group Inc. in Minneapolis; Cigna Corp. in Hartford, Conn.; WellPoint Health Networks Inc. in Thousand Oaks, Calif.; Anthem Inc. in Indianapolis; Humana Inc. in Louisville, Ky.; PacifiCare Health Systems Inc. in Cypress, Calif., and Health Net Inc. in Los Angeles.

Aetna Inc., headquartered in Hartford, Conn., announced in May that it would settle a class-action case with nearly all the physicians in the United States over claims that the health care company unfairly cut reimbursements to doctors. Under the settlement involving more than 600,000 physicians, the company says it admits that it interfered with physician recommendations regarding patient treatment. As a result of the settlement, Aetna will adjust its definition of medical necessity to a less restrictive standard.

Aetna uses bill-cutting software that cuts doctors' bills to what the health plan thinks it should pay, rather than what the doctors are billing, physicians say. For instance, a physician who does a biopsy in his or her office after an exam will bill the insurer for both the exam and the biopsy. But claims-processing software that insurers use widely will automatically slice out the exam charge and pay only for the biopsy, physicians say.

Under the agreement, Aetna will let doctors have a significant say in how its claims-processing software evaluates reimbursement for medical treatment. The settlement agreement also establishes a billing dispute external review board, an independent body.

Attorneys estimate that the settlement is valued at about \$470 million, including cash payments of about \$147 per physician. Aetna will also donate \$20 million to set up a foundation that physicians will run to study methods to reduce medical errors, childhood obesity, and racial disparities in health care. Aetna also will pay about \$50 million in legal fees to be divided among the plaintiffs' attorneys.

Other pending class action suits include one against Cigna. In 2002, a state court in Madison County, Ill., granted class-action status to a suit against Cigna over the use of bill-cutting software named ClaimCheck. The suit represents nearly 300,000 physicians who accept Cigna's health plan members as patients. ClaimCheck reviews the codes physicians use and checks them against its own proprietary payment rules. Cigna is one of about 450 health plans, about two thirds of all plans, using ClaimCheck to process their claims, according to McKesson Corp., the company in San Francisco that markets the program.

—MS

(Continued from page 3)

requisite data," Rajendran explains. "When you have a line-item report showing every instance of underpayment, you can take that to an arbitrator. The problem is obtaining that data. That's where this software is useful."

Nobelus has developed software that incorporates the necessary payment rules from insurers and uses existing data from a physician's practice management system to calculate, audit, and report underpayments. The software also makes the process of appealing an underpayment faster and easier for the physician's staff. "The real advantage we offer is that we are a service backed by a system, so we can offer speed and expertise without the price tag of additional staff members," says Rajendran.

### Early Audit Results

When developing the software, Nobelus did a number of audits of practices across different specialties and insurers and found that underpayment consistently ranged from 7% to 13% of receipts.

One of the most significant problems physicians face in seeking to recoup underpayment is the sheer complexity of physician billing processes. Insurers will change what they pay for a single code under one contract in a single year, often as many as four times, and they will add or subtract modifiers that also affect what they pay.

Further, most practices are under the false impression that all payers follow the same standard guidelines implemented under the resource-based relative value scale that Medicare has used for many years. Under each contract that it has with physicians, a payer will implement a different set of rules to calculate and adjust its payments.

As a result, the medical reimbursement process comprises an average of 24 steps, as compared with eight steps in the retail sector, experts say. Most

medical practices simply lack the resources, time, and tools to monitor payments for every line item under every contract with every patient. "When someone tells you this is an easy problem to solve, you should be wary," Rajendran warns.

### **Limiting Factors**

While many practice management system vendors say they offer modules to help physicians calculate payments accurately, these vendors often do not make accommodations for the various fee modifiers insurers use to cut payments, Rajendran says. Practice management system vendors suggest that physicians merely need to input their fee schedules for the various contracts so that the systems can calculate the contractually expected payment automatically, she adds. Yet, the fee schedule is only the starting point for calculating payments accurately, and without taking into account the many factors that affect payment, the results are erroneous and misleading, she says.

Some practices outsource their billing processes hoping that a company specializing in medical billing will navigate the reimbursement issue more effectively than the practices' office staff. Unfortunately, billing services often use the same inadequate tools that physicians use, Rajendran says. To date, only hospitals have been able to implement systems that monitor payments effectively, and those hospitals that have done so have seen a significant return on investment in such systems. But access to such sophisticated technology and the resources to manage it have been prohibitively costly for

most practices, Rajendran comments.

### **Full Disclosure**

What physicians need is a system that can match the requirements under the physician's contract with the insurer and with what the insurer actually pays, Rajendran explains. Doing so accurately allows practices to appeal underpayments efficiently as they occur and gain new insight into the financial effects that a particular payer has on a practice.

"Nobelus can reverse-engineer payer tactics by analyzing their track record and report the true effects of the contract back to the practice," Rajendran explains. "In the end, knowing how the payers perform is more valuable than how they say they perform." Therefore, the reports such software generates may allow physicians a practical way to combat any insurers' abusive business practices, she adds.

Another company in the field of reimbursement validation is Medical Present Value in San Antonio, Texas. Its service, Phynance, does claim and payment verification by checking the accuracy of all claims and payments by payer, contract, and line item. It sells the service primarily to groups with more than 20 physicians.

