

# PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

March 15, 2003

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## Crisis Leads Physicians to Drop Insurance

**J**uergen Eisermann, MD, 48, never imagined he would one day relinquish the security of malpractice insurance. But last summer, his insurer, the Farmers Insurance Group, of Los Angeles, told Eisermann and his three partners in a Miami infertility practice that it was leaving the Florida market.

For minimum coverage with a new insurer, the group's liability insurance that had cost the practice \$240,000 annually would more than double to \$510,000, and, Eisermann learned, only two commercial insurers were willing to underwrite a new policy.

### Insuring Thyself

"All four of us would have to work salary-free for four months to pay the premium," Eisermann says. "We are not risk takers but for that amount, we decided to self-insure." With certain caveats, self-insuring, or "going bare," is permitted under Florida law.

As rates across the country continue to rise sharply for the third year in a row, physicians in Miami-Dade County, where Eisermann practices, had the dubious distinction of having the most expensive premiums in the nation, according to the *Medical Liability Monitor*. Last year, obstetrician-gynecologists in Miami-Dade County paid \$201,375 for malpractice policies that had a limit of \$1 million per occurrence and \$3 million per year; for the same policy, general surgeons paid \$174,368, and internists paid \$56,153, MLM reported.

Physicians with claims histories paid even higher premiums, if they could find coverage.

As a result, in Florida and other states where coverage is either unaffordable or unattainable, increasing numbers of doctors are making the gut-wrenching decision to go bare. "It's hard to get data but my impression is that more doctors are being forced to consider that option," says Richard Anderson, MD, chairman of The Doctors' Co., a malpractice insurer in Napa, Calif., that has physician clients in every state.

Recognizing the difficulty physicians face, the AMA's Board of Delegates passed a resolution in December, altering its 22-year-old policy recommending physicians carry liability insurance to protect themselves and their patients. The new policy leaves the decision to physicians.

"We know bare doctors are out there," says Russell Kujan, a spokesman for the Maryland State Medical Society. "They don't want to announce it. The most paranoid doctors fear that someone will make an example of them."

Maryland allows physicians to self-insure. Other states, such as Florida, have no policies requiring malpractice insurance, according to an AMA report last year, *Summary of State Laws Mandating Minimum Levels of Professional Liability Insurance*. At least seven states, including Kansas, Massachusetts, and Wisconsin, require minimum

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## Advice for Physician-Owned Practices

Declining revenue, increasing expenses, and a mounting workload are putting physicians under pressure. For most physicians, these issues pose a dilemma because they are not trained to solve business problems, consultants say.

Michael E. Gerber, CEO of E-Myth Worldwide, a business consultancy in Santa Rosa, Calif., says that doctors believe they are entrepreneurs when they are not, and most lack the skills needed to manage a business. Gerber, the author of *The E-Myth Physician: Why Most Medical Practices Don't Work and What to Do About It*, calls this misperception the e-myth, or entrepreneurial myth. To succeed, physicians need to reform their practices, Gerber says. First they need to define their vision of a dream practice. Next they need to engage employees in that vision, identify key functions, and establish consistent processes.

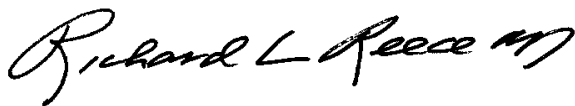
Nathan Kaufman, senior vice president for health care strategy at Superior Consultant Co., in San Diego, suggests that primary care physicians may want to begin charging extra for personalized services, such as being available 24 hours a day, making house calls, and interceding on patients' behalf with managed health plans.

Kaufman also recommends that physicians drop HMO contracts that do not provide sufficient revenue to cover office costs and that they require copayments at the point of care. Physicians need to make these changes because revenue is dropping by 3% to 6% per year and expenses are rising by 6% to 8%.

Fitzhugh Mullan, MD, author of *Big Doctoring in America: Profiles in Primary Care*, predicts that PCPs will prosper because new technologies will create a growing demand for interpretation, coordination, and the human touch that many patients say is missing under managed care. However, solo practitioners will need to become more efficient and seek to appeal to informed consumers who want timely, personal, and high-quality care, he adds.

Daniel K. Zismer, PhD, a health care consultant for Dorsey/Health Strategies in Minneapolis, believes solo practitioners and small primary care groups are endangered because reimbursement is declining and they generally have little in cash reserves. He is more optimistic about single-specialty groups, saying they tend to generate more revenue, can expand into dominant specialty groups, add profitable ancillary services (such as ambulatory surgery), or invest in specialty hospitals.

Taken together, these experts are suggesting that regardless of specialty, all physicians need to develop new, more efficient business models in order to overcome the business pressures that are hindering their success.



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# Physicians Find Ways to Comply

By Richard L. Reece, MD, editor in chief

**A**fter years of anticipation, the first portion of the Health Insurance Portability and Accountability Act went into effect in October; another deadline for compliance looms next month. HIPAA has major implications for all physicians, who must ensure that their practices comply so that they can receive payment on claims and avoid penalties for noncompliance with privacy standards.

Many physicians are concerned about, even overwhelmed by, the steps they need to take to be in compliance. As a result, physician readiness for HIPAA varies widely, according to James Weintrub, MD, a practicing plastic and reconstructive surgeon in Providence, R.I., and founder and CEO of Digital Physicians Network (DPN) an information technology firm that specializes in compliance. "Some physicians feel that HIPAA does not affect them, while others have made

deadlines," Weintrub explains. "That deadline dealt with electronic transactions and got a fair amount of publicity from physician organizations, professional societies, and health plans, and physicians were encouraged to file for the one-year extension for compliance with the transactions in HIPAA."

## Taking Steps

Physicians who are bewildered by HIPAA requirements have several options: They can ask their local hospital or health plan for the name of a reliable HIPAA consultant, seek assistance from a medical society, or purchase a CD. "There is a host of resources available," says Weintrub. "Some sources are free on the Internet; others are available from professional organizations, and a whole array of consulting services are available as well. The costs of these services vary widely depending on the service and the nature of the deliverable."

