PHYSICIAN PRACTICE
OPTIONS™

February 15, 2000

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Making Medicare Work: Efficiency and Low Inpatient Days Required

Is it possible to deliver quality care to Medicare patients under managed care? That's a question many physicians may be asking after watching HMOs, which once courted senior citizens, leave the Medicare business altogether, blaming deep cuts in reimbursement rates as a result of the Balanced Budget Act in 1997. Those HMOs that continue to enroll seniors lean hard on physicians to keep costs down. In turn, many doctors are choosing to terminate their relationships with risk contracts that leave them liable for costs if they overspend the per-member-per-month (PMPM) fee HMOs designate for each patient.

But some physicians have found a way to make Medicare work. As associate medical director of the Tufts Managed Care Institute in Boston, Richard Dupee, MD, a board-certified geriatrician, lectures widely on the topic of managed care, how it pertains to quality treatment for the elderly, and how his medical colleagues can profit from it financially and personally (in terms of clinical satisfaction).

Real-World Experience

The CEO of his group practice, Wellesley Medical Associates in Wellesley, Mass., Dupee also is president of the Massachusetts Geriatric Society, and CEO of MedWest LLC, a management services organization (MSO) comprised of 13 primary care physicians in strategic alliance with the New England Medical Center in Boston. He is also associate clinical professor and chief of the geriatrics service in the department of medicine at NEMC.

To be sure, caring for the frail elderly is a significant challenge. Compared with the rest of the population, Dupee says, these patients are four times more likely to be hospitalized—where the biggest risk and highest costs are. "Because the elderly tend to be sicker, with multiple chronic illnesses, they use more services," he explains. At 14% of the population, they account for about 35% to 40% of all health care spending.

Success in Medicare managed care can come only if physicians whittle their annual inpatient hospitalization days—measured as days per thousand in a physician's risk pool—to below 1,000, Dupee says. The national average is 2,000.

"You can recoup a significant amount of dollars if you don't practice 'in the Medicare way,'" Dupee explains. "That means you don't keep patients in the hospital over the weekend waiting for a nursing home placement or waiting for a stress test on Monday. These bad habits are the fat in the system and the reason why Medicare is running out of money. If you pay much more careful attention to managing patients, understand what you've got to do from the time they come into the emergency room until the time they are discharged, have a plan of attack, move your testing along quickly, call for timely specialty consults, then you will save all those dollars that were originally earmarked for the hospital services fund. And that goes back to the risk pool."

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EDITORIAL

How We Identified The Top Trends for the Year

Since we started *Practice Options* in 1996, we have attempted to compile a list of some of the most important trends each year. When putting together our list this year, we began with a thorough review of the news stories about physician practices, health care, and managed care over the past 12 to 14 months and then we interviewed as many experts as possible.

We believe a review of all of the news affecting physicians is illuminating because newspaper articles and news releases are designed to capture and report on the top news stories each day, and these stories accurately reflect American consumers' attitudes and actions.

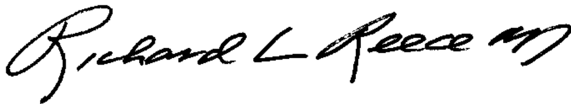
We started by reviewing all of the news articles and news releases that we have collected since February 1998 from a wide variety of news-gathering organizations including *The New York Times, The Wall Street Journal, USA Today, The Boston Globe, The Los Angeles Times*, and *The Washington Post*. Other sources included online news-collection services such as AOL, BusinessWire, and Reuters Health.

From this collection of more than 5,000 articles and press releases, the editors of *Practice Options* developed a list of 15 trends and predictions and prioritized them according to their relevance to practicing physicians. Then, we sent this list to our 15-member editorial Advisory Board of *Practice Options* and to 25 other experts including practicing physicians, physician executives, health care executives, hospital administrators, health care entrepreneurs, consultants, and journalists.

We asked each expert to rate the trends and predictions based on a scale of strongly agree, agree, neutral, disagree, and strongly disagree. The top 10 trends received the highest scores from our experts. In our coverage of these trends ("Top Health Care Trends for 2000," page 3), we list the top 10 trends in the main article. The other five were ranked somewhat lower and are listed in the sidebar ("Beyond the Top Ten, Here Are Five Other Trends To Watch," page 4).

Simply by reviewing the news over the past year, it is clear that a number of factors are affecting the practice of medicine. The most significant factor may be the Internet and the role it is playing in helping to make the practice of medicine more efficient and more challenging. But another important factor evident from reviewing our compilation of news stories is that consumers are generally ahead of the medical establishment in setting health care trends. American health care consumers have started a revolution in how they approach health care, and the dimensions of this revolution are evident in the daily news. American consumers want improved access to health care. They want higher quality, and they expect that physicians will be warm, supportive, and be thoroughly familiar with the latest technology.

One last note about our coverage of trends: We originally had planned to publish our list of trends for 2000 in January. But late in our production cycle, a developing story forced us to change our planning. Therefore, we present our list of health care trends for 2000 in this issue. For more information on trends affecting physician practices, readers can visit mdoptions.com.



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Top Health Care Trends for 2000

By Richard L. Reece, MD, Editor-in-Chief

Physicians will develop a much more visible presence on the Internet in the coming months and years, and the Web will allow physicians to cut their practice overhead by outsourcing many business operations currently performed in their offices, according to an informal poll of physician leaders and consultants. These experts also predict that e-mail and hand-held computers will change how physicians and patients interact and that more health care business will be conducted over the Internet as physicians, health care provider organizations, and American consumers become more savvy about how the Internet works.

Out of the top 10 trends that physician leaders and consultants have identified for the year, five relate to how physicians are using the Internet to do business. The other five trends are: a continued rise in the number of procedures done in physicians' offices, pharmaceutical manufacturers' continued use of physicians to conduct new drug trials, continued growth in the use of specialists, increasing mobility among physicians seeking more attractive practice opportunities, and integrated delivery systems will continue to shed the physician practices they acquired in recent years.

1. Physicians' presence on the Internet will increase dramatically. James Adams, MD, a cardiologist in Larkspur, Calif., commented that physicians will need Web sites because so many businesses are doing so today. "This is a no-brainer," he said. "Out here, everybody and his mother has a Web site."

Some 37% of physicians use the World Wide Web, a proportion that almost doubled in two years and that is expected to continue to rise, according to a study released in December by the AMA. The AMA based its figures on interviews with 1,084 office-based physicians and compared the latest results with those of a study done in 1997. The earlier study showed that only 20% of physicians were using the Web.

The latest survey showed that 41% of physicians used a computer in 1999 and of those who did not have access to the Web, 58% planned to begin using the Web within six months, the AMA said. The AMA survey showed that more physicians are using the Web to promote their practices and to send information to patients.

Use of the Web will grow as companies offer free Web space and assistance in building Web sites to physicians nationwide. Physicians will soon find that having a Web site will be necessary to practice effectively, according to the experts.