Two years ago, MPV did a study for the Texas Medical Association in Austin that helped to quantify the extent of underpayment medical groups face. The results of the study showed that one in five claims by MPV's Texas provider clients was valued by payers below the contracted amount and that the value of the underpayment averaged 5% of each practice's net-collected revenue. MPV

also found many of the problem claims had multiple line-items, involving surgical and other specialty procedures.

Reduced and inaccurate reimbursements often result from contract terms and payment policies that are not fully disclosed to physicians, MPV says. Payers use multiple line-item adjudication in their payment software, meaning the value of each CPT code on a claim depends on the presence of other codes and modifiers, medical necessity criteria, and other complex and often obscure rules, MPV says. Also, insurers use what they call bundling edits, which result in paying a single reduced fee for several services.

Phynance values claims, identifies errors before filing, allows for review and correction prior to submission, and reduces payment cycles by submitting clean claims, MPV says. Phynance then flags contract-level errors in paid amounts and compares payment to codes, providing explanations for appeals.

It is clear that for any service or software to be effective in a physician practice, it also must be seamless, meaning it cannot result in interruptions in patient flow, Rajendran adds in closing. "We needed to help practices solve the payment problem by holding the insurers accountable to the contract in an affordable manner," she says. "We've done a good job of meeting these goals. We believe this is a practical solution to an impractical problem."

—Additional reporting by Martin Sipkoff, in Gettysburg, Pa. Readers seeking more information may call Terry Rajendran at 719/448-0316. More information on practice strategies is available on our Web site (see page 16).

**"The use of computer software to conduct reimbursement validation on a regular basis could be extremely valuable. Payers make mistakes in reimbursements all the time."**

**—John McDaniel, Physician Management Group**

# Physician Capacity Declines, Report Says

Comparing data on patient visits from 1997 with those from 2001 shows that patients waited longer for appointments to see physicians in 2001, and more physicians reported having inadequate time with patients, according to a new study by the Center for Studying Health System Change.

These results came despite an increase both in the supply of physicians during the same period and in the proportion of physicians working with nurse practitioners and other caregivers, the study shows. Also, physicians reported that even though they spent more time in direct patient care, they still did not have enough time to see patients.

## Three Surveys Completed

A health care research organization in Washington, D.C., the Center for Studying Health System Change (HSC) examined physician capacity in three telephone surveys. One was done at the end of 1996 and the beginning of 1997, another in 1998 and 1999, and the third in 2000 and 2001. In total, HSC interviewed about 8,000 physicians who provide direct patient care for at least 20 hours a week.

In the most recent report on the survey, *So Much to Do, So Little Time: Physician Capacity Constraints 1997-2001*, HSC defines physician capacity as the ability to provide services relative to demand. Capacity depends on several factors, according to the report, including physician supply, the amount of time physicians

are willing to devote to patient care, the types of physicians in a practice, and patients' demand for services.

The report provides numbers on the amount of time physicians spent on patient care in 1997, 1999, and 2001, and examines data related to physicians' capacity to provide care, including the number of support staff, the average wait time for appointments, and the demands on physician time that constrain capacity. The report is available on the Web (at [www.hschange.org](http://www.hschange.org)).

A primary indicator of strained physician capacity is the rising proportion of patients who did not get or postponed needed care because they could not get a timely appointment, the report says. In 2001, 5% of Americans did not get or postponed care because they couldn't get an appointment soon enough, compared with 3.4% in 1997. (The proportion of patients who could not get a timely appointment in 1999 was not provided.)

One factor limiting physician capacity may be managed care rules that allow patients to seek more care without paying much more in out-of-pocket costs, according to the report. "Current physician capacity constraints may ease if higher out-of-pocket costs prompt patients to seek less care," it states.

## Adding Physicians

Increasing the number of physicians who deliver care could help to increase capacity, the report says, but other factors may limit the number of

physicians available to provide care. According to the report, the number of physicians increased between 1995 and 2000, from 260 to 276 physicians per 100,000 people. But advancements in medical technology may mean physicians have more to do for each patient and thus less time to see more patients.

"As the practice of medicine changes rapidly and becomes increasingly complex, physicians have more diagnostic and treatment options for a larger pool of patients," the report says. "Medical advances have transformed once terminal diseases (for example, many types of cancer) into chronic conditions that physicians must manage long term. Increased treatment capabilities may be causing physicians to shift how they spend time as they provide and interpret more diagnostic information and discuss results and treatment options with their patients and with other physicians."

Perhaps partly because of improved medical options, physicians spent more time in direct patient care between 1997 and 2001, although they worked fewer hours overall, according to the report. The time physicians spent in direct patient care grew from 44.7 hours a week in 1997, to 46.6 hours in 2001 (it was 44.7 hours in 1999), while their average medically related work week fell from 55.5 hours in 1997, to 54.4 hours in 2001. (It was 54.5 hours in 1999.) Overall, the proportion of time physicians spent in direct patient care activities increased from

**"Current physician capacity constraints may ease if higher out-of-pocket costs prompt patients to seek less care," says the report by the Center for Studying Health System Change.**

81% in 1997, to 82.6% in 1999, and to 86.3% in 2001.