The forms are provided. In contrast, for compliance with HIPAA, forms are not provided, no context is given, and simplified information (such as the information that can be found on the government's Web site with respect to taxes) is not available. As a result, compliance with HIPAA is not easy to accomplish."

Several companies have produced compact disks that attempt to provide context for the HIPAA regulations, strategies for achieving compliance, and forms to facilitate the compliance process. DPN, which provides strategic solutions to physicians, has produced a CD for Blue Cross-Blue Shield of Rhode Island entitled, "Getting Your Practice Ready for HIPAA." BCBS of Rhode Island has given the CD to its participating physicians.

## The Physician's Perspective

The best CDs will present the information from the physician's perspec-

**"Health plans are interested in promoting electronic claim submissions in order to avoid the expensive proposition of processing paper claims," says James Weintrub, MD, of Digital Physicians Network.**

involved preparations for meeting the HIPAA standards for privacy, security, and transactions," he notes.

Last October, physicians who were not in compliance with HIPAA's transactions regulations had to send in a request for an extension, indicating that they would comply by this October. Completing this step alerted many physicians to the fact that HIPAA is a serious effort by the government that will be enforced, Weintrub says.

"The October 2002 deadline was the first of many HIPAA compliance

Weintrub notes that HIPAA compliance is hard work. "Doctors must spend time, money, and energy to become HIPAA compliant," he says. "That's the stumbling block. HIPAA is an unfunded mandate declaring that physicians have to meet certain requirements. Furthermore, the federal government has not provided tools and forms that would make compliance easier to achieve. For example, when it comes to paying taxes, the federal government is very explicit in terms of what people need to do and how they need to do it.

rather than focusing on the legal or regulatory issues of the information technology requirements of the act, Weintrub says. The most useful CDs on HIPAA compliance present the information in a straightforward and unambiguous way so that a practice knows what it needs to do to meet the requirements, he adds. Lists of other sources for help and sample forms and sample agreements that are required under the act are the type of other useful information that should be included.

Health plans are promoting

*(Continued on page 4)*

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HIPAA compliance among physicians for cost reasons. "BCBS of Rhode Island and other health plans are interested in promoting electronic claim submissions in order to avoid the expensive proposition of processing paper claims," Weintrub explains.

The cost to a health plan of processing an electronic claim is considerably lower than it is for handling a paper claim. "Processing electronic claims costs a health plan only several cents each compared with the \$4 to \$7 on average it costs to process paper claims," Weintrub says. "Therefore, it is in the best interest of health plans to encourage HIPAA compliance by physicians."

Such savings will also accrue to the government, as Medicare and Medicaid claims will be less costly to process electronically than paper forms would be. "The federal government has identified the need to drive down administrative health care costs, especially in Medicare and Medicaid," Weintrub observes. "One way to accomplish this goal is to process health care transactions in a standardized and electronic fashion. In a few years, it may be mandatory for physicians to submit all Medicare and Medicaid claims electronically. So the physicians who submit claims to Medicare and Medicaid (which means most physicians in the United States) may eventually have to submit those claims electronically."

### **Society Support**

The state medical societies are another source of help on HIPAA compliance. The Connecticut Medical Society, for example, has

done intensive work in helping to prepare doctors for HIPAA. "In 2001 we began to receive solicitations from consultants, vendors, and law firms that were promoting HIPAA compliance products," says Cameron Staples, general counsel for the society. "We wanted to become more conscious of what the marketplace was offering and to review the products that were going to be offered in our state."

Society members met with representatives from the county medical associations, the Connecticut Medical Insurance Co., and an IPA to review the proposals and meet with vendors. The society chose to work with PrivaPlan Associates, Inc., a company in Santa Fe, N.M., that offers a CD to help physicians comply with HIPAA. The PrivaPlan CD is also used by medical societies in Louisiana and California.

"We had the CD customized to meet the requirements of Connecticut law, and then made it available to our members," Staples says. "In October, we offered a series of six promotional seminars free to our members."

A CD product is useful for physicians in Connecticut because about two thirds of all doctors in the state practice solo or with one other doctor. "Our concern was that it would be those very small groups that would be the least financially able to hire a consultant at a considerable cost in order to become compliant," Staples says. "As a result, we thought some might not go through the steps to meet the act's requirements. We wanted to find an inexpensive product that they could use."

To address follow-up questions about the CD's content, the society

developed a list of frequently asked questions on its Web site (at [www.csms.org](http://www.csms.org)). "We also direct people to the Web site of the federal Centers for Medicare & Medicaid Services (at [www.cms.hhs.gov](http://www.cms.hhs.gov)), which also has a series of frequently asked HIPAA questions," Staples adds.

It is important that CDs offering HIPAA assistance be customized, as needed, for each state. "Usually, federal laws supersede any state law they impact," Staples says. "But Congress felt that HIPAA should permit stronger state privacy requirements to remain in place. So state law would not necessarily be preempted if it is stronger in a particular instance."

"We hired a law firm to go through all the statutes and regulations in Connecticut that might relate to the privacy of health information and then determine in each case why that requirement was more or less stringent than HIPAA," Staples continues. "The lawyers estimated that they had to consider about 5,000 statutes and regulations in Connecticut that had an effect on privacy. Only after they reviewed all of them could they determine when state law superseded federal law, and what medical practices would need to do to be compliant."

### **HIPAA Benefits**

Such CDs will make it easier for physicians to comply with HIPAA and will increase physicians' ease of doing business. "In the long run, HIPAA will benefit physician practices," Weintrub says. "The act will ultimately make available much more information about a patient's health insurance and about a particular claim."

**HIPAA is expected to help physicians avoid the common problem of treating a patient who is ineligible for coverage. The act also may help speed payments and claims processing.**

One common problem in physician practices is that a doctor may see a patient and then submit a claim but find out later that the patient was ineligible for coverage. HIPAA will help physicians avoid this problem.

"Two HIPAA transaction standards have to do with eligibility: the eligibility query and the eligibility response," Weintrub notes. "The eligibility query is sent by the physi-

trative burden practices face, says Staples. The first real burden is simply becoming compliant with the act's privacy regulations.