2. Many health care transactions will be conducted on the Internet. The amount of business related to health care that will be done over the Internet will be more than $300 billion annually, experts predict. Doug Emery, a health care economist in Salt Lake City and president of Zoadigm Health Systems Inc., a company developing global fees for episodes of care, believes $300 billion may underestimate the total. "The Internet is making every health care product a commodity," he says. "Health care business on the Web could become a multitrillion-dollar worldwide phenomena." Tom Ferguson, MD, publisher of *The Ferguson Report,* a newsletter in Austin, Texas, that reports on physicians' use of the Internet, says that while the sales figure of $300 billion is impressive by itself, the Web's effect on the patient-physician relationship will be even more dramatic. "The best option for physicians is to jump onto the Internet now," Ferguson says. "The train is leaving the station."

3. The use of hand-held computers will grow sharply. Palmtop computers which allow physicians to access Internet data, make patient encounter information more accurate, and outcome studies more feasible and relevant, will render obsolete many office-based computer systems, the experts say. Lloyd Hey, MD, a spine surgeon at Duke University, has been among a number of physicians at Duke who are working with hand-held computers and believes they have helped the university to increase revenue while also saving almost $15,000 per physician. What's more, the computers have helped physicians to increase dramatically the amount of data they capture for patient charts and for outcomes research.

Not all experts are convinced, however, that hand-held computers will be useful initially. Bernard Rineberg, MD, an orthopedic surgeon in New

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At a Glance: Top Ten Trends

Here are the top 10 health care trends for the year 2000:

1. Physicians' presence on the Internet will increase dramatically.
2. Many health care transactions will be conducted on the Internet.
3. The use of hand-held computers will grow sharply.
4. The number of procedures done in offices will continue to rise.
5. E-mail communication with patients will become common.
6. Pharmaceutical manufacturers will continue to contract with physicians for drug trials.
7. Some specialists will continue to do well.
8. The Internet will let physicians outsource certain business operations.
9. Physicians will become more mobile.
10. Integrated delivery systems will continue to shed physician practices.

(Continued from page 3)

Brunswick, N.J., and a member of the editorial Advisory Board of *Practice Options,* is skeptical about them, saying their use will not increase sharply for a time. "A steep technological learning curve still exists," Rineberg says. "Using them adds complexity, not simplicity." The best option for physicians considering using hand-held computers is to ask colleagues who use them in their practices how they have helped them to increase efficiency. Approximately 25% of physicians are currently using some form of palmtop device.

4. The number of procedures done in offices will continue to rise. Procedures done outside of hospitals will continue to increase as fees for managed care and Medicare continue to drop. David Kohmesher, an HMO executive at Heritage Medical Systems, in Reseda, Calif., believes that soon only the most seriously ill patients will be treated in hospitals. All others will be treated in physicians' offices, at home, and in other less costly settings. The question for physicians is to determine whether they can do procedures safely in their offices. To answer this question, physicians may need to have their practices evaluated by a consultant or other expert who advises physicians on practice risk.

5. E-mail communication with patients will become common. Physicians will use e-mail to schedule patient visits, provide information to pharmacies and to patients about prescription refills, transmit lab and other test results, and to provide health care information to patients. E-mail will minimize the problem of telephone tag and serve as the conduit for the bulk of patient communications. Neil West, MD, a pediatrician who is medical director for Millennium West, a physician group in Tucson, Ariz., says that even though e-mail will become more common, physicians will still need to meet with patients. "We must schedule a time for patients and doctors to talk," West says. Physicians should survey their current patients to see which ones use e-mail and use that information to communicate and educate patients and to market new services. Many Americans who use e-mail to communicate with family and friends may gravitate toward progressive physicians who communicate with them electronically.

6. Pharmaceutical manufacturers will continue to contract with physicians for drug trials. The search for new pharmaceuticals will mean manufacturers will continue to outsource clinical trials to physicians. This work will become an important source of revenue for many physicians. Harold Kaiser, MD, of the four-physician group Allergy and

Beyond the Top Ten, Here Are Five Other Trends To Watch

While the Internet and other factors are changing the practice of medicine, other trends are having a less significant, but nonetheless important, influence on physicians. Five secondary trends are outlined below.

1. The growing financial insolvency of large capitated groups and IPAs in California means that the use of capitation as a reimbursement model is unlikely to spread to areas outside of California. A study done in September 1999 by PricewaterhouseCoopers, CPAs and health care consultants in New York, shows that 90% of large physician groups in California are expected to file for bankruptcy in the next year or two. The groups are facing rising costs and declining reimbursement rates under capitation. When capitation (in which large for-profit HMOs delegate financial risk to large physician groups) was having some success, many observers had predicted that this method of reimbursement would spread nationwide. Now that strategy is greatly in doubt.
2. Single-specialty groups that have strong market share, close relationships with hospitals, and own some ancillary facilities will thrive, even in markets with high managed care penetration. These groups are attractive to many payers.
3. Health care consumers—not employers, HMOs, hospitals, physicians, or the federal or state governments—will dictate the speed and direction of changes in health care. Consumers will demand easier access to specialists and more information from health plans. For managed health plans, conflicts between the need to deliver quality care and to produce a profit will mean negative media coverage will continue. Patients and physicians will continue to complain about onerous HMO requirements that impede the ability of patients to get the care they want and the ability of physicians to deliver quality patient care. These complaints will continue to erode the public's trust in HMOs.
4. Health care plans and large health care purchasers will continue to seek cost savings through increased education of health care consumers. Health plan executives and health care buyers believe that one solution to rising health care costs is providing consumers with enough knowledge so they can make intelligent and cost-effective decisions about self-care and take steps to prevent illness. Purchasers will begin to give consumers the information they need to judge the quality of health care provider organizations. This information will enable consumers to shop for physicians on the basis of quality and price. Employers are tired of hearing workers complain about HMOs and they are tired of paying the rising cost of managed health care. As a result, more employers will use medical savings and flexible spending accounts in which they will give to each worker a designated amount of pre-tax income for workers to spend on health care.
5. Alternative medicine will continue to be a major force in the American health care market. A close alliance between traditional physicians and alternative practitioners will not occur, however, because traditional physicians do not want to work with alternative practitioners and alternative practitioners do not want physicians questioning their credentials.

Asthma Specialists in Minneapolis, and a member of the editorial Advisory Board of *Practice Options,* has found pharmaceutical trials to be intellectually stimulating and rewarding. His group has been doing trials for 10 years. "But it isn't easy," he says. "It requires a concerted effort by the entire staff."

7. Some specialists will continue to do well. Those specialists who perform lifestyle or life-saving high-technology procedures will be in demand. "Specialization adds value," says Emery of Zoadigm Health Systems. Managed care plans that recognize the value of specialists may see lower costs. UnitedHealth Group, the large managed care organization in Minneapolis, has entered into an innovative incentive arrangement with a health plan—United HealthCare of Florida (UHC)—in which UnitedHealth Group will pay UHC more for meeting certain quality goals related to cardiac care. UnitedHealth Group believes quality specialty care will produce lower costs overall.

8. The Internet will let physicians outsource certain business operations. Physicians who practice in small groups or who work independently will find the Internet will allow them to outsource certain practice management and business functions. William DeMarco, president and CEO of DeMarco & Associates, physician consultants in Rockford, Ill., believes physicians will find this option useful because it will free up management time. But it may require physicians to invest in information systems. "Physicians will still need to get a good information system that not only takes care of the technical and billing aspects of a practice but communicates with patients and helps with the e-commerce aspects of practice development," DeMarco says. Several companies are marketing these services to physicians.

