

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

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CONTENTS

Features

Commentary
Hybrid EMR
Accommodates
Paper 3

Interview
After 15 Years,
Physician Still Finds
Variety of Temporary
Work Fulfilling 13

Departments

Editorial
Report: Caps Help
States Retain
Physicians 2

Technology
Systems Aid Rural
Health Delivery 6

Strategy
Practice Finds
Increasing Efficiency
Requires Making
Numerous Changes 10

Treatments Aim at Hypertension Among Senior Citizens

Hypertension is extremely common among seniors, and a number of strategies exist for managing this condition among the elderly.

“High blood pressure, particularly systolic hypertension, is very common in older people,” says John M. Flack, MD, MPH. “In fact, the senior who does not develop hypertension is the exception rather than the norm. At about 70 years of age, 65% to 85% of seniors will have hypertension.” Flack is director of the Cardiovascular Epidemiology and Clinical Applications Program at Wayne State University School of Medicine in Detroit.

Management Required

“As people get older, their systolic blood pressure rises fairly linearly with age,” says William B. White, MD. “By the time people are about 70 to 75 years old, almost everyone has an elevation of systolic blood pressure (SBP). Everyone in the 80-year-old population will have hypertension.” Diastolic blood pressure (DBP) begins to drop slightly starting about age 60. White is chief of the Section of Hypertension and Clinical Pharmacology at the University of Connecticut School of Medicine in Farmington.

Over the last decade, experts in the treatment of hypertension have

revised downward their definition of hypertension in the elderly, and therefore cardiologists should become more aggressive in treating high blood pressure in this population, White explains.

“A middle-aged person whose blood pressure is 130/90 mmHg is considered a borderline hypertensive, and blood pressure of 135/100 mmHg would certainly be treated,” White says. “In contrast, we used to think that blood pressure of 150/70 mmHg for a 75-year-old patient was acceptable because higher blood pressure was part of the aging process. Now we know that level of blood pressure is not safe and needs to be treated. Most physicians and patients need to understand that we have changed the rules, such that systolic blood pressure is the most important parameter in defining hypertension in the older population. Since systolic hypertension is very common in the elderly, many seniors are receiving, or should be receiving, some kind of treatment.”

Gary E. Sander, MD, PhD, a cardiologist at the Louisiana State University Health Sciences Center in New Orleans, recommends that since hypertension is so common in the elderly, physicians should monitor an elderly patient’s blood pressure and heart rate in both sitting and standing positions. “Aging is often associated with impaired baroreflex

(Continued on page 8)

Report: Caps Help States Retain Physicians

States that have enacted limits on noneconomic damages in medical malpractice lawsuits have about 12% more physicians per capita than states without such caps, according to a recent study by the federal Agency for Healthcare Research and Quality, in Rockville, Md.


The study is the first of its kind to associate caps on noneconomic damages with increased physician supply, AHRQ says. For the study, researchers reviewed the growth of physician supply since 1970, before any state had enacted caps, and found that physician supply has grown more in states with caps than in states without caps. Released in July, the study, "Impact of State Laws Limiting Malpractice Awards on Geographic Distribution of Physicians," is available online (at www.ahrq.gov).

Many physicians favor limits on noneconomic damages in medical malpractice suits, but Congress and some state legislatures have been reluctant to enact such caps. Some experts believe many factors have contributed to rising malpractice insurance rates; for example, the inadequate pricing of such insurance years ago which led to insurance industry losses and lower returns on insurance investments. Many lawyers and some consumer groups do not favor such caps.

For the AHRQ study, researchers analyzed state experiences over the past 30 years and adjusted for the effect of multiple factors believed to affect physician supply, such as per capita income and physician residency training programs, AHRQ says. By 2000, states that had enacted caps had a significantly larger number of doctors per 100,000 county residents (135) compared with states that had not enacted caps (120), the study shows. By contrast, in 1970 there was no statistically significant difference among states in their per capita supply of physicians, the researchers say.

"The robustness of these findings is quite remarkable," comments AHRQ Director Carolyn M. Clancy, MD. "Even when adjusting for numerous state characteristics, states with caps had a significantly higher number of doctors per person compared to states that didn't enact caps."

Speaking about the AHRQ report, Tommy G. Thompson, secretary of the federal Department of Health and Human Services, said, "Our broken medical litigation system is affecting patients' ability to find a doctor. This study confirms and quantifies the association between reasonable limits in medical lawsuits and the supply of physicians available to treat patients who need them. It is critical that we fix this broken litigation system now. In the current system, the fear of excessive awards stimulates wasteful defensive medicine and deters doctors and hospitals from identifying and addressing medical errors, thus increasing costs and decreasing quality."



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Hybrid EMR Accommodates Paper

By Nancy Curosh, MD

For the past year, our office has been using a new type of hybrid medical record system that is an excellent compromise between the convenience of using paper and the functionality of a full-blown conventional electronic medical record. For us, the system offers nearly all of the functionality of an EMR, but has not required us to type or to change the way we see patients. The system, called Zamclin, is offered by Kietra (at www.kietra.com), a company in Portland, Ore., founded, financed, and run by physicians.

We are a small, private, internal medicine and endocrinology practice that operates on tight margins. We have no extra staff or space to devote to computers, IT support, or systems that require a substantial amount of training. We are typical of many practices in that we are experiencing lower reimbursement levels in the face of rising expenses for malpractice insurance, personnel, and chart-related expenses.

Resource Allocation

Deploying a conventional EMR was simply not an option for us. The expenses aside, there is no way that we could type, interact with patients and computers simultaneously, and still maintain the patient volume that we need to stay in business. The training time alone would be a serious problem. Zamclin is an alternative to more traditional EMRs.

Nancy Curosh, MD, is the founder and head of Nancy Curosh, MD, PC, in Portland, Ore. Curosh, two associated endocrinologists, and their staff provide the endocrinology consult and outpatient services for the Sisters of Providence Medical Center in Portland. Readers may reach Curosh by e-mail at curosh@atsp.org.

Kietra's approach is unusual in that it allows a physician to use paper, computers, dictation, or any other means to document visits.