Direct care of patients includes face-to-face contact; patient record-keeping; travel time to see patients; and communication with other physicians, hospitals, pharmacists, and others on a patient's behalf. The report defines medically related activities as administrative tasks, professional activities, and direct patient care, but not time spent on call.

### **Physician Extenders Added**

To assist in patient care, physicians employed more physician assistants, nurse practitioners, nurse midwives, and clinical nurse specialists in 2001 than they had in the past. The proportion of physicians in noninstitutional practice settings who worked with such caregivers increased from 40.3% in 1997, to 44% in 1999, and to 48% in 2001. The trend was most noticeable for group practices of three or more physicians, where the proportion employing non-physician caregivers grew from 53% in 1997, to 58.8% in 1999, and to 65.7% in 2001.

Despite spending more time in direct patient care and having more support staff, many physicians reported having inadequate time to spend with patients. When asked to agree or disagree with the statement, "I have adequate time to spend with my patients during office hours," 34.2% disagreed in 2001, compared with 33.1% in 1999 and 27.6% in 1997.

The HSC report notes, however, that other research demonstrates that the amount of time physicians have spent face to face with patients did

not change during the same period. In an NEJM article, "Are Patients' Office Visits With Physicians Getting Shorter?" (Jan. 18, 2001), researchers said the average duration of office visits increased between 1989 and 1998, from 16.3 to 18.3 minutes according to the National Ambulatory Medical Care Survey of the National Center for Health Statistics, and from 20.4 minutes to 21.5 minutes (also between 1989 and 1998) in the American Medical Association's Socioeconomic Monitoring System.

One contributing factor to diminishing physician capacity may be that the proportion of patients who saw a physician at least once during the year grew between 1997 and 2001, from 77% to 78%, according to the HSC report. (HSC did not report figures for 1999 concerning patient visit frequency.)

Although more patients saw a doctor and physicians spent more time in direct patient care, the average number of physician visits per person remained constant, according to the report. In 1997 and 2001, patients had an average of 3.8 physician office visits a year. Those numbers are supported by the NEJM article: In the nine years covered in that article, the number of visits to physician offices increased from 677 million to 797 million, although the rate of visits per 100 population did not change significantly.

The HSC report notes that increased employment of nonphysician practitioners did not boost the average number of office visits per person. In fact, it states that the average number of office visits to

either a physician or a nurse practitioner remained unchanged, at about four per year in 1997 and 2001. More patients reported seeing a nurse practitioner at least once during the year, and the proportion of those patients rose from 12% in 1997 to 15% in 2001.

Since the average number of office visits to either a physician or a nurse practitioner was constant between 1997 and 2001, a possible explanation for the increase in patients seeing a nurse practitioner is that more patients were seeing both a physician and a nurse practitioner in the same visit, the report says. (HSC did not provide such figures from 1999.)

### **Limiting Factors**

In examining how physicians are spending their time, the report says more diagnostic and treatment options for chronically ill patients are probably reducing physician capacity. Another significant factor is a growing list of preventive services that organizations recommend for primary care physicians who see patients.

The *American Journal of Public Health* reported in April that if all physicians followed all government recommendations aimed at preventing disease and injury, they would spend more than seven hours a day on the standards.

"Physicians may be frustrated by having too much to discuss with their patients in too little time," says the HSC report.

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

**One report said that if all physicians followed all of the government's recommendations aimed at preventing disease and injury, they would be spending more than seven hours a day just to comply with these standards.**

(Continued from page 1)

wide. The outpatient care file includes demographic and other information on outpatient care (such as appointments with physicians, nurses, and therapists), and data on the use of emergency rooms, pharmaceuticals, laboratories, radiography, and diagnostic procedures.

"The national VA hospital database is highly reliable, and it captures a large and well-defined population," Oddone explains. "Using this database, we can provide an accurate picture of the total care utilization for these patients."

For the retrospective cohort study, researchers tracked outpatient care and survival for 11,661 patients admitted to VA hospitals with a primary diagnosis of CHF. "We capitalized on the fact that the VA maintains in a central database all its health care information for patients who were either seen in the outpatient clinics or hospitalized in one of the VA hospitals," Oddone explains. "We assembled a group of patients with a code of heart failure who were hospitalized in the VA system between October 1991 and September 1992. We then tracked the care of these patients for one year."

The researchers divided patients into four groups based on their pattern of outpatient care: GM-only (at least one follow-up visit to a general medicine clinic but no cardiology clinic visits), card-only (at least one follow-up visit to a cardiology clinic but no general medicine clinic visits), mixed (follow-up visits to both general medicine and cardiology clinics), or no-GM/card (no general medicine or cardiology clinic visits, but visits to other VA providers).

The researchers then calculated the mortality rate by group. Among the 11,661 patients, 56% were allocated to the GM-only group, 7% were in the card-only group, 29% were in the mixed group, and 8% were in the no-GM/card group.

### Significant Findings

"The most important finding of the analysis was that heart failure patients who had access to a cardiologist after hospital discharge exhibited improved survival relative to patients who did not have such access," Oddone explains.

The overall one-year mortality rate among the study population was 23%. The mortality rate was lowest for patients who received a mix of general medicine and cardiology follow-up care and for patients who received cardiology follow-up care only (both were at 19%). The mortality rate was 24% in the GM-only group and was highest (at 29%) in the group that received neither general medicine nor cardiology follow-up care.