9. Physicians will become more mobile. Physicians will seek practice opportunities in other parts of the country or will pursue different careers both within and outside of the practice of medicine. Ferguson, of *The Ferguson Report,* comments, "Physicians will also become 'virtually mobile' and less limited by geography in part because of the Internet. As a result, they will be able to live and work where they want."

10. Integrated delivery systems will continue to shed physician practices. A survey last fall by Ernst & Young, CPAs and health care consultants in New York, showed that 96% of large integrated delivery systems were losing an average of $111,000 per physician per year. These large systems will not continue to tolerate such losses and so they will cut their physician staff members. Susan Keane Baker, a physician consultant in New Canaan, Conn., says, "A growth industry in the next decade will be those lawyers who specialize in dismantling hospital-physician marriages." Hospitals and other provider organizations, such as physician practice management companies, have been eliminating physician staff members over the past two years.

—More information on trends affecting physician practices is available at mdoptions.com

Anatomy of a Group Practice Dissolution

By Thomas M. Gorey, JD

Organizational and financial crises are common in modern business—and are increasingly common in health care. From rural groups to the largest investor-owned networks, health care providers face a number of challenges: declining reimbursement from many payers, increasing competition, and growth and turnaround strategies that may not be sustainable. Physicians practice in the middle of such uncertainty and may be unaware of impending crises and unprepared to handle the consequences.

Even some of the most sophisticated group practices face crises and the risk of failure. The recent experiences of the former Burns Clinic in Petoskey, Mich., illustrate how even a well-established medical group with a premier reputation can break up under the pressures of practicing in the new, competitive environment. To analyze the causes leading to the closure of the Burns Clinic and to identify the lessons it holds for other physicians, the Michigan State Medical Society recently sponsored a case study of the group.

A Dream Realized

The Burns Clinic Medical Center, PC, was a multispecialty group in Petoskey that traced its origins to 1931, when it consisted of just three physicians. Dean C. Burns, MD, a general surgeon, had founded the group, fulfilling his dream to develop a multispecialty group in Petoskey that could provide the residents of northern Michigan with superior, comprehensive medical care typically available only in urban settings.

At the same time that Burns was forming his medical group, he was overseeing development of the Little Traverse Hospital, which opened in 1939. During the construction of Little Traverse Hospital, Burns proposed a relationship between the group and the hospital whereby Burns Clinic physicians would staff the hospital and the hospital would provide group physicians with a fully equipped facility in which to practice. Burns' proposal laid the groundwork for a close working relationship and an interdependency between the group and the hospital that continued into the 1990s.

By 1964, the Burns Clinic had grown to become a group of 25 physicians in 12 specialties, and in 1967 it was incorporated. Over the next three decades, the group continued to grow rapidly despite not offering salaries that were competitive with urban medical centers. Nonetheless, the group was successful in attracting new physicians because of its outstanding medical facilities; its cadre of well-trained, highly respected medical colleagues (all of whom were board certified or board eligible); a patient base that presented a diverse and challenging set of health care needs; and a beautiful setting in an area offering a wide variety of recreational opportunities.

Over the years, the activities of the Burns Clinic and the Northern Michigan Hospital (the successor corporation to Little Traverse Hospital) were intricately intertwined and to many Petoskey-area residents, the group and the hospital were one and the same entity. Working together closely, the group rented space in the hospital, and the hospital rented space from the group. Although the two entities were legally separate, they engaged in a number of collaborative ventures.

A significant event in its history was the group's decision in 1994 to enter into a long-term agreement with PhyCor, the national, publicly traded physician practice management company in Birmingham, Ala. The group's leaders believed that to be competitive under managed care, the Burns Clinic would need an infusion of capital and management expertise. As a result, the clinic's leaders began discussions with the hospital administrators about the possibility of merging the two entities. When the discussions regarding a possible merger fell through, however, the physicians decided to look elsewhere for capital and management expertise and eventually signed an agreement with PhyCor.

Even a well-established group can break up under the pressures of practicing in the new, competitive environment.

Capital Acquisition

Although PhyCor stressed the long-term benefits of an affiliation and discouraged the physicians from thinking there would be a significant financial windfall, there is no doubt that many physicians viewed the PhyCor affiliation as an opportunity to acquire needed capital, to enhance the group's primary care base, and to take other steps to strengthen the group. To the cash-strapped group, PhyCor clearly appeared to some as a savior that could relieve the group's growing financial pressures.

The first few years were a period in which the business relationship between the Burns Clinic and PhyCor appeared to be going well. Money that had been part of the acquisition fee was being used to bolster salaries and the price of PhyCor stock was rising. As a result, the average physician member of the group believed the organization was doing well. This period of expansion and renovation created a false sense of security, however, and many physicians assumed the financial stability would last.

Over time, there was a gradual realization that the group was in trouble. There

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was no single event that led physicians to realize something was wrong, but by late 1997 it was clear that the future viability of the group was in jeopardy. Because the final compensation figures for 1997 were disappointing and the prospects for 1998 were bleak, physicians began to realize that the group would not be able to sustain itself financially unless changes were made. By 1998, a number of the higher producing specialists had resigned and others were threatening to do so, making recruitment of new physicians nearly impossible. There was strong pressure to reduce salaries, and the group's executive director of five years (a PhyCor administrator) departed and was replaced with another PhyCor administrator.

During the final months, the physicians went through several stages of denial including anger at the group's leaders, bargaining for time, depression, and grief.

Negative Consequences

When area residents became aware of these problems, the group's reputation came under a cloud. When the group decided to discontinue its affiliation with the Blues plans of Michigan, the negative talk in town rose to a new level. In October 1998, a group of 20 physicians attended a meeting called by the hospital chief of staff to discuss the situation. After the meeting, the group, PhyCor, and the hospital decided to bring in consultants from KPMG, CPAs and health care consultants, to assess the situation. At this time, the number of physicians in the group had dropped from nearly 120 to about 80.

One of the most often-cited causes of the group's demise was its compensation plan. The philosophy behind the plan was to provide salaries that were fair (meaning they represented an average level of productivity per physician), even if they were below the national average. Yet, in the final months, the group decided to accede to the salary demands of the cardiology department, a move that was perceived by many of the physicians who were not cardiologists as a breech of trust—and a change in policy. With this change in policy, more physicians left the group.

Because so many physicians were leaving or planning to leave, the group's management began considering whether the group could remain viable even though it was much smaller than it had been. After running various financial models, including one scenario in which the group consisted of 50 physicians, management realized the organization could not survive because it had too much fixed overhead and would not be able to divest itself quickly enough of assets to sustain salaries.

As one group leader said, "Although there are plenty of successful 50-physician groups, such groups grew up that way. It is hard to go from 100 physicians to 50 overnight."

In December 1998, each physician was asked if he or she would stay on in 1999 to keep the group operating. Since almost all of the physicians said they would stay, the leaders thought the group would survive, albeit as a smaller entity. Many physicians felt betrayed when bonuses for 1998 were announced at a level representing low performance and no more support was coming from PhyCor, which was suffering serious problems of its own. In January of last year, the members of the group voted to disband the organization.