Regardless of how a physician records information, Zamclin is implemented using the application service provider (ASP) model, meaning Kietra keeps all of the servers, backups, technicians, and other hardware needed to maintain the records and data at its secure Internet service facilities. The medical record data are uploaded from each doctor's office to Kietra's servers via a secure Internet link and are then available over the same secure Internet connection to any authorized user.

The EMR allowed this small practice to keep its IT costs low and to forgo the worry of maintaining or backing up EMRs and servers in its office.

This approach has advantages and disadvantages, but for us it has meant that we can keep our own IT costs low and we do not have to worry about maintaining or backing up EMRs and servers in our office. We have easy access to medical records from the hospital or from home. All we needed was a computer, a small bulk-feed scanner, a laser printer, and a broadband Internet connection. In total, these costs amounted to about \$3,000 for the entire office. Kietra doesn't sell hardware but did refer us to a local company that put the system together, installed it, and provides on-site service. The most expensive component of the system was a one-time purchase of third-party scanning software required for

paper-based data entry. This cost us \$6,000, although lower-cost suppliers today can drop the price to \$4,500. Zamclin is sold on an annual subscription basis of about \$125 per month.

Data-Entry Issues

Since no one in our practice wanted to deal with a computer while seeing patients, our implementation of Zamclin was based on paper-based data entry. The implementation took a couple of weeks to set up but the system was quite simple to use thereafter.

First, Kietra took all of our standard billing, lab-order, prescription, and other forms and reformatted them into machine-readable docu-

ments that could be printed on demand on the laser printer. Then Kietra established an account for our clinic and gave each physician and staff person a user name and password. Permission to access various parts of the clinic system and medical record was set according to each person's need to know under federal privacy laws.

Zamclin also can be connected directly to practice management, scheduling, and billing systems. Doing so would make it possible to pass patient information between the systems automatically, and obviating the need to enter billing data by hand, while ensuring that the systems have the same information. Unfortunately, we could not take

(Continued on page 4)

(Continued from page 3)

advantage of this function because our practice management system was due to be replaced and we had not yet chosen a new one.

Once everything was set up, training took about 15 minutes for each physician, and a couple of hours for the receptionist and office staff who would run the system. After on-site training was completed, Kietra provides any additional training and technical support directly over the Internet in real time.

Making Changes

Setting up the system in the office was the most difficult part of the transition. For the physicians, practice procedures from that point on were either exactly the same or easier than they had been before. Here's how the system works.

Every day begins by printing out the billing and encounter sheets for the clinic for that day. Each sheet is customized for each patient and the physician who will see that patient. These sheets are all analogous to the sheets we used previously for recording diagnoses, CPT codes, and vital signs, and for ordering labs and writing notes. We also continued to use our preprinted history and physical notes with anatomical diagrams. Prescription forms also are printed for a given patient.

The patient is taken to an exam room and vital signs are recorded in designated spaces on one of the pages. The paperwork is then placed in the bin outside the exam room just as we had done previously. In our office, we still like to pull the paper version of the chart for clinic visits, but this is purely a matter of preference. Anyone choosing to view the

record on a laptop, tablet, or other computer screen could do so easily.

Just as we have always done, the doctor sees the patient, takes the history, does the physical, and writes the note. As before, the physician fills out the billing sheets and lab orders by checking boxes. If new prescriptions are written, they are done on the page provided. Prescribing refills is particularly fast. All a physician has to do is make an alteration, fill in the quantities, and sign the page. At the end of the visit, the chart is handed to the medical assistant or receptionist, and the doctor moves on to the next patient.

After labs are drawn, the prescription and lab forms are copied and given to the patient to take to the pharmacy and lab, respectively.

Searchable Records

Between patients, the receptionist takes the encounter sheets and puts them in the scanner. As the pages run through, all of the quantitative data about diagnoses, vital signs, procedures, medications, and labs are read and converted automatically to digital values. The progress notes, correspondence, and lab values that come back on paper are scanned and converted to images that can be displayed later. Kietra decided not to convert these free-form pages to text, since it would be too costly and error-prone. In our experience, we have never had a problem recalling or reading a Zamiclin note, so it seems to be a reasonable trade-off.

After one final step in which the computerized values are verified, the information is sent electronically to Kietra, where it is turned into a complete electronic medical record within

seconds. This is where the real magic takes place, since this electronic version is fully accessible and searchable. We can view patients' electronic records, generate reports, review lab work and vital signs over time, upload transcribed dictations, and send messages to patients with very little typing required. A complete electronic record creation and management interface are available for those who would like to click and type.

In the summer, we tested a computer tablet version of Zamiclin that seems to be the perfect combination of pen and computing. Notes can be written completely freehand on the tablet screen using the same practice-specific templates and diagrams that we currently use on paper. Absolutely no typing is required, although keyboard entry continues to be available for anyone who wants it.

Saving Time and Money

Of course, Zamiclin doesn't attempt to do everything. For example, it won't try to tell a physician how to upcode a given procedure. But it does have some nice touches that we haven't seen on other systems, and the drawbacks have been easily tolerated given the simplicity and low cost of the system, and the fact that our practice was not disrupted by installation and training. While our office is sufficiently small that we did not have any dedicated medical records personnel to eliminate, we're clearly saving time and money in the turnaround time needed to write prescription refills, copy records, and look up lab results and patient notes. Its secure built-in patient Web pages and electronic messaging system have saved a significant

“We can view patients’ electronic records, generate reports, review lab work and vital signs over time, upload transcribed dictations, and send messages to patients with little or no typing required.”

By simply clicking on a diagnosis, medication, or procedure, the patient can get pages of excellent educational information.

number of telephone calls.

One nice feature of the program is the completely separate educational Web sites that are automatically and uniquely customized for each patient in our practice. Each of these Web sites is kept secure with its own password and user name. Patient Web sites list all of the diagnoses, medications, tests, and procedures that the patient has had or that we would like the patient to learn about. By simply clicking on a diagnosis, medication, or procedure, the patient can get pages of excellent educational information. This information is in English, but much of it is also available in Spanish. If the patient does not have Internet access, we can print and give these pages to the patient during a visit. Patient feedback has been quite positive about this aspect of the program.

Another nice feature is a database of thousands of consent forms for tests, procedures, and medications. These forms can be printed out at the office for signing, but the appropriate forms also appear on each patient's customized patient Web site. Since office time is scarce, we'll often ask the patient to go home and read about his or her illness, tests, and treatments and call or come back with specific questions.