"Before April 15, practices need to assess how much out of compliance they are through some sort of gap analysis," Staples explains. "They need to examine the way they handle what the act calls protected health information (PHI)

practices for noncompliance, but most of the noncompliance issues will be brought by disgruntled patients or employees. These infractions will be reported to the Office of Civil Rights, the enforcement arm of HIPAA privacy."

### **Speeding Payment**

Because HIPAA standards for transactions relate to electronic transactions and not to the submission of paper claims, some practices may try to get around HIPAA by submitting claims on paper. "But this is not a good strategy because those claims will need to be processed by the health plan individually and payment will be held up," Weintrub cautions.

At a minimum, practices will need practice management software that can submit claims and queries in the standard HIPAA-compliant format. "An upgraded practice management system is generally required for submitting electronic claims and for the ability to do the full collection of HIPAA transactions," says Weintrub. "Alternatively, some practices may choose to use their old system and transmit claims to a clearinghouse, which can reformat the claims and then send them on in the HIPAA-compliant format."

The Connecticut society recognizes the importance of HIPAA compliance, Staples says. "We urge our members to understand that there may be some benefits to HIPAA compliance," he says. "Payment will probably be expedited, and electronic transactions will simplify the claims process. The practices that submit solely paper-based claims, and are therefore not within HIPAA's reach today, must decide whether they'd like to get into this electronic world."

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

**At a minimum, practices will need practice management software that can submit claims and queries in the standard HIPAA-compliant format.**

cian's office to the health plan, and the response is sent back as a second transaction. Under these standards, an office can determine in advance whether a patient has health insurance in place and is eligible. In theory, practices would be able to eliminate the problem of submitting claims, tracking claims, and pursuing accounts receivable where there is little chance of ever being paid."

In addition, HIPAA should alleviate two other common problems for physicians: slow claims processing and mounting accounts receivable. "HIPAA transaction standards specify one standard electronic form for claims, whereas currently various health insurers use about 40 different forms," Weintrub says. "With the implementation of HIPAA, it should be easier for physician practices to complete that electronic form and submit a clean claim. A larger number of clean claims will increase the speed of claims processing and payment, thereby reducing accounts receivable."

### **Going Private**

While HIPAA makes some tasks easier, the privacy and security regulations of the act add to the adminis-

trative burden practices face, says Staples. The first real burden is simply becoming compliant with the act's privacy regulations.

"Practices also need to understand a variety of new opportunities patients have," Staples continues. "For example, patients now have to sign an acknowledgement that they have been informed of their privacy rights. They also have opportunities to amend records. As a result, there is a range of potentially new administrative procedures."

Practices that are not compliant will be taking a risk. "A patient, or an office staff member, might file a complaint," Staples explains. "If practices have done nothing to become compliant, essentially ignoring HIPAA, they stand a much greater chance of having some punitive reaction from the enforcement agencies than if they are making a compliance effort but are falling short in some area."

Penalties for noncompliance will vary. "Depending on the infraction, possible penalties include fines, jail time, and loss of Medicare provider status," Weintrub says. "The government has some resources to audit

# EMRs Help Keep Patients Moving

By Hayward Zwerling, MD, FACP

In December 2001, the nurse who had been working in my office for the previous five years had to quit abruptly in order to tend to a medical emergency in her family. Although we immediately began advertising for a nurse to replace her, it took six weeks to fill the position. During that time, we had to redefine the processes in our small office.

While the experience was one that we do not want to repeat, we nonetheless learned some important lessons that might be instructive for other physicians trying to meet the increasing demands imposed on physicians today. One significant lesson was that if we had not previously invested heavily in computers, we would not have been able to continue seeing the same number of patients as we normally do.

I work as a solo practitioner in internal medicine, and I have a consultative practice in endocrinology. My staff consists of a secretary, a nurse, and a nurse practitioner.

## Information Solutions

On a typical day, we see 25 to 30 patients. Some visits are simple and quick (such as those involving patients with urinary tract infections), but other visits are more prolonged and complicated (such as those involving patients who have poorly controlled diabetes and other medical problems).

Relying heavily on computer-assisted technology, we try to run a paperless office by using electronic medical records software. We use this

*Hayward Zwerling, MD, FACP, is the founder and president of ComChart Medical Software, a company in Lowell, Mass., that makes an electronic medical record program for physician offices. He also practices four days per week as a primary care physician and as a consultative endocrinologist.*

technology to file lab reports and dictate progress notes and radiology results. We also use a computer-operated telephone answering machine and have a Web site (at [www.drzwerling.com](http://www.drzwerling.com)).

To accommodate our normal patient load while we were without a nurse, we had to minimize the amount of time spent interacting with patients. This was a choice we did not want to make, but it was nec-

Also, we eliminated double booking in an attempt to keep my schedule on track. In the past, we had at least two double-booked appointments each day.

## Message Triage

During the time we were short staffed, we relied heavily on our computer phone system to triage messages. When a patient called, he or

**When a nurse quit, a practice learned that if it had not previously invested heavily in computers, it would not have been able to continue seeing the same number of patients as it did previously.**

essary. When we explained the situation to our patients, they were quite understanding.

When we had a full staff, for example, one of them would mail new patients a pamphlet about the practice, including a map and letter of introduction, and request information from them (such as a medical history and health insurance data) prior to the new patients' first visit to the office.

In an attempt to use my secretary's time more efficiently after my nurse left, these forms were posted on our Web site and patients were directed to download them, fill them out, and bring the completed forms with them for the first visit. This strategy allowed us to save the time that would normally be needed to print the forms, address the envelopes, and mail the letters. In our community, about half of the patients can access the Web; for the others, we mail them the forms prior to their first office visit.

she heard a message stating that telephone calls regarding medical issues could not be returned due to our staffing shortage except in the case of an emergency, which we handled in a medically appropriate manner. To discuss a medical issue, all patients needed to schedule an office visit.

Patients who called the office requesting a prescription refill heard a voice message saying that they could pick up the prescription during the following business day or, if they preferred, we would mail a prescription to them or to their pharmacy. The voice message informed the patients that we did not have the staff available to call in prescriptions. In reality, our electronic medical records program permits us to fax prescriptions directly to many pharmacies, but not all pharmacies have fax machines.