The Post-Mortem

Whether a group is growing or contracting, a number of experts believe the organization will follow predictable stages of development, similar to that of any living organism. When a crisis arises and a health care organization is unsuccessful in its turnaround efforts, the organization often will go through a grieving process similar to that reported by psychiatrist Elisabeth Kubler-Ross in her studies of the terminally ill. Once they become aware that they are suffering from a fatal affliction, most patients generally pass through the following five stages in coming to understand their impending death, says Kubler-Ross: 1) denial and isolation, 2) anger, 3) bargaining for time, 4) depression and grief, 5) acceptance.

During the final months of 1998 and the first quarter of 1999, many physicians went through the Kubler-Ross stages of dying: denial that the group would fail; anger at the group's leaders, at PhyCor, at the hospital, and at the Blues plans; bargaining for time; depression and grief. Once the reality of the closing began to be accepted, however, most physicians began making other plans for themselves.

As of March 31, 1999, the Burns Clinic, which had been in operation for 68 years, ceased operations and the group's remaining physicians had either left town, opened private practices in town, or accepted an offer from the hospital to work temporarily under a salary-support agreement. Most of the former Burns Clinic physicians have elected to remain in Petoskey and, of these, the majority have set up their own professional corporations and have remained at the same address. Others have leased office space in town. Many of the physicians who have either established their own professional corporations or accepted employment arrangements with the hospital are using the hospital's management services, while a smaller number have implemented their own billing systems and hired their own staff members.

Many former departments have reconstituted themselves as group practices and some physicians say they too are using the hospital's management services. In fact, the closing of the Burns Clinic has resulted in some physicians being organized along their old departmental lines. The transition has been difficult, but the general sense is that the worst is over.

Physicians who were attracted to the Burns Clinic generally did not want to be involved in the business side of practice. Ironically, many are now operating independent physician practices and will need to manage all aspects of the business of medicine. Will these individual professional corporations be able to sustain the high quality of specialty services previously offered by the Burns Clinic in this rural market? Only time will tell. ■

(Continued from page 1)

Dupee offers the following suggestions for curbing inpatient hospitalization days, and for practicing high-quality, cost-effective, senior citizen care.

Hire a dedicated case manager. Dupee believes a dedicated case manager is essential if doctors are going to limit the all-important hospital days per thousand.

Understand your patient panel. "We are dealing with a population that defies the medical model," Dupee says. "Disease presents atypically. Heart attacks, for example, present not as chest pain, but as shortness of breath." He advises physicians to enroll in geriatric courses to learn how elderly people react to disease, and the special risks they face.

Practice preventive medicine. "Profile frail elderly as soon as they sign up for your practice," says Dupee. His group relies on a geriatric nurse practitioner who sends these patients a risk profile, scrutinizes responses, and calls them in for a comprehensive geriatric assessment. That assessment includes a detailed history, functional physical examination, and discussion about support services (such as family involvement) and personal issues (such as depression). "We use all the information patients and family members can give us to assess patient risk, and if we spot areas where patients are at risk for failing, we intervene immediately. Interventions include a review of the prescriptions a patient is taking, disease management, environmental assessment in the home, and physical or occupational therapy," he adds.

For the frail elderly, Dupee's case manager and geriatric nurse, who work with him closely as a team, know what community resources are available to maintain or to improve function and independence. Deterioration and loss of function, which is so important in overall quality of life, will be costly for the patient and provider. As the patient loses function and becomes dependent, caregivers experience burnout and the patient lands in the hospital. "These are the expensive patients," Dupee notes. "Keeping them independent for as long as possible is to everybody's advantage."

Leave room to grow. Physicians and group practices catering to seniors should have enough capacity to take on new patients and enough time in their schedules to spend a few extra minutes in the exam room, Dupee says. Compared with other primary care disciplines such as pediatrics, in which patients are younger, healthier, and present with far fewer medical complications, geriatric medicine is time-consuming. There is also safety in numbers: the more patients in a risk pool, the greater your chances for success. "In pediatrics, for example, there are very few, if any, full-risk arrangements," explains Dupee. "But in the geriatric age group, where hospital and medical costs can easily skyrocket out of control, full risk is everywhere because insurance plans want physicians to share in cost-containment risks and strategies."

Gather and use information. Don't rely on your health plan's information

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MSO Provides Behind-the-Scenes Support

A well-run management services organization (MSO) can turn frustration into achievement when a physician group is seeking to provide high-quality, cost-effective care to the elderly, says Richard Dupee, MD. Dupee is the CEO of MedWest, LLC, a management services organization that supports Wellesley Medical Associates, a group practice in Wellesley, Mass., where Dupee is a practicing geriatrician.

In 1998, Dupee and his physician group formed a strategic alliance with the New England Medical Center, in Boston, setting up an MSO that Dupee and his colleagues believe has state-of-the-art management information systems, central billing and collection policies, managed care contracting abilities, and pooled clinical information for enhanced patient outcomes.

"Our MSO can provide information well beyond what insurers and managed care plans can provide," Dupee says. "We help member physicians manage their patients, understand where the dollars are going, understand the incredible billing and administrative errors that are made in the system, both on the insurance side and on the hospital side, and help doctors recoup lost money that was rightfully theirs," he says.

Sheer frustration was the impetus. "I would sit down Saturday mornings and try to go through the claims-paid data from the insurance plans," Dupee explains. "I was shocked at the billing mistakes. It was driving me crazy. I was also shocked at the number of referrals for things that I felt could have been handled by the primary care physician. So I got together with Doug Gregory, PhD, senior vice president of managed care and business development at NEMC, who was already looking into the same issues.

"With our expertise in managed care and Doug's expertise in capitation finance, and the hospital's expertise in providing tertiary care, which can be very costly, we put together a first-class MSO using office support staff that already existed at NEMC," Dupee says.

As a result of his experience, Dupee advises physicians to rely on their own analysis of claims, costs, utilization, prior authorizations and certifications, financial contracts, and risk pool performance. Dupee uses his MSO to conduct these analyses, by downloading the data from the health plan and resorting the information to make it more productive and useful.

Once a group has this information at hand, it will know the answers to important questions, such as, which specialty does the group use the most, Dupee explains. "What is the indirect cost of a referral to a specialist in terms of diagnostics and therapeutics? What hospital charges more for outpatient endoscopy? Our information systems supply us with information designed to squeeze fat out of the system," says Dupee.

—LGC

(Continued from page 8)

system, Dupee warns. Instead, create your own system to track everything from patients and referrals to clinical outcomes and reimbursements. His practice has worked with NEMC to create what Dupee calls a state-of-the art MSO to help physicians manage patients and costs.

Refer to specialists only as needed. Controlling specialty referrals is extremely important, Dupee argues. "Referrals can overwhelm a utilization management system," he says. "Bring specialists in as your allies by creating incentives to be as cautious as possible when ordering diagnostics and therapeutics. But finding the right incentive isn't easy."

There are several options, such as contact capitation, which is when physicians in the risk pool pay specialists a pre-negotiated capitated fee per episode per patient, regardless of the diagnosis and duration of treatment. If the patient has a heart murmur, the cardiologist comes out ahead. But if the patient needs an interventional procedure, the specialist likely would incur much higher costs.