A third nice feature is that we can use our practice database to search for the names of patients with specific diseases and medications and automatically send secure messages to all patients fitting a specific profile. Having gone through thousands of

charts by hand when the manufacturer of cerivastatin withdrew this lipid-lowering medication from the market two years ago, we'll be using this feature the next time a drug is recalled.

Fixing Problems

As with any new process, there were problems initially that have been resolved. Some Internet-related installation problems, for example, have been fixed. Still, there are some features that we'd like to see added or improved.

The first one would be an easy way to change or edit the billing sheets and medication lists directly from the office. Currently, Kietra formats these sheets and lists, meaning that if we want to make even simple changes (such as adding or deleting a drug name from a list), we have to ask Kietra's customer service to do so. A forms editor that would allow our office staff to alter a list of medications, diagnoses, and procedures online would be quite helpful.

A second useful tool would be the ability to memorize frequently run reports. The current system allows us to search for various case characteristics (such as all patients with diabetes who have had hemoglobin A_{1c} tests), but it would be convenient to save all of the search parameters as a named custom report type (such as "Vaccinations Due This Month").

Finally, full electronic integration with all of the different clinical laboratories would be great. Such integration will take time even for a small

clinic such as ours because we use several different labs. Kietra is building interfaces with several key labs, but has not yet made these available for use in office practices. Meanwhile, we simply scan in the printed lab reports or enter certain results into the Zamiclin system by hand as needed.

Even given these minor drawbacks, Zamiclin is a solid addition to our practice. It may not be the first choice for large clinics, but it clearly fills an important need for a simple, inexpensive system that gets the job done with a minimum of physician time and trouble. Unlike many of our colleagues who bought more complicated EMRs, our clinical routine and productivity never declined after we took this approach with a hybrid EMR. In fact, we spend far less time on repetitive tasks, such as handling refills and answering questions that are well explained by on-line patient education materials. These sorts of efficiencies will almost certainly expand as the software is improved over time. Also, we hope that Kietra's specially designed tablet interface will take us all the way to a paperless office with little or no disruption of our current work flow or pen preferences.

For physicians in small practices who want to maximize their time spent seeing patients while minimizing their need to type and click, the Zamiclin approach is worth considering.

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

“Unlike many of our colleagues who bought more complicated EMRs, our clinical routine and productivity never declined after we took this approach with a hybrid EMR.”

Systems Aid Rural Health Delivery

Innovations in technology and financing are helping physicians in rural communities to improve the quality of health care they provide, according to a recent report by the California HealthCare Foundation. By working with federal, state, and local governments, private companies are providing some of the necessary funding for new technology, the report says.

Patients and physicians in rural settings face several problems, according to *Rural Health Care Delivery: Connecting Communities Through Technology*. The report was written by the Boston-based First Consulting Group for the foundation, a research organization in Oakland (at www.chcf.org). For patients, the need to travel away from their community for specialty care can result in lost work time, high costs, and the complications of coordinating care in different locales. The likelihood that health information will be missing or incomplete is therefore greater and may cause delays or fragmented care.

Rural physicians and other providers need time to travel to patients in hospitals and nursing homes and so have fewer face-to-face patient visits; they also spend more time on the telephone with patients and other providers than their counterparts in other settings. The net result is limitations on productivity, communication, and education, the report says.

In recent years, tertiary care centers and other delivery organizations have developed a range of technologies to improve communication

among physicians, access to information, and care services to rural areas. Recognizing the benefits possible from using remote technology, Medicare and other payers are easing some restrictions on reimbursement for technology-based services that specialists offer, the report says.

In particular, five technologies are helping physicians improve the delivery of care:

1. The Internet and e-mail
2. Web portals
3. Scanners and digital-imaging technology
4. Video teleconferencing, or telemedicine
5. Remote patient-monitoring systems

E-Mail Applications

Since e-mail requires only a computer workstation, Internet access, and low-speed connectivity, it helps foster a communication network for health-related questions from patients to physicians or among physicians. It also facilitates appointment scheduling, prescription renewal requests, and referral authorizations. More than half (55%) of all physicians use e-mail to communicate with other physicians for professional purposes, the report says.

Robert Webber, MD, a primary care physician in the rural community of Watsonville, Calif., found the most significant benefits of e-mail involve communicating with specialists and transmitting lab results and X-ray data, the report says. Since there are no rheumatologists in Watsonville, Webber has developed a consulting relationship using e-mail

with a rheumatology group in Santa Cruz, Calif., for example, according to the report.

Web Portal Applications

Applications based on Web portals allow rural physicians and patients to share patient-specific data, medical information, and remote educational data. Medical-related Web portals offer a broad range of applications and are typically sponsored by hospitals, academic medical centers, libraries, and professional training centers, according to the report.

Patients can learn about specific medical conditions and see detailed information about a specific organization's resources for a given medical condition using Web portal applications. Physicians can locate and print medical information to answer clinical questions using online libraries, free Web sites, such as Medline (at www.medlineplus.gov) or Intellihealth (at www.intelihealth.com), and a number of commercial vendors. "The key to successful use of these medical services is to integrate health reference links with the provider's other applications, such as prescription writing tools, electronic medical records, or e-mail communication vehicles," says the report.

For rural providers, a solution to the time involved to mail records back and forth is a centralized Web-based health record containing information provided by hospitals and patients that physicians can access and that meets federal and state privacy standards. An example is Eastern Maine Healthcare, a physi-

In recent years, health care delivery organizations have developed a range of technologies to improve communication among physicians.

cian and hospital network in Bangor that created MyOnlineHealth, a Web portal that allows participating patients to engage in secure communication with physicians and other providers. Patients can communicate with physicians, request an appointment, view laboratory test results, and obtain a prescription refill online. They also can complete health risk assessment surveys online and receive feedback from physicians, who can send them health information about their specific needs, says the report.

Digital Imaging

Providing access to remote specialist services is one of the most successful uses of technology to support rural health delivery, the report says. Since about 90% of specialty physicians practice in urban areas, some specialists (particularly radiologists, pathologists, and cardiologists) are in short supply in rural areas, the AMA says.