When a patient arrived for his or her office visit, I brought the patient into the examination room myself. In an attempt to keep myself on sched-

## **The electronic medical records program made it easy to document care and thus stay close to schedule by using a combination of voice dictation, template progress notes, and point-and-click notetaking.**

ule, I obtained only those vital signs that were clinically necessary for each visit. If a patient had a urinary tract infection, for example, I might not ask the patient to step on the scale for a weight measurement.

### **Patient Education**

During a typical office visit before becoming short staffed, I often did a fair amount of patient education and gave the patient medical literature relevant to the issue at hand. But this was not a typical time, and in order

tant studies, such as chest x-rays for suspected pneumonia or stress tests, and the patients scheduled the routine studies, such as mammograms.

Fortunately, our electronic medical records program made it easy to document care and thus stay close to schedule by using a combination of voice dictation, template progress notes, and point-and-click notetaking. Thus, most progress notes were completed by the end of the office visit, and all notes were completed by the end of the day. In addition, our

who had critically important results, to report the lab findings. But most patients in the practice accepted this change in our policy.

One function that clearly suffered when we did not have a nurse was the restocking of supplies in our exam rooms. As a result, I would occasionally find that the exam room did not have a paper cup or stool guaiac cards; thus requiring that I leave the examination room. I also found that I was running late in my schedule. Although I usually run no more than 20 minutes behind schedule when we have a full staff, I was sometimes running 30 to 45 minutes behind schedule in the six weeks we spent without a nurse. Nevertheless, the patients were gracious and seemed to understand our situation because I had taken the time to explain the problem to them.

During the six-week interval that we were without a nurse, we carried a full patient load, and we believe it was possible only because of our investment in technology. But it was also possible because my staff responded to the situation with the utmost degree of professionalism. They understand that running a small office requires the staff to be flexible with respect to their assigned duties and responsibilities.

Over the six weeks, the processes in our office ran with relative ease but everyone seemed to be under considerably less stress once we had a new nurse on staff. And, computer innovations notwithstanding, we believe patients get better care when a nurse is involved.

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

## **During the time without a nurse, the staff recognized that running a small office required professionalism and flexibility.**

to stay on schedule, I would direct patients to my Web site and suggest that they could download the relevant patient handout materials.

If a patient needed more education than was available on the Web, I would recommend that the patient return during a subsequent visit to meet with me or my nurse practitioner. During this time, my nurse practitioner's day was mostly unaffected by the situation, since she has her own group of patients whom she sees.

Whenever possible, we would reschedule routine immunizations, such as those for tetanus and for pneumonia, for the next office visit, when I anticipated having a nurse. Since the nurse had scheduled radiologic studies for patients in the past, this task needed to be reassigned. My secretary scheduled the more impor-

electronic medical records program allowed us to fax notes on consults directly from the computer in the examination room to the referring physician, thus permitting my secretary to direct her energies toward other endeavors, such as answering urgent telephone calls, checking in and checking out patients, and collecting copayments.

### **Normal Results**

Previously, it had been our office policy to notify all patients about all test results, but not having a nurse forced a change in this policy. We revised our voice mail message to indicate that we would call patients only if their test results were abnormal.

In reality, we called a few patients, particularly those who were anxious about their results or

# Primary Depression Care Cuts Costs

**T**reating mental health disorders in primary care settings lowers costs and improves the quality of medical care overall, experts say. Therefore, providing mental health services should be a major component of primary care, according to guidelines on treating depression issued in September by the American Academy of Family Physicians (AAFP) in Leawood, Kan. Many physicians believe, however, that they lack the ability and the time to diagnose behavioral disorders.

"Physicians often do not recognize patients' behavioral health issues," says Rick Harris, PsyD. "For patients dealing with mental health problems, such as anxiety and depression, the failure of physicians to properly diagnose and appropriately treat their conditions is a serious issue." Harris is a psychologist and president of Collaborative HealthCare Inc. (CHI) a company in Denver that markets behavioral assessment tools for primary care and oncology practices.

## Screening Tools

"Identifying patients with depression can be difficult in busy primary care settings where time is limited, but certain depression screening measures may help physicians diagnose the disorder," says Martin S. Lipsky, MD, chairman of the Department of Family Medicine at the Feinberg School of Medicine at Northwestern University in Chicago. Lipsky and Lisa Sharp, PhD, assistant professor in the Department of Family Medicine at the Feinberg School,

wrote the AAFP's guidelines for evaluating and treating depression in primary care settings. The guidelines, "Screening for Depression Across the Lifespan: A Review of Measures for Use in Primary Care Settings," were published in the Sept. 15 issue of *American Family Physician*.

The guidelines say that depression occurs in children, adolescents, adults, and the elderly and manifests as a combination of feelings of sadness, loneliness, irritability, worthlessness, hopelessness, agitation, and guilt, accompanied by an array of physical symptoms. "Recognizing depression in patients in a primary care setting may be particularly challenging because patients, especially men, rarely spontaneously describe emotional difficulties," the guidelines say.

When mental health problems are not addressed, patients tend to overuse medical services and become an increased burden on their physician's time and resources, experts say. "A significant amount of the suffering and problems of patients in primary care cannot be explained based on findings of organic, medical, or physical disease," says David Sobel, MD, director of patient education and health promotion for Kaiser Permanente's Northern California region in Sacramento. "Up to 20% have diagnosable psychiatric disorders, and about 80% of patients are suffering significant levels of psychosocial distress, which often expresses itself through physical or bodily symptoms."

Studies show depression treatment

in primary care can be effective. In an article in *JAMA* (Dec. 11), "Collaborative Care Management of Late-Life Depression in the Primary Care Setting," researchers said that when older adults receive effective treatment for depression in primary care settings their depressive symptoms are reduced.

Also, a review of claims records of patients of 457 family physicians and internists at a large HMO in Rochester, N.Y., showed that patients of primary care physicians who diagnosed the largest number of mental health disorders among their patients had 9% lower overall health care expenditures and inpatient expenditures were 20% lower for these patients, compared with patients of PCPs who diagnosed the smallest number of such disorders.