Some risk pools use reverse capitation, in which a primary care physician will be paid on a fee-for-service basis and the specialists are capitated. This arrangement encourages primary care physicians to make frequent patient contacts and to manage as much care as possible.

A more traditional incentive plan involves setting aside, or carving out, a percentage of the PMPM reimbursement fee for a specialist. This arrangement can be time-consuming to negotiate but gives the specialist, like the PCP, a revenue stream regardless of whether he or she sees the patient. The specialist and PCP might also share risk, unlike contact capitation in which the specialist is capitated per episode. The downside to a risk-sharing arrangement is the time and effort that goes into contract negotiations to decide how much to pay each of the various specialists.

Above all, remember that the PCP controls referrals with his or her pen, Dupee stresses. "If you as a primary care doctor have information about a very costly specialist who has outcomes that are no different from anybody else's, then you can alter referral patterns," he says. "I often tell my colleagues that each referral is like signing a personal check. So be sure you have exhausted your own expertise before you ask for help."

Never say no. "We're in a highly competitive service industry," Dupee says. "Never say no. If you can't see a patient who has a headache until tomorrow or next week—instead of today—then you'll never succeed in primary care. Get more office help, realign staff duties so physicians or nurse practitioners can spend more time with patients, delegate to someone else, but don't say no." Agreeing to every reasonable patient request means having protocols in place for everything from headaches to shin splints so the triage staff know when to get a nurse or doctor involved.

Protocols should cover certain office situations, too. "When a patient passes away, one secretary in our practice is responsible for involving all caregivers in signing a sympathy card, and mailing it to the family," Dupee says. "Personal touches are critical."

Managed care and cost-effective care are basically quality care, Dupee believes. "The issue here is not sacrificing quality or saying no to a diagnostic procedure or therapy that the patient needs," he explains. "The goal is to give higher quality care because everybody pays closer attention. In the long run, that saves money and produces better outcomes."

—Reported and written by Lisa Gilson Clancy, in Hopkinton, N.H. More information on practice management strategies is available at mdoptions.com.

Case Manager Is Dedicated

The one piece of advice that Richard Dupee, MD, says is most important for physician groups seeking to succeed when providing care to Medicare participants is to hire a dedicated case manager to do on-site, daily reviews of all hospital admissions. "It's a rarity," admits the practicing geriatrician whose group, Wellesley Medical Associates, in Wellesley, Mass., employs a full-time case manager to oversee more than 900 geriatric patients, about 20% of whom are frail elderly. He estimates that fewer than 25% of all physician groups nationwide have such a dedicated case manager.

The preferred case manager would be a registered nurse or someone with a medical background, Dupee says. It is critical that he or she be familiar with the continuing care pathway in the community—hospitalization, inpatient and outpatient services, and community-based health care. "Our case manager is in the hospitals, out on the road, and in the nursing homes," says Dupee. "It's her job to be sure that the care plans for the patients we admit are solid and quick—appropriate, concise, and with a defined goal. That takes constant communication, with the patient, family members, specialists and the primary care physician, who needs to be involved from the beginning to the end. She makes sure everyone is on the same page, with the same expectations."

The key to managing the care of elderly patients who are hospitalized is to start discharge planning when the patient is admitted. "The case manager makes sure systems are in place so that when necessary, we can transfer patients to a skilled-nursing facility or nursing home, or set up home care, 24 hours a day, seven days a week," Dupee says. "If possible, we avoid the emergency room. If we've got an elderly patient with pneumonia who needs intravenous antibiotics, but is otherwise stable, then we do that safely in the nursing home, at significantly less cost.

"The problem that occurs in geriatric medicine is that we tend to keep our patients in the hospital for too long," adds Dupee. "Almost half of hospital admissions result in some adverse event that could have been prevented, such as pneumonia, infection, or bed sores from inactivity."

—LGC

Changes Mean More Income for PCPs

Medicare is continuing to make changes in the method it uses to compute physician payments. This year, half of the compensation Medicare will pay physicians will be based on the resources physicians use to provide medical services, and half will be based on historical charges. In 1998, Medicare compensation was based entirely on each physician's customary charges to patients.

Under the new formula, primary care physicians will be earning more, and specialists will be earning less. But specialists who will lose money disagree with the formula the Medicare program is using for its new fee schedule, and a coalition of medical professional associations has filed suit challenging the change. Anesthesiologists, for example, will be paid 8% less under the new rule. "I don't necessarily call our projected 8% fee schedule cut fair," comments Karin Bierstein, practice management coordinator for the American Society of Anesthesiologists, in Park Ridge, Ill.

Cognitive Service Payments

The adjustment in compensation methodology began last year, when the government based a fourth of Medicare compensation on the resources physicians used to deliver care. Within two years, all Medicare compensation will be based on the resources physicians use to provide a service—such as the cost of equipment and paying support staff—rather than on what physicians charge for delivering health care services.

"For Medicare and insurers, procedures traditionally have had a higher price than cognitive services," explains Peter Kongstvedt, MD, a partner and health care consultant with Ernst & Young, CPAs and consultants, in Washington, D.C. "As a result, there's been less payment to a physician for performing a careful history and physical exam than for doing a procedure involving scalpels and machines."

Medicare bases compensation on a fee schedule that specifies payments to physicians for more than 7,000 services and procedures, ranging from routine office visits to cardiac bypass surgery. In 1998, Medicare paid physicians about $35 billion. Payments were projected to rise to $37 billion in 1999, and practice expenses are projected to constitute about $20 billion of this amount, and the balance will go primarily for physician services and malpractice insurance.

The new system of expense reimbursement, using a formula called resource-based practice expenses (RBPEs), is fairer than the previous system because it breaks the link between Medicare practice-expense payments and historical charges, Medicare officials have said. The federal Health Care Financing Administration (HCFA), in Washington, D.C., the agency responsible for administering Medicare, has studied the issue of physician payments and found that the charge-based system did not fairly compensate physicians for practice expenses, explains HCFA Administrator Nancy Ann DeParle.

"By making sure that Medicare pays physicians fairly, we help ensure that Medicare beneficiaries will continue to have broad access to the physicians they need to stay healthy and productive," says DeParle.

Under the old system, for example, a physician who performed coronary bypass surgery received practice-expense payments that were more than 100 times greater than what he or she would be paid for an office visit. But costs for bypass surgery are only about 40 times higher than costs for an office visit, according to HCFA calculations. The new compensation formula addresses this imbalance by tying payments closely to actual expenses, says Kongstvedt.

"By lowering the value of invasive procedures, such as cardiac surgery, and raising the value of cognitive services, resource-based compensation addresses the imbalance between cognitive and procedural services, at least to some extent," Kongstvedt says. "Many large insurance companies, such as the Blue Cross Blue Shield companies, are following suit in their determination of reasonable fees."

Resource Value Units

The Medicare fee schedule allowance equals the sum of the three resource value units (RVUs), which vary according to the type of service provided: work-relative values, practice expense-relative values, and malpractice-relative values. RVUs are relative to five-digit billing codes, known as current procedural terminology (CPT) codes, which the AMA developed. The relative values for physician work have been established since the inception of the Medicare fee schedule in 1992.

Under HCFA's formula, the physician work component accounts for roughly 55% of the total value of each Medicare service provided. Practice expenses account for 42%, while mal-

From Charged-Based to Resource-Based

(Within two years, practice-expense relative values will be entirely resource-based.)