In urban areas, many academic medical centers and independent radiology practices have the capacity to read more images than their own practices demand. Technology plays an important role in connecting the demand to the supply, says the report. Using digital diagnostic equipment or digitized scanned images, diagnostic specialists can read images from multiple sites and send back interpretations electronically in a matter of hours.

For example, the radiology department of the Cleveland Clinic can connect the clinic to a physician group or hospital that has only a CT scanner, X-ray, or MRI. The clinic provides all other equipment and infrastructure. The Cleveland Clinic can supply off-hours radiology coverage and subspecialty expertise that

rural hospitals can't attract, the report says.

Video Teleconferencing

Video teleconferencing, or telemedicine, allows patients, their primary care physicians, and specialists to communicate in real time using interactive video equipment. At the point of origin, clinical assistants help the patients and control the equipment. Telemedicine consults are most common for dermatology, mental health, cardiology, emergency triage, and orthopedics, the report says. The key to making telemedicine work well is high-speed data transmission, according to the report.

The telemedicine program at the Department of Veterans Affairs Medical Center in Iron Mountain, Mich., allows physicians and other providers in clinics in Milwaukee or Chicago to assess patients at the Iron Mountain facility in real time. Robotically controlled microscopes allow pathologists to render diagnoses with the same accuracy they would have as if they were onsite, the report says.

Remote Patient Monitoring

One problem many hospitals face in rural areas is a potential lack of intensive care services. Many of these hospital services are at risk of being closed because qualified specialists, physicians, and technicians are not available for 24-hour patient care monitoring and services. Technology can connect monitoring equipment from a rural hospital to remote specialists who provide continuous monitoring. Telecommunications options, such as dedicated telephone lines and pagers, can alert nurses

about problems within seconds of the sounding of a monitor alarm. When a physician is involved in remote monitoring, providers can use video teleconferencing to support communication between an intensivist and caregivers at another site, says the report.

At Allen Memorial Hospital in Moab, Utah, for example, a lack of skilled technicians to support patient monitoring resulted in a majority of cardiac patients being transferred to other facilities. This caused hardship for the patients, who had to travel at least 100 miles to the closest tertiary hospital, as well as for the 38-bed hospital, which was losing patient revenue. Allen Memorial collaborated with physicians at St. Mark Hospital in Salt Lake City by installing monitoring equipment in the ICU that transmits data to a telemetry center at St. Mark Hospital, where technicians watch the data streams, validate alerts, and contact ICU nurses at Allen Memorial immediately via pager or phone as needed.

Funding and Reimbursement

E-mail services and Web portals are inexpensive, but the other technologies mentioned in the report can be very expensive. The report explains, however, that funding to start and maintain these programs is available from a number of sources, and it lists potential sources.

"The starting place for building a partnership is to identify organizations with common interests and goals for solving a particular health delivery problem," the report says.

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

Technology plays an important role in connecting the demand to the supply, says the report.

(Continued from page 1)

function, such that when an individual stands, the reflexive increase in heart rate may be inadequate to compensate for venous pooling of blood in the extremities, resulting in reduced cardiac output and postural hypotension,” Sander wrote in an article in *The American Journal of Geriatric Cardiology* (Aug. 2, 2002).

Comorbid Factors

Managing hypertension is particularly important because the condition can cause or exacerbate other health conditions. Chronic, uncontrolled hypertension can lead to stroke, blood vessel damage, heart failure, heart attack, or kidney failure. “Reductions in the incidence of heart failure, heart attack, and stroke occur when high blood pressure is successfully treated,” Flack says.

Another age-related complication is the development of end-stage renal disease. “Many older people develop chronic kidney disease and have a number of complications related to that condition, even if they never need dialysis,” Flack continues.

Among Americans aged 45 to 65, and especially men, there is a prevalence of myocardial infarction related to uncontrolled hypertension, smoking, hypercholesterolemia, and diabetes, White says. “But when people get older, there is a very large increase in fatal and nonfatal stroke and congestive heart failure,” he adds. Researchers are interested in preventing these two diseases (stroke and CHF), which are complications of hypertension and can be prevented with good control of systolic pressure, White explains.

What’s more, heart attacks are a significant concern as well, although there is not necessarily an increase in the prevalence of heart attacks in the

hypertensive elderly population compared with that of those who are middle-aged and have severe uncontrolled hypertension, White says.

Cardiologists and all caregivers also should watch for hypertensive emergencies. A hypertensive emergency occurs when high blood pressure is associated with ongoing damage to the heart, brain, kidneys, vascular system, or eyes.

Clinical trials of medication use in elderly people with hypertension demonstrate that medications, if they are effective at lowering blood pressure, will reduce the rate of strokes and the development of heart failure to a much larger extent than they will reduce the rate of heart attacks, White says.

Cognitive Function

A recent study also showed a link between poor cognitive function and hypertension. The study, presented in a poster at the Joint Meeting of the European and International Societies of Hypertension in Prague in June 2002, included more than 1,500 elderly individuals who visited a geriatric outpatient clinic complaining of memory problems. Olivier Hanon, MD, and colleagues at the Department of Geriatrics at Broca Hospital in Paris, tested the subjects for cognitive impairment using the Mini Mental State Examination and grouped them into four categories: no cognitive impairment, mild cognitive impairment, Alzheimer’s disease, and vascular dementia.

All subjects were given a complete physical examination, during which blood pressure was measured. After analyzing the data, the researchers found a significantly larger number of individuals with hypertension in the groups with mild cognitive impair-

ment (65%), Alzheimer’s disease (70%), and vascular dementia (79%) than in the group with no cognitive impairment (50%).

Treating even mild hypertension can have significant health benefits. Also presented at the 2002 Joint Meeting in Prague were other data from a large clinical trial called the Study on Cognition and Prognosis in the Elderly. The SCOPE data showed that treating mild hypertension in the elderly may significantly reduce the risk of stroke and major cardiovascular events. SCOPE followed the outcomes of almost 5,000 elderly patients with hypertension treated at 527 sites in 15 countries.

The patients ranged in age from 70 to 89 years and had mild hypertension (treated or untreated), reflected in a sitting SBP of 160 to 179 mmHg or a sitting DBP of 90 to 99 mmHg, and good cognitive function. Compared with the control group, a 28% reduction in the risk of nonfatal stroke was observed in the treatment group. The SCOPE analysis also showed that reducing blood pressure did not increase the rate of cognitive decline or the development of dementia in elderly patients.