## Recognizing a Need

"PCPs who diagnose more mental health disorders in their patients may recognize when unexplained medical symptoms are the result of emotional distress or a mental health problem," says Thomas L. Campbell, MD, author of an article on the Rochester findings in the April 2000 *Journal of Family Practice*. They also may be less likely to order unnecessary diagnostic tests, refer patients to specialists, or admit patients to the hospital, researchers say in the article, "Do Physicians Who Diagnose More Mental Health Disorders Generate Lower Health Care Costs?"

About 15% of all primary care patients have anxiety or depressive

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**When mental health problems are not addressed, patients tend to overuse medical services and become an increased burden on their physician's time and resources, experts say.**

## Report Calls for Screening

**P**rimarily care clinicians should screen adult patients for depression, according to a report by the Preventive Services Task Force of the federal Agency for Healthcare Research and Quality in Rockville, Md. Formal screening makes it easier to identify depression, a common and treatable condition that patients and their doctors often fail to recognize, the AHRQ report says.

“Clinicians should have systems in place to assure accurate diagnosis, effective treatment, and follow-up if patients are to benefit from screening,” says the report, *Screening for Depression in Adults: A Summary of the Evidence for the U.S. Preventive Services Task Force*. The report was published in the May 21 *Annals of Internal Medicine*.

The task force found that 5% to 9% of adult patients in primary care suffer from depression and that as many as 50% of cases go undetected. “Although there are many tools available to screen for depression, there is little evidence to recommend one over another,” the report says. “Clinicians can choose tools that are appropriate for their patients and practice setting.”

Physicians seeking an initial assessment system that may be as effective as using more sophisticated screening instruments to identify mental health problems in patients can ask two simple questions, says Alfred Berg, MD, chairman of the task force and chairman of the Department of Family Medicine at the University of Washington in Seattle. Physicians can ask patients: “Over the past two weeks, have you ever felt down, depressed, or hopeless?” and “Have you felt little interest or pleasure in doing things?” An affirmative response to these questions may indicate the need for more in-depth diagnostic tools, Berg says. —MS

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disorders, says Arne Beck, PhD, research and development director at Kaiser Permanente Colorado, an HMO that developed an extensive integrated behavioral medicine program in the mid-1990s. Kaiser researchers found that undiagnosed and untreated patients with mental health problems, such as depression, present a significant challenge to PCPs because about 60% of patients with common psychiatric disorders seek primary rather than mental health care, Beck says.

Depression has been shown to be the second most common diagnosis in primary care, according to Helen Burstin, MD, director of the Center for Primary Care Research of the federal Agency for Healthcare Research and Quality, in Rockville, Md., and

Junius Gonzales, MD, chief of the Services Research and Clinical Epidemiology Branch of the Division of Services and Intervention Research at the National Institute of Mental Health in Bethesda, Md.

Burstin and Gonzales have found several key reasons that depression goes undiagnosed in primary care: lack of knowledge or training on the part of physicians and other providers, inadequate compensation for PCPs who treat patients with depression, lack of patient recognition that they have depression, and the high costs associated with visits and medication.

“Some studies report that as many as 50% of patients who need care for depression are not getting diagnosed

or are not being compliant with recommended treatments,” says Burstin.

Burstin and Gonzales recommend that psychiatrists train PCPs to be more aware of how patients with depression present.

### Integrated Care

Assessment, diagnosis, and treatment of mental disorders and diseases in medical settings are known as integrated behavioral medicine, a branch of medicine defined in 1977 at a conference at Yale University, according to Richard C. Kennerly, a behavioral psychology instructor at the University of North Texas in Denton, who has studied the history of behavioral medicine.

More than 25 years later, few physicians use integrated behavioral medicine to improve the quality of care they provide, even though such integration can be professionally rewarding, says Alexander Blount, EdD, director of behavioral science in the Department of Family Medicine and Community Health of the University of Massachusetts in Worcester. When PCPs screened for depression among patients during regularly scheduled visits, 20% scored positive for depression, and 81% of those patients were not currently in treatment, according to the National Mental Illness Screening Project, a nonprofit organization in Wellesley Hills, Mass.

### High Scores, High Costs

“For physicians, the most compelling reasons to integrate care are that doing so improves their working lives and makes their patients happier with the care they receive,” says Blount.

Many PCPs generally do not use mental health case-finding tools and instruments in these settings, Beck says. “Many physicians are concerned about the time required to administer and score the instruments, the potential for disrupting office routines, the paperwork they

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levels of coverage as a condition for licensure.

### **Insurance Required**

An overwhelming majority of doctors carry liability insurance for pro-

visioned by Floridians for Quality Affordable Healthcare. Three county medical societies and a regional hospital association support FQAH. Most of those surveyed had been sued at least once. Among respondents,

Sharing Project.

More upsetting than financial expenses are the time required and the emotional burden created by these actions. "Even if a medical malpractice insurer is involved, lawsuits take a lot

## **Some physicians are altering practice patterns by eliminating risky procedures (such as vaginal birth after caesarean section), obstetrics, emergency room call, nursing home consultations, and reading mammograms.**

tection of their assets and because coverage is required to participate in health plans or to obtain hospital privileges. Out of fear of losing significant portions of their physicians, hospitals and health plans are easing policies to allow physicians to go without insurance. "Increasingly, hospitals have no alternative but to allow physicians to use their facilities regardless of their insurance status," says Curtis Rooney, JD, senior associate director and counsel of the American Hospital Association, in Washington, D.C. "Otherwise, hospitals would not be able to provide adequate services."

Numbers of bare doctors are difficult to track because there is no central repository for reporting data. Florida doctors are required to record their insurance status every two years when they renew their licenses. By last fall, the Florida Board of Medicine listed only 5% of the state's 48,000 physicians as bare, considered grossly underreported because of the lag in reporting time.

A clearer picture arises from a November survey of 1,600 practicing physicians in three Florida counties that have the most expensive rates, near the cities of Miami, Fort Lauderdale, and West Palm Beach. Among respondents, 5% went bare in 2001, 16% in 2002, and 52% were considering going bare this year, according to the survey commis-

100% of the neurology and vascular surgeons had been sued, 94% of the general surgeons, and 89% of the radiologists. The only physicians who reported that they had not been sued were allergists.