	Charged-based	Resource-based
1999	75%	25%
2000	50%	50%
2001	25%	75%
2002	0%	100%

Source: *HCFA, Washington, D.C., 1999.*

practice insurance adds about 3%. The sum of these values is adjusted for the geographic location where the service is provided and other variables. Medicare then pays the resulting dollar amount to physicians for treating Medicare patients.

Practice expenses include direct and indirect expenses. Direct expenses are nonphysician labor, medical equipment, and medical supplies needed for each procedure. Indirect expenses, such as the cost of general office supplies and utilities, cannot be tied to individual procedures, so HCFA used generally accepted techniques to allocate expenses to each medical procedure. Working with virtually all major medical specialty societies, HCFA convened expert panels and conducted extensive research to estimate the direct expenses for different medical procedures and services. HCFA also used information gathered by the AMA's Socioeconomic Monitoring Survey.

Practice and malpractice expenses were based on historical charges until 1994, when Congress directed HCFA to change from charge-based relative values to practice-expense relative values by 1998, and directed that malpractice expenses be resource-based starting in 2000. The Balanced Budget Act of 1997 delayed implementation of the new rule and implemented a gradual four-year transition, beginning in January of last year. Under the transition timetable, practice-expense relative values will move from being charged-based to resource-based (See table: "From Charged-Based to Resource-Based," page 10.)

Specialists Hurt

Overall in 1999, physicians earned about 5% less than they earned in 1998 for treating Medicare patients, HCFA says. But under the proposed fee schedule for 2000, physicians who provide services primarily in office settings, such as family practice and internal medicine specialists, will receive increased payments, while physicians who provide services primarily in hospital settings will receive decreased payments (See table: "New Payment Method Has Some Negative Effects.")

Using RBPE to determine the expense-related component of Medicare fees caused payments for evaluation and management services in general to go up for 1999. Reimbursement for office visits by established patients increased between 12% and 55%, and fees for visits by new patients climbed as much as 34%. At the same time, RBPEs caused fees for procedural services to drop. Reimbursement for a colonoscopy for lesion removal, for example, decreased by 12%. What HCFA pays for treatment of a retinal lesion declined by 18%.

As a result of the changes, family physicians took in about 2% more in Medicare reimbursement last year, while two surgical specialties—cardiac and thoracic—realized approximately 8% less, HCFA officials have said. Dermatologists got an increase of 2%, while gastroenterologists saw a decrease in fees of 2%.

The median annual income of family physicians was about $124,000 in 1998, according to the American Academy of Family Physicians (AAFP), in Leawood, Kan., and about 22% of that amount was derived from Medicare. Roughly, then, the average family physician stood to make $545 more from Medicare in 1999, says Kent Moore, manager of reimbursement issues for the AAFP. By 2002, income for family practice physicians will rise by $1,900 when compared with their 1998 income, Moore says.

As for neurosurgeons, their median 1997 net income was $288,830, according to the American Association of Neurological Surgeons (AANS), in Park Ridge, Ill. About 25% of that amount comes from Medicare, says Katie Orrico, AANS director. The switch to RBPEs will cost the average neurosurgeon a little more than $2,100 this year and more than $7,900 in 2002.

Many private insurers will follow Medicare's lead and make similar payment adjustments, experts say. "The changes are improving the economic position of nonprocedural medical services, and that will encourage the use of noninvasive medical care," says Kongstvedt. "On the whole, this may be a good thing for health care. It may be more in line with what we as a society need, which is more cognitive services and a de-emphasis on more expensive and dangerous procedures."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice management is available at mdoptions.com.

New Payment Method Has Some Negative Effects

(The exact effect on a practice will depend on its mix of services and where services are provided.)

Specialty	Change (percentage)
Anesthesiology	-8%
Cardiac surgery	-9%
Cardiology	-3%
Clinics	0%
Dermatology	2%
Emergency medicine	1%
Family practice	2%
Gastroenterology	-2%
General practice	2%
General surgery	0%
Hematology/Oncology	1%
Internal medicine	1%
Nephrology	1%
Neurology	1%
Neurosurgery	1%
Obstetrics/Gynecology	2%
Ophthalmology	0%
Orthopedic surgery	2%
Otolaryngology	2%
Pathology	1%
Plastic surgery	-1%
Psychiatry	-1%
Pulmonary	-1%
Radiation oncology	0%
Radiology	-1%
Rheumatology	6%
Thoracic surgery	-7%
Vascular surgery	0%

Source: *Federal Register, July 22, 1999.*

Application Service Providers Help Physician Groups Cut Software Costs

Dave McComb is the vice president of research and development at OrganicNet, Inc., an application service provider in San Francisco that develops software to integrate the management of clinical and business processes in health care. McComb has 20 years of experience in software technology development and deployment.

James Snyder, MD, is vice chair of the department of medicine, University of Nevada School of Medicine. Board-certified in internal medicine and endocrinology, Snyder has 20 years of experience in clinical practice.

Richard L. Reece, MD, editor-in-chief, conducted this interview. More information on how physicians are using information technology is available at mdoptions.com.

Q: *First, what is an application service provider (ASP)?*

McComb: The software industry has some remarkably convoluted definitions for what is a genuinely simple concept. A succinct definition is that an ASP hosts, deploys, and leases software applications over the Internet from a centralized network facility that it manages.

Snyder: I do not wish to complicate matters, but it is important to add that there are two basic types of ASPs. Some develop their own application software. Others acquire the rights to deploy solutions that other companies develop and thus deliver third-party software over the Internet.

Q: *Briefly, can you explain how an ASP works?*

McComb: An ASP provides application software and the necessary technology infrastructure to maintain the software on their servers. For the solutions for which they serve as the host, the ASP manages the hardware for the network and the software for the application and the operating and database management systems. Applications are then distributed over the Internet. Customers download just the client software for the solutions they need and run the applications directly over the Internet from the ASP's servers.

Q: *Can you offer an example of how this would work?*

McComb: Sure. Let's use a business-to-consumer example. For your PC at home, you can drive over to the local computer store and buy antivirus software, maintenance update software, a hard drive clean-up program, a PC performance optimizer, and so forth. When you get home, you have to install each individual program on your PC.

On the other hand, you can go the Web site for McAfee.com Corp., a company in Santa Clara, Calif., that develops antivirus and PC-maintenance software, and subscribe to the McAfee Clinic, an online PC manager. You use all sorts of PC utilities right over the Internet. As a consumer, you don't have to bother with buying and installing separate packages. And, when McAfee updates any of its PC utilities, all the upgrades are automatically available and instantly useable the next time you sign on.

Snyder: It works the same way for business-to-business software, including health care applications that physician groups use. Rather than buying, installing, and maintaining software on their own servers, group practices can subscribe to various business and clinical solutions and run them over the Internet from centralized servers.

Q: *I understand that the ASP concept is relatively new. Are many vendors adopting the ASP model?*

McComb: Yes. It's to the point now where virtually all major software vendors and information technology companies have started initiatives to host applications over the Internet.

Snyder: Adoption of the ASP model seems more advanced in arenas outside of health care, including financial, human resources, and manufacturing applications. But, health care IT companies, both older vendors and newer ones, are deploying software over the Internet.