Compared with the patients in the mixed and card-only groups, those in the GM-only group had a 26% increased risk of mortality, and those in the GM-card group had a 48% increased risk of death.

Other factors associated with a higher mortality rate included age, white race, a hospitalization in the year before admission for CHF, the number of prior hospitalizations, an increased length of stay during CHF hospitalization, and increased comorbidity.

"Given the increasing complexity of care for CHF patients and the high

morbidity of CHF, it is not surprising that CHF patients may benefit from multidisciplinary care," notes Oddone. Most patients with CHF are older and have multiple medical illnesses, such as diabetes, arthritis, and depression, he adds. A multidisciplinary approach to care may improve outcomes for CHF patients who either have these other conditions or are at risk for them.

The researchers also found that the mixed group had the greatest number of clinic visits (an average of 14.5 visits per year). GM-only patients averaged nine visits per year, while card-only visits averaged seven per year. There was no evidence that the patients seeking both general medicine and cardiology care were sicker or older than those in the other groups.

"The visit frequency analysis revealed that cardiology clinic visits did not supplant the general medicine clinic visits," Oddone offers. "Rather, these patients received more follow-up care." The researchers did not analyze the effects of visit frequency on survival, he adds, explaining that some patients may have been more likely to seek care and it might be possible that improved outcomes are linked to visit frequency.

### Research Implications

To determine the consistency of results, the researchers performed the same analysis on a second cohort of patients admitted to the VA system between October 1994 and September 1995. "We wanted to see if the survival differences that we observed in the early cohort (when treatments such as ACE-inhibitor therapy were starting to become

(Continued on page 9)

**The mortality rate was lowest for patients who received a mix of general medicine and cardiology follow-up care and for patients who received cardiology follow-up care only (both 19%).**

(Continued from page 8)

more widely understood, but before beta-blockers were commonly used for treating patients with heart failure) persisted into later years," says Oddone. "In fact, we found that the results did not differ significantly between the two cohorts."

"The main implication of the study is that access to cardiologists confers better outcomes in patients with heart failure," Oddone continues. "In order to enhance care quality, patients with heart failure who are sick enough to be hospitalized should, at some point, see a cardiologist. The cardiologist can evaluate the patient, assess the patient's medical regimen, and provide an opinion as to whether the patient should undergo a procedure such as cardiac catheterization, PTCA, or coronary artery bypass graft."

The analysis did not reveal why the outcomes for the card-only and the mixed groups were better. Cardiologists may be more likely to implement more complicated treatment strategies or know more about CHF care, Oddone speculates. "The study cannot tell us why outcomes were better in certain groups," he says. "The only thing we can do is make inferences. The data indicate that there is some aspect of cardiology care that improves survival rates. Lower mortality may be due to the knowledge and expertise of cardiologists, their more appropriate use of pharmacological management, or their more aggressive use of revascularization procedures."

To enhance the quality of care CHF patients receive, physicians will need to understand why care by a cardiologist leads to better outcomes, Oddone explains. "We need to assess

what is being done for these patients," he says. "Does cardiologist care lead to better outcomes because cardiologists are more aggressive in suggesting procedures that ultimately help reduce mortality? Do cardiologists provide a more rigorous and more specialized approach to the medication management of these patients? Cardiologists may put a greater percentage of these patients on beta-blockers or a higher and more appropriate dose of ACE-inhibitors, or they may exhibit better management of diuretics. Currently, we do not know the answers to these questions."

"I would encourage cardiology researchers to examine the effect of care patterns on mortality prospectively to define why cardiology care confers survival benefits," Oddone continues. "Understanding the factors that drive better outcomes will enable us to build these factors into disease management programs that will drive reductions in mortality."

### Determining Factors

Determining the factors driving lower mortality is difficult, however, especially since the study was not a randomized clinical trial. "We did not randomly allocate patients to a pattern of care," Oddone emphasizes. "While we attempted to adjust for the differences in comorbidity and severity of illness, there still could be some other, unmeasured reason for mortality differences resulting from a bias in which patients ended up in the different groups."

"In addition," Oddone continues, "we did not have access to important clinical information, such as measures of left ventricular function or use of specific medications. In general, ret-

spective database analyses are typically limited in that they do not tell us why certain events occurred. Our study indicated that care in specialty clinics led to better outcomes, but not why this occurred. We do not know if patients did or did not receive appropriate medications, for example, or if they were appropriately evaluated for revascularization procedures."

Once cardiologists understand which aspects of their care improve outcomes, they could pursue closer referral relationships with primary care physicians that would enable them to provide collaborative care.

"The real policy implications involve helping health care institutions ensure that optimal care is provided to these patients," Oddone says. "Ensuring optimal care will likely involve defining the necessary interactions and communications between cardiologists and primary care providers who together will oversee the care of CHF patients. Defining optimal disease management models and implementing them appropriately are crucial for patients with very complex and high-mortality diseases like CHF."

What's more, the study may provide background for more specific disease management research, Oddone notes. "Prospective research is needed to answer some of the questions that our study has raised," he says. "Only when we understand the drivers of better outcomes will we be able to create disease management programs that have a major impact on CHF mortality."