Self-insuring is a risky game of livelihood roulette that is not for the faint of heart. Doctors must find experts and pay legal fees, settlements, and judgments out of their personal bank accounts. In some states, bare doctors who can't afford to pay at least part of a judgment can lose their licenses. At the same time, an underlying benefit of having no insurance means doctors don't have to succumb to insurance company clauses that force them to settle claims quickly regardless of guilt or innocence.

### **Defense Costs**

"Even though 70% of all medical malpractice actions brought against physicians result in no indemnity payment to the plaintiff or his or her attorney, they are, nonetheless, costly to defend," Lawrence Smarr said last year when testifying before the U.S. House of Representatives. Smarr is president of the Physician Insurers Association of America, in Rockville, Md. The average legal cost to defend a meritless claim last year was \$23,000. For doctors who went through trial and got a favorable verdict, the cost averaged \$86,000, according to the PIAA's Data

of time from doctors and they take a toll emotionally," says Christopher Nuland, JD, an attorney in Jacksonville, Fla., who represents nine Florida specialty societies. "It affects the way physicians live, the way they practice, and their faith in their profession. It's incredibly demoralizing."

Going bare has spawned a cottage industry of financial planners who specialize in directing physicians in how they can legally hide assets by shifting bank funds to offshore trusts or putting money under the names of family members. And, self-insured physicians sometimes declare bankruptcy, which can help them to avoid paying judgments.

Many attorneys on both sides of the issue believe bare physicians who protect their assets may be litigation-proof and less prone to being sued. Going without insurance discourages lawsuits by lowering the physician's financial profile, says Howard Rosen, JD, CPA, a law professor at the University of Miami. "If an attorney knows a doctor has a great asset-protection plan, he realizes he won't get paid and won't assume the risk and costs of litigating the case," he explains.

To prevent lawsuits from ever getting to the filing stage, insured and bare doctors are taking measures to reduce their exposure. One step involves referring patients who might be litigious or may have had a bad outcome to doctors associated with

public hospitals where the ability to collect on a lawsuit might be limited under law. Physicians are advised to check their state laws for the extent of protection under these laws.

Patients who are obese, suicidal, asthmatic, diabetic, or insured through Medicaid, and women who have premature babies are among those being banished from some practices. Moreover, physicians are altering practice patterns by eliminating risky procedures (such as vaginal birth after caesarean section), obstetrics, emergency room call, nursing home consultations, and reading mammograms.

### **Being Selective**

"Now we're more selective about patients and procedures," says Eisermann, the Miami fertility specialist. "We are much more aggressive in using screening techniques for genetic illness, doing more genetic testing than may be required."

The result of such increased caution is that patients in several states (including Mississippi, Nevada, Pennsylvania, and West Virginia) are having trouble finding physicians to provide care. In these states, trauma centers, rural health clinics, and maternity wards have closed, and physicians in obstetrics and neurology, among other specialties, are moving elsewhere or not taking new patients.

"If your child falls off the bleachers in a football game and sustains a head injury in Charleston, you have to transport that child to Pittsburgh, which is 50 miles away, or to Morgantown, W. Va., which is 75 miles away," explains Evan Jenkins, executive director of the West Virginia State Medical Association.

The issue involving access to care will not abate as long as incentives to reduce care persist. As just one example, several insurers offer discounts to obstetricians in Las Vegas who limit the number of babies they deliver annually to 125, half the usual num-

ber. Other insurers reduce premiums for radiologists if they do not read mammograms.

Some physicians who are unable to afford malpractice insurance or are reluctant to go bare and fear a malpractice suit are simply closing their practices. In 2000, *Baltimore* magazine named Gina Sager, MD, 42, one of the top breast surgeons in the region. Yet, even with the \$25,000 deductible her insurer required, her premiums were unaffordable. She could not go bare since Baltimore hospitals require physicians to carry medical malpractice insurance. Johns Hopkins, for instance, requires obstetricians and neurosurgeons to have malpractice insurance policies with a limit of \$3 million per occurrence and \$5 million per year; physicians in other specialties are required to have policy limits of \$1 million and \$3 million.

Last May, after four lawsuits she attributes to bad outcomes not medical mistakes, Sager closed her practice. "I realized I didn't have to do anything wrong to be sued again," she says.

Doctors who do not want to go bare are dealing with a huge increase in rates by working harder, spending less time with each patient, reducing overhead, cutting staff, forgoing office renovations, and putting off capital improvement purchases. When possible, they are reducing premiums by cutting coverage to as low as \$250,000 per occurrence and \$750,000 per year. Though low rates may seem appealing, such limits may leave a physician underinsured. The median jury award in medical malpractice claims was \$1 million in 2000, according to Jury Verdict Research, in Horsham, Pa.

### **Target Practice**

Conversely, some physicians fear large policy limits make them a target for aggressive litigators. "Do high coverage limits encourage lawsuits? It's 50-50," says Cliff Rapp, vice pres-

ident, risk management, FPIC, Jacksonville, Fla., one of that state's largest physician insurers.

Those physicians who simply cannot find affordable insurance and who are not close to retirement may have few options but to go bare. But critics say it's irresponsible for physicians to go without insurance. "Imagine if all automobile owners were allowed to drive without insurance," says Jonathan Schochor, a Baltimore plaintiff attorney who is past president of the Maryland Trial Lawyers Association.

Attorneys fear that if significant numbers of asset-protected doctors go bare, plaintiffs would be unable to collect judgments and lawyers working on a contingency-fee basis will go unpaid. "Lawyers may have killed the golden goose," Florida attorney Nuland says. "Why do you think so many trial attorneys are trying to get doctors to form self-insurance trusts? It's the only guaranteed way to obtain funds from a judgment."

Patient advocacy groups, such as Public Citizen in Washington, D.C., have aligned themselves with plaintiffs' attorneys. "There is no medical malpractice insurance crisis," Joan Claybrook, president of Public Citizen, said at a press conference last fall in Fort Lauderdale, Fla. "Rather there is excessive doctor malpractice and an insurance industry profits crisis."