Challenges in Treatment

While medications can be effective, difficulties remain in controlling hypertension in the senior population. “Blood pressure tends to be much higher in older people; that makes it more difficult to lower pressure,” Flack observes. “In addition, older people are more likely to have reduced kidney function, and their kidneys are spilling proteins; both of these factors make it difficult to control blood pressure and, in fact, will cause pressure to rise. Furthermore, the elderly are more likely to have

(Continued on page 9)

High blood pressure is very common in older people. At about 70 years of age, 65% to 85% of seniors will have hypertension, experts say.

(Continued from page 8)

diabetes, a condition associated with hypertension that makes hypertension more difficult to control. Finally, seniors are a bit more sensitive to side effects related to medications and to falling blood pressure, which is a challenge to both patients and physicians trying to control hypertension."

Approximately 75% of White's patients are seniors 60 to 100 years of age. "As we age, our arteries get very stiff, with calcium buildup and scar tissue developing in the walls of the arteries," he says. "Since these non-compliant arteries have lost elasticity, such that they do not relax and distend normally, drugs do not work as effectively. Therefore, hypertension in the older individual can become quite resistant to treatment."

The elderly also may have elevated blood pressure in the large arteries of the legs, arms, and aorta, but they also might have some regional narrowing of arteries to the brain or the kidneys. "Therefore, if blood pressure is lowered to an acceptable level as measured in the arm, it may actually be too low in the brain," says White.

Lifestyle Changes

Lifestyle modifications are often prescribed for elderly patients with high blood pressure. "Treatment for hypertension almost always starts with lifestyle modifications, such as salt restriction in the diet and alcohol restriction," says Flack. "Salt restriction is difficult because 85% of salt intake is already in foods, so certain high-sodium foods must be avoided. Appropriate aerobic exercise is suggested, along with weight loss for overweight patients. Restricting saturated fat intake and certainly substituting some of the fat and salt in the diet with foods that are higher in potassium and minerals, such as green leafy vegetables

and fruits, also lower blood pressure."

These suggestions are problematic in that they may be difficult to implement even though many patients try to comply. "The idea that older people won't change their diet is a myth," Flack asserts, adding that research has shown that older adults are just as willing, if not slightly more willing, to change their diet than younger persons are. "On the other hand, given that seniors often need to get their pressure down from very high levels, lifestyle modifications alone may not work."

Therefore, in most cases, drug therapy is needed. "The mainstay of therapy until now has been to give combinations of medications that target the resistance or the tension that has developed in the artery itself," White explains. "For example, calcium channel blockers relax the muscle layer of the artery, and diuretics reduce overall plasma volume in the body and also reduce the resistance in the artery. More recently, we have been increasingly using a class of drugs called angiotensin II receptor blockers, or ARBs."

While the benefits of medication therapy may be significant, most physicians begin treatment conservatively by suggesting lifestyle changes. "Any consideration of antihypertensive therapy should first consider the effectiveness of nonpharmacologic interventions to reduce blood pressure," Sander recommends.

Regardless of age, heart-healthy habits can help hypertension sufferers lower their blood pressure. Data from the Trial of Nonpharmacological Interventions in the Elderly (TONE), published in JAMA (March 18, 1998), demonstrated that reduced salt intake and weight loss can be feasible, effective, and safe strategies in reducing hypertension in the elderly.

Specialty Care

While primary care physicians can treat most patients with hypertension, including those who are elderly, according to the American Society of Hypertension in New York, for various reasons these patients should see a specialist in hypertension in order to receive optimal care. The following are several indications for considering a consultation by a hypertension expert, according to the society:

- Refractory hypertension, not controlled adequately by two or more antihypertensive drugs
- Suspected white-coat hypertension with need for specialized tests (such as ambulatory BP monitoring or BP recorded at home)
- Secondary hypertension (including rare genetic disorders) requiring special tests and interventions
- Multidrug therapy because of complex disease states (such as the conditions in hypertensive patients who also have diabetes, asthma, pulmonary disease, or depression)
- Elderly patients with hypertension who have symptoms impairing quality of life that may be related to adverse drug reactions or to underlying disease.

National and international guidelines recommend specialized care for the elderly who have hypertension and require such expertise, the society says. "It has become apparent that the increasingly overburdened primary care practitioner, facing a broad variety of medical problems in daily practice, can be helped by experts functioning as a resource for advice," the society adds.

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

While PCPs can treat most patients with hypertension, these patients should see a specialist in hypertension for optimal care.

Practice Finds Increasing Efficiency Requires Making Numerous Changes

By implementing a series of changes over several years, a Colorado practice has measurably improved efficiency, lowered overhead, and increased revenue. What's more, increased efficiency has allowed the physicians to see more patients than ever before.

Primary Care Partners is a 25-physician, three-site primary care group in rural western Colorado. Gregg Omura, MD, is a family physician in the group's five-physician Western Colorado Physicians Group in Grand Junction. The practice has a long tradition of innovation and continuous improvement; Omura is the group's self-appointed developer of new processes.

No Easy Answers

"There isn't one simple answer to practice improvement of the kind we need today," says Omura, who is a strong proponent of applying proven quality improvement techniques to health care. "You have to address problems on many fronts."

Omura has led his practice to adopt innovations, such as electronic medical records, open-access scheduling, and care teams. The combination of changes has improved both efficiency and effectiveness: Compared with data collected two years ago, appointments have risen by 20%, and the number of no-shows has dropped by 17%; charges have increased by 22%, gross revenue by 21%, and income by 20%. Staff and

patient satisfaction has never been higher.

Like the vast majority of practices, Omura's group once relied on paper charts. But the shortcomings of this system were often evident: Information was not readily available when and where it was needed; the records were time-consuming to maintain; and they occupied a significant amount of physical space.

"We had thought about constructing an addition on the building for more chart storage," recalls Omura. "We realized we could spend a lot of money on bricks and mortar and solve the problem for a while, or we could spend a lot of money on converting our records to a computer system and solve the problem forever. We opted for the computer system."