—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).

**Once cardiologists understand which aspects of their care help improve outcomes, they could pursue closer referral relationships with primary care physicians and provide collaborative care.**

# Health System Seeks to Improve Care by Developing Information Systems

**M**any health systems are adopting electronic medical records and other information technologies to improve practice efficiency and enhance care quality. One system that has been successful in doing so is PeaceHealth, in Bellevue, Wash. PeaceHealth consists of six hospitals and four medical groups serving patients in Alaska, Oregon, and Washington.

## Technology in Practice

The effect of technology on practice style is a significant concern at PeaceHealth, says John L. Haughom, MD, PeaceHealth's senior vice president for health care improvement. "We are constantly focused on how we fit new technology solutions into physician workflow and how we ensure system speed," he comments. "We have adequately addressed the system speed issue, because we have system response times now that are well under a second, typically running around 0.4 seconds. So we do not get many complaints about the screens not showing up fast enough.

"But we still have to work hard to get the information in the system ideally optimized to support the work process of physicians in the way they want to do their work," Haughom continues. "We are constantly redesigning screens to facilitate their work processes. We are looking at the use of handheld computers for that very reason. One complexity is that

there is no single perfect process, because every discipline has its own way of doing things."

While PeaceHealth has made progress in using electronic technology, it still has quite a way to go, notes Haughom: "To some extent, technology is a moving target because care is changing. People think I work with technology. But the truth is that I spend the majority of my time managing people through change and working with work processes and figuring out how to optimize them. Eventually the technology piece comes in, but it's not the primary focus."

## Electronic Patient Records

Since 1992, PeaceHealth has been developing an electronic patient record. "When we first introduced the electronic medical record in 1994, the physicians rejected it," Haughom says. "In 1996, they grudgingly accepted it. By 2000, 95% of them reported that they wouldn't go back to the paper record."

While PeaceHealth physicians have found significant value in the electronic medical record, they also have found that it is not perfect. "For example, in Eugene, where we have one of PeaceHealth's bigger medical staffs, the physicians have embraced the electronic medical record enthusiastically, but many are frustrated because it is not better," he explains. "It's an interesting phenomenon: They will set the bar for information

system capabilities; we will work hard to reach the bar; and then by the time we start approaching it, we have other meetings with the physicians and they have once again raised the bar. I think that cycle will repeat indefinitely. The physicians are getting comfortable with it, and they like the access to the information, but they are always noticing the flaws and the imperfections of the system and they want more—which is fine."

As a result of this cycle, Haughom's job has changed from managing physician resistance to managing physician expectations. "Suddenly, the attitudes of physicians have shifted toward acceptance," he relates. "The challenge now is that everyone wants everything too fast, much faster than time and resources allow."

Now that electronic patient records are being used widely, PeaceHealth is seeking to use other technologies in practice. "The first several years were devoted toward developing the infrastructure and physician awareness of the infrastructure, and cultivating the willingness of physicians to use it," Haughom explains. "While that infrastructure development will never go away (since we are always going to be developing it), the majority of that work is now complete. Currently, our attention is shifting toward refining our systems and developing advanced decision support capabilities.

"So, for example, we are creating a

**"We are constantly focused on how we fit new technology solutions into physician workflow and how we ensure system speed."**

**—John Haughom, MD, PeaceHealth**

very robust data warehouse capability that is used both by the operational business staff and by clinicians," the senior VP continues. "This capability includes certain functions (such as analytical abilities to enhance revenue) and a chronic disease database for specific conditions (such as diabetes, congestive heart failure, asthma, and cancer). We have put a lot of momentum behind these projects."

### **Computerized Order Entry**

Many organizations, including the Institute of Medicine, in Washington, D.C., and the Leapfrog Group, a business coalition also in Washington, D.C., are promoting the use of computerized prescriber order entry systems and PeaceHealth is doing so as well. It has been working on a physician order entry project, which Haughom plans to be the precursor to an advanced real-time physician support system with expert rules and other functions. "On the outpatient side, we are entrenched in our order entry project," he says. "PeaceHealth physicians are writing about 400,000 prescriptions a year on the outpatient side, and they like the system. But computerized order entry is a lot simpler on the outpatient side than it is on the inpatient side. On the inpatient side, we are just getting into it."

Computerized order entry is part of a significant cultural shift, Haughom notes. "We are trying to develop some good, efficient support systems that are coupled with physician order entry in order to increase appeal to physicians," he explains. "To encourage them to use this system to write the orders, we want to build efficient support so that when they use the sys-

tem, they will get enough information that they wouldn't otherwise have."

Seeking to make the prescriber order entry system attractive to physicians, PeaceHealth is negotiating with LDS Hospital in Salt Lake City to implement an antibiotic assistant decision support program that LDS developed. "The plan is to implement this decision support tool in conjunction with the physician order entry program," Haughom explains. "This tool will provide the physicians with instant information and support in their decisionmaking to offset the headaches of having to write their own orders."

### **Handheld Tools**

Among the many options physicians have for information system hardware, personal digital assistants may have only a limited potential, Haughom believes. "PDAs are always going to be used, but their use will probably be limited to specific circumstances," he notes. "For example, physicians will use them to get emergency lab results or drug information. But in terms of the practice of medicine—seeing patients, doing rounds, and making decisions—the tablet PCs will be more useful. Among the myriad of device choices, tablet PCs offer the most promise.