While parties on both sides argue over the issues, some patients may be suffering the worst fallout from the crisis. A patient who is legitimately injured by the medical mistake of a bare doctor who is asset-protected may not be able to have his or her medical expenses reimbursed. "When a truly deserving patient is issued a judgment, it could become increasingly likely the patient will not be able to collect the full amount of the award," Nuland says.

—Reported and written by Maureen Glabman, in Miami. More information on physician practice strategies is available on our Web site (see page 16).

## Physicians have found that instead of asking patients questions about their behavioral health, they can give patients hand-held devices that help quantify and qualify mental illness.

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create, whether they provide specific psychiatric diagnoses, and whether they can detect mental disorders other than depression," he explains.

Proper diagnosis in primary care settings begins with the use of assessment tools that are simple to administer and do not disrupt practice routines. CHI and other companies market assessment tools to screen patients for mental health problems, such as depression and anxiety.

In an effort to control costs, several managed care companies encourage the use of behavioral health assessment tools. A 1999 study by Anthem Blue Cross and Blue Shield in Manchester, N.H., led the HMO to form a committee of primary care and mental health clinicians to develop behavioral medicine guidelines. Today, Anthem encourages PCPs to watch for potential depression risk factors, including prior episodes of depression, family history of depressive disorders, prior suicide attempts, medical comorbidities, lack of social support, stressful life events, and substance abuse.

CHI promotes the use of automated surveys that patients complete by themselves in four to six minutes, says Harris. Patients use hand-held devices developed by Point-of-View Survey Systems in Denver that ask diagnostic-related questions. To assess patients' mental health, CHI uses the Quick PsychoDiagnostics Panel (QPD) and the Brief Symptom Inventory 18 (BSI 18).

"Using these tools, physicians can know up front which patients have specific behavioral disorders," says

Harris. "This information gives them a deeper understanding of their patients and helps them make more precise treatment decisions."

PCPs find that using hand-held devices to administer these tests is a cost-effective use of resources, says Jeff Greiff, MD, a PCP in Plantation, Fla. Greiff began using the CHI product after he received a grant to study depression in cancer patients in 2000. He now uses the device with any patient he believes may be suffering from depression. "We found that instead of sitting around and asking questions for an hour, patients can sit with the device," Greiff says. "They get all the appropriate questions, and then the program quantifies and qualifies their illness."

### Assessing Symptoms

The BSI 18, published by NCS Pearson Inc. in New York, gathers patient-reported data to measure psychological distress and psychiatric disorders. Patients rate the extent to which they are distressed by faintness or dizziness, nervousness or shakiness, feeling lonely, feeling tense or keyed up, and spells of terror or panic. Appropriate for adult patients aged 18 and older, the BSI 18 is written at a sixth-grade level, and most patients can administer the survey themselves on a hand-held device in four minutes.

The QPD Panel, published by Digital Diagnostics Inc., in Aspen, Colo., screens for 10 mental health disorders based on the diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition), including major depression; bulimia nervosa; alcohol or substance abuse; and dys-

thymic, bipolar, generalized anxiety, panic, obsessive-compulsive, and somatization disorders. Patients administer the QPD in six minutes without physician or staff involvement. The questions are written at a fifth-grade level. Both the BSI 18 and QPD Panel are available from the publishers.

The hand-held devices can be placed in a unit that reads the results of the BSI 18 or the QPD Panel and provides an automated report using numeric scores to indicate the severity of symptoms, a specific psychiatric diagnosis, and a list of the symptoms leading to the diagnosis.

Last year, the federal Centers for Medicare & Medicaid Services introduced new procedure codes for the assessment of psychological and social factors related to the prevention, treatment, and management of physical health problems, says Harris. As a result, physicians may be able to secure reimbursement from a variety of insurers for using tools such as the BSI 18 and the QPD Panel to screen patients for behavioral health disorders.

An integrated behavioral medicine service helps mitigate the stigma of mental illness by reframing it in the context of providing good health care. Patients today want one-stop care, and most prefer not to be referred to other practices, especially for behavioral health services, Harris explains.

"Physicians have an important role to play in helping patients with mental health disorders get appropriate treatment," Beck explains. "Using efficient and effective screening tools for patients suspected of disorders can improve the quality of care."

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

# Consumer-Driven Focus, Chronic Care, IT Will Be Key to Success



*Brooks O'Neil is a senior principal at Triple Tree, an investment bank in Minneapolis. He worked for 15 years in the health care practice of U.S. Bancorp*

*Piper Jaffrey, an investment banking firm in Minneapolis. He is the author of the report, A Prescription for Health Care, which Triple Tree published last fall. Editor in chief Richard L. Reece, MD, discussed with O'Neil the four themes he believes will transform health care over the next 10 years.*

**Q:** How do you see health care evolving over the next decade?

**A:** The health care delivery system in this country faces major issues. The largest one is that quality of care needs to be improved dramatically. There are also issues related to the ever-escalating cost of care and access to care for the 40 million Americans without health insurance.

The environment is ripe for change because employers are frustrated with the health care costs they are being asked to bear. At the same time, consumers are increasingly frustrated with the cost of care, the limited access to care, and the quality of care.

We identified four themes that will play a major role in transforming health care over the next 10 years.

The first theme is the concept of consumer-driven health care. We expect a transformation of the insurance landscape from an employer- and a government-driven system to one that is oriented toward the consumer, who will gain control over purchasing decisions and dollars.

The second theme involves customized care centers. We believe there will be a major change in the way providers are organized to deliver acute care. We expect the development of focused units that are customer friendly and deliver care for specific conditions, such as cancer, heart disease, orthopedic ailments, and kidney failure.

The third theme is chronic care management. This concept has been talked about for a long time, but given the aging of the population and the rising cost of care, consumers, employers, and insurers will all become willing and able to buy services to treat chronically ill patients much more effectively.

Fourth, the glue that holds the first three themes together is information technology. Health care spending for IT will be increasingly oriented toward outsourcing. Rather than buying computers and software and hiring people to run these systems, health care constituencies will hire firms to handle an entire IT function in specific areas, such as billing, transcription, and medical records.