Q: *So, the ASP model represents a fundamental change in the way software is distributed and deployed. The customer does not buy and install applications (plus the operating system and database system needed to run them) on their own servers.*

McComb: That's right. That's the essence of the ASP concept. It's the logical evolution of the basic client-server software model. The ASP maintains the entire server side of the system. The customer downloads only the client software that it needs. The Internet is the network.

Snyder: Shifting the administrative burden, and costs, of system administration from internal resources to an ASP is one of the features that makes the ASP model attractive to group practices. A clinic does not have to buy and maintain its own servers and all the associated software. For

> **"Rather than buying, installing, and maintaining software on their own servers, group practices can subscribe to various business and clinical solutions and run them over the Internet."**
>
> *—James Snyder, MD, University of Nevada*

physician group practices contending with the constraints of limited IT resources and budgets, it can be a good alternative.

Q: *Are some health care organizations, however, reluctant to give up control?*

Snyder: On balance, most physicians and group practices I know would be happy to give their IT management headaches to someone else, especially if the price is right.

Q: *That brings us to the issue of pricing. Dave, you said that ASPs lease software. How is software priced under the ASP model?*

McComb: I hesitate to use the buzzword "revolutionary," but the ASP model turns traditional software pricing upside down. Instead of paying a large up-front license fee (plus annual maintenance calibrated as a percentage of the license amount), the customer pays a monthly or annual subscription.

Snyder: Subscription pricing can be an advantage for physician groups. It lowers initial software acquisition costs, often enabling group practices to pay for IT solutions they need out of their operating budgets, rather than as a large capital expenditure. The ASP model can reduce costs in several other ways as well. Both ongoing system maintenance and upgrades cost less, since the ASP handles system administration. Fewer internal resources have to be directed to IT staff, equipment, and space.

McComb: Some IT industry analysts estimate that the total cost of hosted applications can be 25% to 30% less than licensing and managing applications internally.

Q: *Can you explain how these companies reduce costs so much?*

McComb: Let's go back to the McAfee example. If you go to the computer store, you'll pay a license of $30 or more for each individual software package you buy. That can cost about $150, and you then have to install each separate utility on your hard drive. If you subscribe to the online PC clinic, you pay about $30 a year, and that covers all the applications, plus some extra software management tools. So, for the amount you'd spend buying the software individually, you can rent them all for five or more years. McAfee's costs are lower in the ASP model because when they modify any of their utilities, they just make the changes one time on the server side of their system and therefore incur a negligible marginal cost to distribute the upgrades to their customers over the Internet. Plus, they have no outdated inventory. They can pass such savings on to their subscribers, who know that all application improvements will be instantly available to them online.

"Subscription pricing lowers software acquisition costs, often enabling group practices to pay for IT solutions out of operating budgets."
—James Snyder, MD, University of Nevada

The advantages? You avoid the drive to the mall. You spend less money up front. The client software is easier to install than the complete set of applications and takes up less disk space on your PC. You get all software upgrades without having to go out and buy them individually and install them incrementally, and that's certainly an advantage for utilities such as antivirus software. Any time you sign on and run the antivirus software over the Internet, you are guaranteed to get protection against the most recent crop of viruses.

Q: *Are there other sources of cost reduction in the ASP model?*

McComb: One of the other subtle areas of cost saving for software vendors is in the reduced complexity of environments to support. In the traditional model, where all the software is installed on the customer's computers, vendors have to support multiple brands and multiple versions of server operating systems, database management systems, and other server-side tools. With the ASP model, there is no variation, because we can simply support whichever operating system and database best suits our applications. This reduced complexity lowers vendors' costs, and we can pass these savings on to our customers.

Q: *Jim, are there other advantages, especially for physician group practices?*

Snyder: Using the Internet enables you to deploy applications efficiently across separate sites. Running software over the Internet from one common database allows users in different offices to access and share the same data, such as appointment scheduling and clinical information. This feature can be an important advantage for group practices that have several offices or for larger integrated delivery systems.

Moreover, physicians are concerned about software solutions that might not deliver as promised. With the flexibility and the relative ease of software deployment over the Internet, the ASP model makes it easier for group practices to try out software on a trial basis. This feature helps reduce physicians' risks and costs.

Q: *Dave, what does a group practice need to run applications over the Internet from an ASP's servers?*

McComb: The requirements are actually quite modest. Internet access of at least 56K is generally required. Access via an ISDN line is better, and back-up connectivity with a modem and phone line is a good idea. Most PCs with a Pentium processor are fine. We usually recommend that physician group practices have PCs with a minimum of a Pentium 133 MHz processor, one gigabyte of storage on the hard drive, and at least 32 MBs of RAM.

Snyder: Most physicians now access the Internet routinely both at work and at home for a variety of uses. There is a growing awareness that clinics that do not currently have a fast connection to the Internet will need to get one in the near future anyway, so it's not likely to be a big barrier. When physicians see how using the Internet can enhance their practice, the remaining barriers will fall away. And, in my experience, it is much easier to get an additional PC and an Internet connection than to get an in-house information systems group to install another server, especially if the application you want requires a different operating system or new database.

(Continued on page 14)

(Continued from page 13)

Q: *How do you address physician concerns about the reliability and security of the Internet?*

McComb: Let's talk about reliability first. It all comes down to network capacity. Some ASPs go so far as to guarantee 300% excess capacity to ensure availability and reliability. It's become standard practice for ASPs to guarantee contractually 99% plus availability.

Snyder: You know the overall reliability of the Internet is now up over 95%. Based on my experience with internal servers going down, reliability of the Internet is not that big an issue relative to the reliability of internal networks.

Q: *And, what are the issues related to security?*

Snyder: Two years ago, most people were reluctant to enter a credit card on the Internet, and people had to fax or phone them in. Now, people are much more comfortable with encryption and recognize that the Internet is generally at least as secure as the phone or fax.

McComb: All sensitive information should be encrypted for transmission over the public network; beyond that the security issues are pretty much the same as for traditional systems. Firewalls are necessary to limit unauthorized access. In addition, good ASPs deploy intrusion detection software.

Q: *Dave, can you give us a definition of those terms?*

McComb: A firewall is a set of software and hardware that sits in-between an organization's servers and the rest of the Internet. Intrusion detection tools are software programs that assess and block unusual or unauthorized use.

Q: *Are some types of applications that physicians need more logical for the ASP model than others?*

McComb: No, I don't think so. Both clinical applications and traditional practice management applications can be deployed via the ASP model.

Snyder: Basically, I agree, but let's focus on clinical applications for a moment. Let's consider a large multispecialty practice with an asthma and allergy department. Say that some of the physicians in just that one department want to use an outcomes application to collect and use data on patient-reported health and functional status for clinical decision support and for their internal quality monitoring and improvement initiatives. The ASP model provides a cost-effective way to bring that specific clinical solution right to that particular set of clinicians. With the ASP model, meeting their needs stays simple and doesn't become a major IT issue for the whole group.

> **"The ASP model can give group practices access to state-of-the-art applications and free physicians from concerns about their hardware or software becoming obsolete."**
>
> ***—Dave McComb, OrganicNet Inc.***

Q: *How does a physician group practice evaluate ASPs?*

Snyder: The ASP obviously has to offer solutions with features and functions that meet physicians' requirements.