"A tablet PC is a computer that's about the size of a clipboard, a little under an inch thick, and weighing one to two pounds," Haughom explains. "It has a big screen with touch-screen capabilities. Doctors can carry it with them from room to room and from patient to patient. Tablet PCs are just now coming on the market, but within three to five years they

are expected to be in widespread use in medical practices because they will be able to provide so much information given their large screen size."

Voice recognition technology also is likely to become more popular as well, Haughom says. "Voice recognition has proven quite valuable in certain areas, particularly in radiology departments, emergency rooms, and pathology labs. We use voice recognition and it works well, saving a lot of time and money in producing reports. But voice recognition will probably not find widespread use in general medical practice. It may find more applicability as the technology develops over the next 10 years. We need to see improvement in the software and computing processing power to deal with the fact that people's voices and methods of speech vary from one time to the next."

### **Web-Based Systems**

Any discourse on technology in health care must include a discussion of how medical practices are using the Internet. "The important aspects of our Web technology efforts have included developing an intranet, an internal Web site to provide physicians and other staff with ready access to information, to enhance communication, and to support process improvement," Haughom says.

"Our Web site was opened to the public in January 2000 (at [www.peacehealth.org](http://www.peacehealth.org)); it has features designed to inform, educate, support, and build loyalty among patients and the public at large," Haughom notes. "The site allows patients to find a physician, ask a medical question, do health-related research using a search

*(Continued on page 12)*

**"Suddenly, the attitudes of physicians have shifted toward acceptance," Haughom relates. "The challenge now is that everyone wants everything too fast, much faster than time and resources allow."**

(Continued from page 11)

engine of the best sites, take virtual tours of medical facilities, and much more. We have also established a community health record, which is an electronic medical record that maintains patient information on a private, secure network linked with participating providers.”

Given the proliferation of Web usage among patients, Haughom believes physician practices should have their own Web sites. “As more business is transacted over the Internet, it will be important for physicians’ to have Web sites and that these sites be able to handle rising patient expectations,” he says. “For example, patients increasingly will expect sites to have the capacity to allow them to update prescription requests, get their lab and test results, accept payments, schedule appointments, and so on. The sites also should assist with physicians’ personnel needs, allowing them to recruit and accept applications online.”

To take full advantage of the Web’s potential, a physician’s site must be interactive. “It must allow users to send secure e-mail inquiries and other messages to the physician’s office, and it must have a mechanism for responding,” Haughom comments. “Such interaction creates a one-to-one connection, establishes the personal relationship patients want, and will distinguish one practice from other medical practices.

“While the Web may not seem personal at first glance (after all, it is simply a large network of computers), it allows for detailed exchanges between physicians and patients,” he adds. “Wise use of the Web poses a

win-win proposition. By meeting a patient’s needs for education, information, and support, physicians can simultaneously cultivate patient loyalty and empower patients to take better care of themselves.”

### Peer Recognition

As physicians and health care organizations develop technologies to improve care process, they may want to take a lesson from the efforts of PeaceHealth. “Our former CEO was a truly visionary woman who decided in 1991 that the organization needed to get ready for a very different type of health care beyond the year 2000,” says Haughom, who became involved in technology issues while practicing in internal medicine and gastroenterology. In the early 1990s, PeaceHealth engaged a large consulting firm and a group of 70 PeaceHealth staff to participate in a project to improve how the organization used technology.

“We concluded that the future was going to require three things: a much more integrated, seamless form of care (we are still figuring out what that means); a culture of quality and quality improvement; and the technical infrastructure to support the first two requirements.” Haughom says. “I was happily in practice at the time, but when the process was finished in 1992, the CEO asked me to study what resources would be required for the quality and the technical requirements. I researched these topics and outlined a plan and an infrastructure that needed to be put in place for PeaceHealth. I started doing this part time, but eventual-

ly it became a full-time job.

Looking back over the work that has been done in the intervening years, Haughom says he has found each project the organization has tackled to be exciting and rewarding. But the projects themselves are not the goal. “I didn’t embark on technology development just to do an electronic medical record,” he says. “I went into it to change care, and we’re doing that. We have a long way to go, but it is exciting to see that we are starting to have an impact on care and are getting some outside recognition for what we have done.”

Last year, PeaceHealth was one of seven organizations to win a Pursuing Perfection Grant from the Robert Wood Johnson Foundation in Princeton, N.J. The \$1.9 million grant is being used to implement some of the recommendations that the Institute of Medicine has made in recent years. “About 270 organizations applied nationwide, and we were one of seven organizations that won,” Haughom says. In addition, PeaceHealth has been designated three times (in 1999, 2001, and 2002) as one of the 100 most wired hospitals in the country by *Hospitals and Health Networks* magazine.

“The grant and recognition did not change our direction, but did give us funding to expand on supporting our technology development and clinical quality improvement efforts, and added a lot of credibility to what we are doing,” Haughom concludes.

—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).