Electronic Records

The cost of implementing an EMR is often the first hurdle practices face in converting to a computer system. But consider the costs of maintaining paper records, say the experts. According to *Cost Survey: 2002 Report Based on 2001 Data*, by the Medical Group Management Association in Englewood, Colo., the median cost for staff who manage medical records in multispecialty practices is \$7,495 per year per full-time equivalent (FTE) physician. Another \$5,891 per physician goes to transcribers. Using an EMR means a typical savings of more than \$13,000 per physician each year. Those

savings alone can cover the average cost of an EMR, which MGMA estimates at \$10,000 per physician.

Omura and his partners carefully researched a number of EMR systems, settling on Practice Partner Patient Records by Physician Micro Systems, Inc., in Seattle. Among the features they liked was its format, which is similar to a paper chart.

"It's important to get the right system and to use it to its maximum potential," says Omura. "A good EMR should make the physician more productive. There are popular programs out there that actually decrease the doctor's productivity. Doctors don't want to be data-entry people, so they need to get a system that makes their work easier, not harder."

The practice spent several months planning for the new system, outfitting each office, exam room, nurse's station, and the back office. The system was relatively easy to learn, requiring the staff to take only several weeks of training.

The second hurdle many practices face regarding electronic records is the daunting prospect of converting patients' paper records to electronic versions. Omura's practice knew this process could not be done quickly, so the physicians established a plan to do it gradually. Once the system was running, physicians began using it to dictate summaries at the end of every day from the charts of the patients who were being seen frequently or

Compared with data collected two years ago, appointments have risen by 20%, and the number of no-shows has dropped by 17%.

who were in for a regular physical examination. The transcriptions then could be added into the EMR and all the relevant sections of the chart, including medication list and allergies, would be automatically updated.

Using this approach, it took the staff about a year to convert all patient records from paper to electronic charts. Now, physicians can add most progress notes during patient visits, and the system can accommodate dictation as well.

The conversion to the EMR saved the practice money in several ways, says Omura, paying for itself in about two years. Besides saving him between \$500 and \$700 a month on transcription costs, the EMR allowed the practice to cut front-office staff from 7.5 FTEs to three, thereby reducing overhead by 6% and saving the practice about \$75,000 per year.

In addition, getting rid of the paper files saved the practice from building an addition, and allowed the physicians to convert the former file rooms into exam rooms, making it possible to see more patients more efficiently.

Improving Access

The most effective EMR doesn't mean much if patients aren't being seen in an efficient and timely manner. With a no-show rate of almost two patients a day, Omura's practice was losing revenue and the physicians were losing their patience. This was another problem that needed fixing.

Through the Institute for Healthcare Improvement (IHI) in Boston, Omura had learned about open-access scheduling, sometimes

called advanced access. Developed by Mark Murray, MD, and Catherine Tantau, RN, practice consultants in Sacramento, Calif., open access is designed to smooth out each day's schedule, give patients better and more timely access, and reduce the rate of no-shows. Attracted to the idea of increasing efficiency and meeting patients' needs in a more timely manner, Omura decided to try open access with his patients.

Open access uses advanced queuing theory to reengineer the standard appointment scheduling system, leaving the majority of the slots on a given day open for patients who call that day. "Demand is relatively consistent, and the day fills like a glass, from the morning up, not piecemeal," says Omura. It's a rare day that doesn't fill, he says, but when that happens, he's glad to have the empty slots at the end of the day when he is tired, not at the beginning or scattered throughout. And for patients, the benefit is obvious. "Every patient can get in within an hour or so of when he or she calls," he adds.

Like the process used in implementing an EMR, developing open access cannot be done overnight. It involves some short-term pain for long-term gain, namely working down the current backlog of patients. This is generally done by temporarily adding extra slots and working longer hours, or adding more staff.

Among the benefits of open-access scheduling are that both telephone access and staff availability improve because the need to triage patients over the phone, or "tease out information" as Omura puts it, is elimi-

nated, as well as the sometimes lengthy negotiations involved in making appointments. Patients' use of urgent or emergency care settings also decreases.

Omura's foray into open access proved so successful that two of the five physicians in the office use open-access scheduling today. Two others use a partial open-access system, and one has elected to use a standard approach to scheduling. Omura often sees his partners' overflow patients, since his schedule is more open than theirs.

Team Care

The philosophy behind open access is to do today's work today. This approach applies both to appointment scheduling (meaning seeing patients the day they call) and to the content of the visit. "Before open access, if a patient came in with an abnormal skin lesion, I would examine and diagnose it during one visit, and schedule the patient to return for an excision," says Omura. "Now I do it all at the first appointment."

This approach was more satisfying for patients, Omura found, and reduced the need for additional appointments. But it also was more time-consuming for him. "When I started doing more for patients in a single visit, I realized I couldn't do that the way my practice was structured," he says. "I didn't have enough nursing staff to prep the patients."

After analyzing how he was spending his time and what tasks his staff was doing, Omura learned an important lesson. "I realized I was doing too much of everything, and I didn't

(Continued on page 12)

"A good EMR should make the physician more productive. Doctors don't want to be a data-entry people, so they need to get a system that makes their work easier, not harder."

—Gregg Omura, MD, Western Colorado Physicians Group

(Continued from page 11)

have to be directly involved with every aspect of patient care," he explains. So, he began to delegate more responsibility to his registered nurse and his medical office assistant. Also, he hired a third assistant (a layperson) who was trained to take vital signs, initiate prescription refills, and triage patient phone calls. In this way, he created a care team.

The team approach to care allows Omura to spend more of his time doing the things that specifically require his expertise, such as clinical decisionmaking and building relationships with patients. The EMR, open access, and delegating of tasks support him in increasing his efficiency, enabling him to add about eight more patient slots to his weekly schedule.

"Eight more slots filling at about \$110 per visit more than pays for the additional staff," he says. The use of team care highlights the fact that the most expensive part of a practice's overhead is the physician's salary. As a result, team care creates a better balance between cost and revenue, says Omura.

Consistency of Care

To support consistency of care across the team, Omura relies on about 150 medical history-taking templates available through his EMR. The templates prompt the physicians and other providers to get and record all appropriate information from patients. He and his staff have customized the templates to fit their needs.

The templates help make team care effective, says Omura, because they ensure consistency of information among providers. Focused on specific diagnoses, each template offers questions and prompts observations related to each diagnosis, which

can range from abdominal pain to depression. Clinical staff enter patient responses directly into patient records, using a computer in the exam room.