McComb: I'd recommend focusing on three questions: Is the system usable? Is it adaptable? Is it reliable?

The usability issue is much the same as for traditional software: Does it do what you need it to do, and is the response time adequate for what you need? As we know, change in health care is constant, so it is important to determine how your vendor can adapt solutions to changes in the requirements of your particular clinic. The issue of reliability is that you need to be absolutely assured that your data will be preserved and your access will be available. Some ASPs that have established their own data centers have not had the capital to provide the degree of redundancy needed for that assurance.

Q: *Jim, is it important for physicians to consider the two basic types of ASPs?*

Snyder: Yes, it can be important. With an ASP that does not develop its own health care applications but instead hosts and leases third-party software, you have the potential complication of dealing with two vendors: the ASP and the firm that develops the software. In this case, physicians need to make sure it is clear who is responsible for maintaining the application. Physicians should seek an ASP that has domain expertise in health care so that the ASP understands physicians' clinical and business processes and challenges.

McComb: Additionally, if an ASP does not develop and own the applications it is renting, managing the issue of adaptability to change becomes more difficult.

Q: *Are there other qualifications that physicians should consider?*

McComb: Physicians should ask about membership in the ASP Industry Consortium. ASPs that belong to the consortium are industry leaders committed to fostering standards and promoting best practices for the Internet.

Q: *Jim, are you currently using any applications over the Internet?*

Snyder: We are piloting outcomes management with an application that runs over the Internet. We are just getting started, but so far, I am encouraged. Implementing the software over the Internet is the right way to go. Improved data acquisition and management can make outcomes management more effective and help us improve patient care. And, our solution should reduce our transcription costs.

Q: *In summary, any final thoughts on the ASP model for health care?*

McComb: The ASP model is a good fit for health care. It can give group practices access to state-of-the-art applications for clinical and business processes and free physicians from concerns about obsolescence.

Snyder: Physicians are looking for integrated solutions that help us care for our patients and run our business. Running applications over the Internet from a centralized server managed by a competent firm, and paying a monthly subscription fee instead of buying and supporting software, can be a practical, cost-effective solution to our IT problems. ■

AMA Union Expects To Begin Negotiations Within a Year

The union formed by the American Medical Association, Physicians for Responsible Negotiation (PRN), became operational in December. The organization accepted 40 applications in the first hour from prospective members, said union President Susan Adelman, MD.

A pediatric surgeon from Southfield, Mich., and an AMA trustee, Adelman said PRN began accepting applications at an informational session for interested physicians on Dec. 4. That session was the first opportunity for prospective members to join the union, which was authorized by the AMA House of Delegates in June.

Just a week after PRN opened its offices in rented space at the AMA's Chicago headquarters, the National Labor Relations Board (NLRB) ruled that residents are both students and employees, Adelman said. That ruling means that PRN can begin an outreach campaign to residents.

Currently several national labor unions, including a meat packers union in New Jersey, are soliciting employee physicians, AMA Executive Vice President E. Ratcliffe Anderson Jr., MD, said during opening ceremonies of the AMA's House of Delegates. Anderson and Adelman emphasized that PRN will have no ties to existing labor unions such as the AFL-CIO.

PRN, which is a legal entity separate from the AMA, expects to have its first negotiating unit recognized by the NLRB in about a year, said Ross Rubin, acting executive director of PRN. First, PRN needs the support of the prospective bargaining unit before it can petition the NLRB to establish it as the recognized bargaining agent, he said. "Fifty percent plus one [of the employees] must select the negotiating entity in order for it to be recognized by NLRB," Rubin said.

Physician Communication Skills Course Has No Effect on Patient Satisfaction

A widely used CME program designed to improve physicians' communication skills fails to alter general patient satisfaction. Despite this result, physicians who participated in a study of the program believe their skills "moderately" improved, according to researchers in Illinois and Oregon.

Jonathan Betz Brown, MD, at the Center for Health Research in Portland, Ore., and colleagues there and at the University of Chicago, randomly assigned 37 clinicians to attend the training program, "Thriving in a Busy Practice: Physician-Patient Communication." Thirty-two clinicians from the same facility were assigned to the control group.

About 75% of the participants were physicians and the remainder were physician assistants, nurse practitioners, and optometrists.

The Art of Medicine questionnaire was used to assess patient satisfaction with clinicians' communication skills and overall satisfaction with the office visit. Clinicians' skills were assessed before and after the intervention. The results appear in the Dec. 6 issue of *Annals of Internal Medicine*.

The researchers found that patient satisfaction following the intervention improved "on average" in both groups. In fact, "...scores improved slightly more in the control group than in the intervention group," although the difference was not statistically significant.

In contrast, clinicians in the intervention group felt that the program significantly improved their awareness and confidence in dealing with difficult patients. They also reported considerably less frustration during office visits following the intervention program compared with what was reported before the program.

The investigators write, "[I]t is difficult for a single, brief CME course—no matter how interactive, learner-centered, and well designed—to improve general patient satisfaction in the contemporary health care environment."

Writing in a commentary, Paul D. Cleary, MD, of the Harvard Medical School in Boston, suggests that one of the reasons why the intervention failed to influence patient satisfaction may be that "[m]ost patients have excellent clinical experiences most of the time, and it is hard to improve those experiences." Also, "...behavior, especially such fundamental behavior as communication style, is hard to change." (Ann Intern Med 1999;131:822-829;859-860.)

Managed Care Wins Key Ruling, But Larger Issue Looms

A U.S. appellate court has handed the managed care industry a small victory in its uphill battle against a wave of class action lawsuits attacking its financial and patient-care practices.

The ruling on Jan. 3 affirmed a lower court decision to dismiss a case against several HMOs for failing to disclose their financial incentive arrangements with physicians. Chief Judge Reynaldo G. Garza of the Fifth U.S. Circuit Court of Appeals found that no such duty exists under the Employee Retirement Income Security Act (ERISA), the federal law governing employee benefit plans.

Aetna US Healthcare, one of the defendants, immediately embraced the ruling as "...yet another blow to the viability of the recent class actions brought against HMOs."

But Garza's decision is far from the last word on the subject, managed care attorneys say. Recently, plaintiffs' attorneys have filed class-action lawsuits against managed care plans for failing to disclose financial incentives.

One key case, scheduled for oral presentation before the U.S. Supreme Court this month, could help bring clarity to the issue of financial incentives. Wendy Krasner and Barbara Mayers, health care partners of McDermott, Will & Emery, noted that the Fifth Circuit found no duty to disclose physician incentives and that the high court will consider whether having those incentives at all represents a breach of duty under ERISA.

(Source for all items: Reuters Health)

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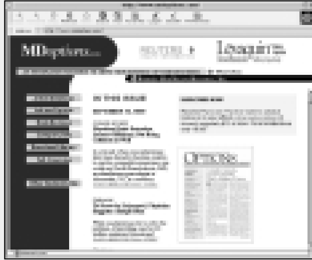

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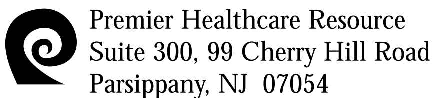

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