**“Wise use of the Web poses a win-win proposition. By meeting a patient’s needs for education, information, and support, physicians can cultivate patient loyalty and empower patients to take better care of themselves,” says Haughom.**

# Proven Technologies Can Increase Efficiency, Expert Says



**Michael Alper** is president and CEO of Meridian Healthcare Management, Inc., a management services organization in Woodland Hills, Calif.

Meridian provides outsourced managed care technology and administrative services to risk-bearing provider organizations, IPAs, medical groups, integrated delivery systems, and major health plans. Alper discussed trends in health care and the adoption of computerized management services with Richard L. Reece, MD, editor in chief.

**Q:** Your company stresses that systematic, organized, and purposeful use of information technologies and automating business processes is necessary for physician practice success. Why is that?

**A:** We have found that the use of proven technologies, when appropriately deployed, can increase efficiency and therefore theoretically free up additional resources that can be used to lower costs, enhance access to care, and improve reimbursement.

**Q:** Do you view the outsourcing of administrative services over the Internet as a force for change?

**A:** Many health care organizations have inadequate infor-

mation technology systems and, perhaps even more important, do not understand business processes. In those cases, outsourcing to an organization that can leverage efficiencies and economies of scale is certainly a big advantage. Eliminating some of the burdens that cause delays and hinder access to patient care will improve patient and physician perspectives of how managed care operates. Computerized technology can make the health care system operate both more effectively and more efficiently.

Still, the incorporation of new ways of doing business is uneven. For example, we have a very robust Internet connectivity product that allows physicians, health plans, and other providers to access our database of member information, verify eligibility, verify the contract and provider panel for that market, instantly obtain authorization for referral services and inpatient care, and submit claims electronically with expedited payment. Yet despite all of our best efforts, only about one third of the claims we get for more than 500,000 enrolled members across all of our customer base are submitted electronically. For the same 500,000 enrollees, however, more than 70% of all the referral transactions [prior authorizations required by most HMOs] are handled via the Internet. We are confused as to why one trans-

action often happens over the Internet, while the other does not even though the other transaction is the one that offers real economic benefits to the provider.

**Q:** Do you find that physician groups are reluctant to give up their legacy systems to transfer many of these functions to the Internet?

**A:** Most physicians are not willing to walk away from the technology investments they have already made. They do not want to spend new money. They have a system in place, and they are accustomed to their collections taking 30 to 60 days. Since many physicians have gone through bad computerization transitions in the past, making a change scares them. Although they know that there are good, efficient ways to conduct transactions over the Internet, they just do not want to take that risk. Interestingly, we find that the same physicians who do not submit claims electronically do their shopping on the Internet. They are using the Internet to meet their personal needs efficiently, but they don't want to trust their business to it.

**Q:** What are some of the ways provider organizations can capitalize on the Internet?

**A:** First, they can learn more about online claims submission and adjudication. Currently, the normal process for claims submission

(Continued on page 14)

**“Only about one third of all the claims that we get for more than 500,000 enrolled members are submitted electronically. For those same 500,000 enrollees, however, more than 70% of all prior authorizations are handled via the Internet.”**

(Continued from page 13)

is this: Providers see a patient in their office, check off care descriptions on a form, and hand that to the billing office staff, who put that information into a computer system and mail it to the payer. The payer receives a huge volume of mail that needs to be opened, sorted, date stamped, and prioritized. Then the data need to be manually entered into its own computer system. That drawn-out, inefficient process can be eliminated when a physician's staff sends the claims information entered into a computer electronically to the payers, thus improving cash flow.

Second, providers should pursue real-time managed care transactions and online reporting because these functions provide information physicians can use to improve their business decisionmaking. Organizations involved in managed care—whether they are risk-bearing provider networks or health plans—do not often have accurate or timely information. Another issue is that organizations often have too much detail and can't see the macro issues that the data can reveal. Online reporting allows practices to analyze major topics (such as utilization, patient acuity mix, illness severity, costs, and other data) and then drill down into focused areas to identify significant issues in terms of patient costs, behavior, and illnesses.

Third, physician groups or organizations can decrease their administrative burdens through the use of the Internet. When physicians can automate their data, they need a smaller office staff.

Fourth, moving to Internet-based administrative systems decreases

overhead expenses. Sixty percent of the cost of processing a claim is due to the labor required for data entry. This cost can be vastly reduced by on-line claims submission.

Finally, Internet-based administrative systems improve customer service. By making real-time data available in the practitioner's site, administrative items (such as eligibility and benefit verification) or referral requests can happen at the point of care.

**Q:** *Do you think the health care environment is changing rapidly at this point?*

**A:** We are making slow, but steady progress. The delay is due to the fact that we are talking about health care for individuals, and people regard their health care as a very personal issue. Consumers are limited in their choice of coverage by their own ability to pay, but still their desire for good access to care and state-of-the-art care results in a higher cost of care. There is still a lot of confusion from the consumer perspective as to what is good coverage, what is quality health care, and what is good access. These are issues that the industry has been wrestling with for many, many years, and it is much closer to resolving them.

**Q:** *Do you think that the consumer backlash against managed care is warranted?*

**A:** Certainly, there is a huge consumer backlash against health care delivery as a whole, and managed care (meaning care provided by HMOs) has really taken the brunt of that backlash. However, assigning responsibility for the nation's health

care delivery problems to HMOs is inappropriate. HMOs are just a highly visible target.