"The templates are crucial to efficiency because they allow a tremendous amount of delegation," Omura explains. By the time physicians see their patients, he says, most of the important information is already in the progress note, and they can spend their time "doing things that require an MD after their name."

Moving Forward

Each success strengthens Omura's devotion to continuous improvement. "I feel renewed and invigorated as we do things better and better," he says. So now he is leading the practice through an ambitious eight-point program to redesign other aspects of patient care, modeled on IHI's Idealized Design of Clinical Office Practice program. IDCOP brings together professionals from across the country to work together to redesign a practice for greater effectiveness and satisfaction, often at the most fundamental level.

Called the Renaissance program, the redesign at Primary Care Partners has eight specific goals, the first four of which involve chronic disease management. Specifically, they aim to improve care and management for patients with diabetes, hypertension, heart disease, and depression. The practice intends to develop a comprehensive care plan for 90% of patients with these conditions.

Acknowledging the sense of independence and autonomy that most physicians guard, Omura doesn't expect every one in his practice to approach care in the same way. "We want to focus on outcomes, not on

process," he says.

The EMR system is an important component of improving outcomes, in part because it can produce population-based data. "Even the best doctors are surprised by what they learn when they start getting data," Omura says. "We all focus on who we are seeing. We know our patients with heart disease are taking aspirin because they are coming in regularly. But what about the noncompliant ones who aren't coming in? My perception is skewed because I'm not seeing the whole population. That's why population management is so important."

Over the next several years, Omura plans to make even more changes. He wants patients to have electronic access to their medical records, a medication list, and lab results; he also wants them to be able to request appointments through a secure Web site. What's more, he wants to offer specialists access to patients' records (with patient permission and within privacy guidelines) to allow for a more comprehensive understanding of patients' needs and more seamless care across the continuum of providers.

Omura has no doubt that the changes his practice has implemented have been good for both the practice and the patients. They have also been good for him, professionally and personally. "Practicing is more enjoyable because you are working as a team," he says. In addition, thanks to more efficiency, Omura's income rose compared to that of previous years, even though he took four weeks vacation, more than ever before.

—Reported and written by Ann B. Gordon, in Wayland, Mass. More information on physician practice strategies is available on our Web site (see page 16).

The EMR, open access, and delegating of tasks have helped Omura to add about eight more patient slots to his weekly schedule.

After 15 Years, Physician Still Finds Variety of Temporary Work Fulfilling

R. Cyril Bieger, MD, JD, is a 69-year-old pathologist in Seattle. Over the past 15 years, he has completed more than 50 assignments as a *locum tenens* physician. A graduate of Xavier University in Cincinnati, Bieger received his medical degree from St. Louis University Medical School in St. Louis, he interned at the University of Utah in Salt Lake City, and he received his pathology training at the University of Wisconsin in Madison, the University of Cincinnati, and the Mayo Clinic in Rochester, Minn. His subspecialty training is in medical microbiology and forensic pathology. Bieger also earned a law degree from the University of Puget Sound (now Seattle University) in 1986. Editor in chief Richard L. Reece, MD, discussed with Bieger the life of a *locum tenens* physician.

Q: Would you explain for our readers who are interested in pursuing *locum tenens* work how and when you entered this field?

A: After working at the coroner's office in San Diego for nine months, I moved to Seattle in 1988 hoping to find full-time employment there. While I was looking for a position, I did *locum tenens* work, and I have been doing it ever since.

Q: What is the process that physicians need to follow in order to be eligible for *locum tenens* work and how do they obtain the licenses they

need to practice in different states?

A: There are a couple of ways that physicians can get into this field. One way is through various *locum tenens* agencies, such as CompHealth in Salt Lake City. These agencies are always seeking qualified people to fill positions, and they will help physicians to obtain state licenses, as well as do all the necessary administrative work. Filling out the medical license applications can take quite a bit of time and effort, and states are requiring physicians to provide detailed background information.

Another way that physicians can get into the *locum tenens* field is to develop a network of contacts, meeting as many people as possible at medical gatherings, and keeping their eyes and ears open about possible opportunities. It is helpful if they have a medical license in the state in which they want to practice before they begin networking, so that they can move quickly when an opportunity arises. I had a list of the states in which I wanted to work and obtained state licensing in those states.

Q: In how many states have you practiced as a *locum tenens* physician? What is your process for accepting assignments?

A: I have held licenses in 16 states, but now I am down to

six: Idaho, Michigan, Ohio, Oregon, Washington, and Wisconsin.

I work on a first-come, first-served basis. With new clients that are seeking temporary pathology services, I send two copies of a formal agreement, with my signature, stating that I agree to provide coverage for pathology services as described in the agreement. If the client approves the terms, the client will sign both copies and send one back to me. With a signed contract, I will provide the pathology services needed.

Some clients repeat over the years, which makes the process of accepting those assignments simple. Subsequent assignments with the same client are typically arranged by telephone, after which I send a letter confirming that I will provide coverage as discussed.

Q: How long is a typical assignment in a given location?

A: The length of a *locum tenens* assignment can vary from one day to six months or even longer.

Q: Does the client usually pay for your expenses and malpractice coverage?

A: Typically, clients pay for travel and housing expenses, but *locum tenens* physicians pay for their own meals and entertainment. Clients cover malpractice insurance costs, and it is important

(Continued on page 14)

R. Cyril Bieger, MD, JD, a pathologist who works as a *locum tenens* physician, has worked in a variety of settings, from those with one pathologist to those with as many as 20 pathologists, in academic institutions, and in hospitals.

(Continued from page 13)

for physicians to be sure of the malpractice insurance coverage before starting their assignment.

Q: How do you obtain your locum tenens work?

A: Most of my work is through repeat assignments. Usually, there is a pathologist contact who requests my services. I have obtained new assignments by word of mouth and by reputation.

Q: Do you find a lot of variety in your practice life?

A: Yes. I have worked in pathology practices with one pathologist and as many as 20 pathologists, in academic institutions, community hospitals, and other types of practice environments—a wide spectrum of settings.

Q: Does a locum tenens physician often cover for a one-person practice?