My own family members say that HMOs provide bad care. But, in fact, the HMO does not provide any care. It provides an insurance product and access to a panel of providers, physicians, and hospitals. These caregivers are the decisionmakers. Accusations against HMOs by consumers are perhaps reasonable in cases where HMOs are limiting benefits, coverage, or access to providers. In the western states, most care is delegated to capitated provider delivery networks that make decisions on a local basis about patient care given local economics.

**Q:** *Is the market shifting away from HMOs to PPOs?*

**A:** Not in California, where we still see a very large penetration of HMOs. We are pretty clear here in California and some other western states about the differentiation between HMO and PPO products. Nevertheless, premium increases are such that we are seeing the gap narrow between PPO and HMO premiums. At the same time, we are also seeing HMOs expand their access to a larger degree. As a result, the products are starting to look a little more similar than they did in the past.

**Q:** *Do these changes reflect the fact that HMOs are trying to adjust to the backlash?*

**A:** Yes. Overall, the HMOs are in a kind of interim state. They are allowing greater access to a broader variety of providers, relinquishing some of the restrictions that were historically part of their benefit plans,

**“Interestingly, we find that the same physicians who do not submit claims electronically do their shopping on the Internet. They are using the Internet to meet their personal needs efficiently, but they don't want to trust their business to it.”**

**“There is still a lot of confusion from the consumer perspective as to what is good coverage, what is quality health care, and what is good access. These are issues that the industry has been wrestling with for many, many years, and it is much closer to resolving them.”**

and creating richer benefit packages and tiered benefit packages, but cost increases are declining. Some HMOs are doing a good job of adjusting to the backlash; others are not.

**Q:** *There seems to be a lot of rhetoric about consumer-driven health care and shifting costs to consumers. Is that movement real?*

**A:** Yes. Cost issues are probably the primary driver of change, and helping consumers understand what the actual costs are is a very hot-button issue.

At the same time, the perception of quality is always a hot-button issue. The true measurement of quality remains elusive. People are fascinated when health plans announce that they want to offer better provider payments for high-quality care, but the reality is that they are having a tough time figuring out how to actually measure quality.

**Q:** *What is the significance of defined contribution plans?*

**A:** There has been a lot of discussion about the defined benefit plan versus the defined contribution plan. Some of the big health plans, such as Cigna and WellPoint, are introducing defined contribution plans on an experimental basis this year. Still, the defined contribution plans have not been adopted to any significant degree.

**Q:** *How much longer are employers going to tolerate double-digit percentage increases in premiums?*

**A:** As an employer with 350 employees, I can say that I am not going to tolerate it much longer. We are evaluating our health care benefit, and we are looking at providing the administrative functions for

our employees on our own and contracting with a physician network to provide care.

**Q:** *Will the rest of the nation move toward developing a health care environment like that in California?*

**A:** No. The California model works well here, but much of health care is cultural. For example, people in the Boston metropolitan area will tolerate 30% higher premiums than those in California and not even blink. That's a cultural phenomenon. They are wedded to the idea that academic medical centers provide a superior brand of service and those are the places to go. It's fascinating to try to figure out why people are willing to do that.

Similarly, some health care markets, such as the one in Minnesota, have seen the development of large group practices with 150 physicians or more in a group. Other states are characterized by small groups of five or fewer physicians. So there are a lot of differences.

**Q:** *Has capitation caught on anywhere else besides the West?*

**A:** Capitation is common in several markets, including California, Oregon, and Washington state. There is some capitation in Colorado, Florida, and Texas; and there are small pockets of capitation in Chicago and in the Northeast and Mid-Atlantic states.

**Q:** *How are the huge nonprofit plans such as Kaiser Permanente performing in the market?*

**A:** There is not a big difference between a nonprofit plan and a for-profit plan except in terms of their access to capital. Operating performance is not driven by corporate

structure. The operating performance of most plans is fairly similar, and no one plan is emerging as having the perfect model.

**Q:** *How are physician groups fairsing in California?*

**A:** Today, the requirements for an IPA or medical group to stay in business are much tougher than they were 10 years ago, given the economics of medical practice. Many physician groups have failed. But we are not seeing a wholesale bankruptcy of capitated provider networks. Some organizations are well run, some are poorly run, some are well capitalized, and some are poorly capitalized. All of those issues influence an individual group's viability.

**Q:** *Do you see an exodus of physicians from California?*

**A:** No, not as much as I thought we would see. California is still a very popular state. Many people here are insured and have good access to health care services. I haven't seen the mass exodus that was predicted.

**Q:** *What other trends are you seeing in California?*

**A:** As in other states, increases in premiums do not seem to be allocated sufficiently toward physician practices. We heard health plans talk about big bumps in costs related to pharmacy. Now they are talking about big bumps in costs for hospital services. It seems that with every premium increase, the dollars are going someplace other than to physician practices.

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

# CARDIOLOGY OPTIONS.com



## Our FREE online resource includes:

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

### E-MAIL UPDATES

Let CardiologyOptions.com come to you! CardiologyOptions.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at CardiologyOptions.com or fill in your name and e-mail address below and fax it to us at **973-682-9077**.

**Name:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

# CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

August 15, 2003



Premier Healthcare Resource  
150 Washington St.  
Morristown, NJ 07960

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