A: I have covered one-person practices, but that is usually not the case. In general, I work in a two- or three-person practice. Many of my assignments have been in practices with two pathologists in which one pathologist wants to take time off and the other pathologist would be overwhelmed by the amount of work without some outside help.

Q: Do you often run across other locum tenens physicians on your assignments?

A: Yes. Often, hospital-based physicians, such as anesthesiologists and radiologists, are locum tenens physicians.

Q: What are the benefits of having a career as a locum tenens physician?

A: Some of the benefits of locum tenens work for physicians—as a career or as a temporary situation—include better control of their time, of the regions in which they work, and for whom they work. It also affords the ability to travel to new places and meet new people. I see parts of the country that I probably would not have visited otherwise.

Another benefit of locum tenens work that I have found is having the opportunity to observe a variety of practices, seeing different laboratory setups and methods of practice, as well as learning from the experience of the pathologists I have worked with. I have worked with people whose talents and interests vary, which makes my work life interesting.

Locum tenens work also provides additional contacts for future opportunities. Finally, it also involves fewer responsibilities than a permanent position, with no administrative work and probably no call.

Q: What are some of the challenges of locum tenens work?

A: One challenge can be the travel involved. With a full schedule, travel takes a toll on the body and makes it difficult to manage even basic things at home, such as answering mail and paying bills. I make sure I am never away from home for more than three weeks at a time. When on a long assignment, I will come home every three weeks to check the mail and the house and take care of any problems.

Another challenge I must keep in mind is that I am not a member of

the client's staff but, quite simply, a temporary worker. I do not participate in decisions affecting the work environment. For physicians who like to participate in strategy and planning, this is a major downside of locum tenens work. Basically, the job of the locum tenens physician is to do what the client needs and to do the best job possible.

What's more, locum tenens work might be a challenge for married physicians and those who have other obligations at home. I am divorced. Being single frees me to accept assignments quickly and to accept assignments that require me to be away from home for long stretches of time.

Finally, when locum tenens physicians are not working, they are not getting paid. They also do not receive any of the typical employee benefits, such as health insurance, disability, and paid vacation and meeting time.

Q: When you go to a new location, do you feel isolated from the life of the community or do you blend in?

A: I have never thought of it in terms of being isolated. I look on my assignments as an opportunity to learn about a new practice and a new community. With that attitude, I start exploring and probably see more of the community than the local people do.

Q: Is another downside of locum tenens work the unpredictability and uncertainty of when you are going to get an assignment? Are there some dry stretches?

A: There are some dry stretches, but just when I think nothing

“Physicians looking for a permanent position would benefit from locum tenens work in order to try living in a certain geographic area or working in a particular type of practice.”

—R. Cyril Bieger, MD, JD

Organization Helps Set Locum Tenens Standards

The use of *locum tenens* physicians is growing at a rate of about 20% annually, according to published reports. This growth is fueled in part by consumer demand for greater access to specialty care, which has made it difficult for organizations to recruit full-time physicians.

The Latin term *locum tenens*, which means “to hold the place of” or “to substitute for,” is used to describe physicians who accept temporary assignments across various health care settings.

As the practice of taking on temporary physicians has grown, it has created a need for standards in the industry, according to the National Association of Locum Tenens Organizations. NALTO is a professional association in Altamonte Springs, Fla., that was created to provide health care organizations with high standards of service and to represent the industry as a whole. NALTO was created to address the unique aspects of *locum tenens* placement and to increase the level of service provided in this specific segment of the physician recruiting industry. Its members are held to a code of ethics developed specifically for the *locum tenens* industry, the association says.

When choosing a staffing company, a physician considering temporary work should seek one that is a member of NALTO, the association advises. Some clients pay for malpractice insurance. If not, then the physician should seek a staffing company that provides malpractice insurance for the physicians they place. What’s more, the physician should try to determine if the company has the financial resources to pay their physicians regularly. The physician should find out if the company offers the services necessary to ensure that all details have been taken care of when the physician arrives to work (such as licensing, credentialing, and hospital privileges) and makes all travel and housing arrangements, the association says.

In addition to these guidelines, the staffing company should place a high priority on providing quality service, NALTO says. By providing quality service to its physician clients, the company should have enough professional staff to provide each physician with personal attention; comprehensive services (such as those administered by payroll, travel, and housing departments within the company); qualified physicians who meet strict credentialing standards; and most important, enough assignments to allow its physicians to choose among client companies, the association says.

According to one study, only about 4% of physicians in nonacademic settings accepted *locum tenens* assignments in 1987, but by 2000, that proportion had grown to 15%.

—DJN

(Continued from page 14)

is going to happen, the phone rings and I am busy again. For ten years, I have not been home in Seattle during the summer. I’ve always been

busy then, and usually it’s because I am covering for people with children who are out of school on their summer vacation.

Q: To whom would you recommend this sort of life?

A: *Locum tenens* work is suitable for physicians who have just finished their residency. They may be seeking interim work to help them decide where to settle. Physicians looking for a permanent position would benefit from *locum tenens* work in order to try living in a certain geographic area or working in a particular type of practice. These physicians may find it helpful to do *locum tenens* for a group they are considering joining in order to get an idea about the group before making a commitment.

Also, there are some physicians near retirement who may not really want to retire. They might want to consider doing *locum tenens* work on a part-time basis to keep their hand in medical practice.

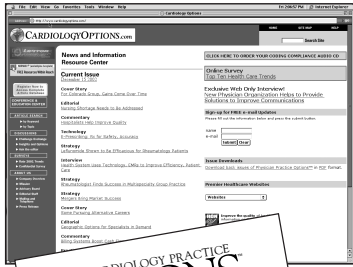
Q: Do you have any final thoughts about the obligations of a *locum tenens* physician?

A: *Locum tenens* physicians on assignment have an obligation to provide the best service and to do the best job they can, to never embarrass their client, and to remember that they are not in charge. Rather, they are guests, there at their client’s wishes. If they are asked to do certain work and they are trained and capable of doing it, they are expected to do that work.

Furthermore, *locum tenens* physicians must get along with people, including the staff. If they do not get along with the staff and, as a result, create friction, they will not be asked to come back. No client wants a troublemaker. Basically, *locum tenens* physicians are given the assignment because the client already has trouble, meaning not enough staff. The *locum tenens* physician is there to help the situation.

—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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