These forces will begin to manifest themselves in the market independently. Employers, for example, are considering the concept of consumer-driven health insurance programs. We think the big explosion in enrollment in such plans will occur next year, but we will begin to see a clear movement in that direction this year. As that theme begins to take hold in the marketplace, it will begin to drive changes on the provider side, such as the development of customized care centers and chronic care management programs. It will also force providers, insurers, consumers, and employers to reconsider the way they manage health care information and to invest in IT systems that will make them more efficient and effective.

**Q:** Do you think there's enough critical mass and investment among consumer-driven health plans to make this a reality?

**A:** The common perception in the marketplace today is that there is not. A fair case can be made that there are not enough alternative plans available. There is not enough capital or management, and there has not been enough time devoted to experimenting with various alternative consumer-driven plans. But because of the overall landscape (meaning 12% to 15% health care inflation this year) the likelihood that consumer-driven health plans

*(Continued on page 14)*

**“We expect a transformation of the insurance landscape from an employer- and a government-driven system to one that is oriented toward the consumer, who will gain control over purchasing decisions and dollars.”**

(Continued from page 13)

will grow over the next couple of years is very high. There will be dramatic pressure on the traditional insurers and on new consumer-driven players to offer meaningful alternatives to employers. Over time, the government programs, Medicare and Medicaid, will offer consumer-driven programs as well.

**Q:** *What adjustments has the Internal Revenue Service made in how we account for health reimbursements that are conducive to consumer-driven plans?*

**A:** The IRS action on this issue is a significant development. There is an historical quirk in the way employers buy health insurance: They are allowed to buy health benefits on a pretax basis. That is the primary reason that health insurance is largely employer-driven today. Last year, the Treasury Department dramatically expanded the potential of health reimbursement accounts (HRAs) by allowing employers to contribute money to those accounts and consumers to spend that money on a pretax basis.

Furthermore, these accounts were made portable and transferable. Historically, flexible spending accounts have been structured as “use it or lose it” accounts, which dramatically limited the amount of money anyone was willing to contribute to them. In its decision last year, the Treasury Department allowed rollovers, so money not spent this year can be retained in the same account to be spent later, and if an employee leaves a company, he or she can keep the account.

These are major provisions that will allow for a dramatic expansion in the amount of money contributed to these accounts and hence their effect

on the marketplace.

We have heard that some major health insurers are at least considering offering a consumer-driven alternative. When some companies make this offering, others will follow. In the next two or three years, we will see a major expansion in the number of consumers that have dollars to spend directly on their health care.

**Q:** *Are these developments helpful to the 40 million Americans who are uninsured?*

**A:** It is very helpful for them. Employers, large or small, will be able to offer an insurance plan to their employees that is much more affordable than the plans currently being offered. The structure that may be most appealing to a large number of people is a plan that offers low-cost catastrophic coverage, along with an HRA that individuals will use to pay for basic care expenses. Employees can contribute a modest amount to these accounts on a pretax basis, allowing them to take advantage of the pretax spending opportunity that the government is providing.

**Q:** *What effect will consumer-driven plans have on physicians?*

**A:** Historically, the health delivery system has been very inwardly focused. In other words, often the prevailing mindset was that the system was there to serve doctors, and doctors were there to serve hospitals, and all of the support and ancillary services were there to support the doctors and the hospital. But the demands of the marketplace will force a shift in focus, so that physicians will need to understand what consumers want rather than focusing on some other constituent.

**Q:** *What do consumers want from their doctors?*

**A:** Consumers want what they want in most other markets. They want access to quality care, convenience, service, affordability, communication, and information.

Delivering what consumers want means physicians and other providers are going to need to focus on having locations and hours that are convenient and staffing that allows more effective and efficient management of patients. Long waiting times will not be tolerated. Consumers will self-monitor the quality of care, and they will hold providers accountable if they're not getting high-quality medicine. Some might argue that consumers are not capable of self-monitoring, but I see evidence all over the health care system that consumers are arming themselves with more information, much of it provided over the Internet, and that allows them to quickly become savvy consumers of health care.

**Q:** *How can physicians succeed in this new environment?*

**A:** Considering transformations that have occurred in other industries over the last 20 or 30 years, most notably in the retail sector, it is likely that the days of a highly independent, small, locally focused physician or provider organization are numbered. Rather, the winning providers will be part of sophisticated organizations that have effective management and that can access capital. In fact, access to capital is going to be one of the most important competitive variables over time.

Over the long term, chain operators that have a sophisticated business model that they can execute in a high-quality, cost-effective fashion will come to dominate health care, just as such operators dominate the

**“The demands of the marketplace will force a shift in focus, so that physicians will need to understand what consumers want rather than focusing on some other constituent.”**

## Many doctors do not realize that paper claims processing is rapidly going to become obsolete, not only at the level of Medicare and Medicaid, but for all health plans too.

retail landscape.

The best examples in the hospital market are HCA, in Nashville, and Tenet Healthcare, in Santa Barbara, Calif. Despite the recent problems Tenet has experienced, the for-profit chain operators continue to prosper in the hospital market. The players that succeed in this market will streamline their functions and not try to provide all services to all people in a community. They will focus on high-quality acute-care services in the most important surgical areas. The core activities of hospitals are the specialty areas that generate the most revenue, and those areas include cardiovascular, cancer, and musculoskeletal care.

Several years ago the concept of a dedicated heart hospital was highly controversial. Today, in Minneapolis, all of the major hospitals in the market (and they are all nonprofit systems) are building dedicated heart centers. The concept of a dedicated heart center has become mainstream. Similarly, we will begin to see more dedicated orthopedic hospitals. Also, diagnostic imaging and surgery centers and cancer and dialysis centers are all areas that are ripe for consolidation and rationalization.

If physicians are going to prosper in this environment, they will need to find ways to participate in the economics and the care management around these core service areas.

**Q:** *The majority of doctors are involved in primary care. Will primary care physicians be left out because they do not provide specialty services?*

**A:** They will not be eliminated in the health care system, but they are, for sure, at the lower end of

the food chain. Hence, the revenue and profit potential for PCPs is going to be modest at best. In the future health care environment, the most important thing for them is to get into an efficient delivery model that can provide superior service on a cost-effective basis. Again, factors such as location and hours of service will be vitally important. Primary care is the area of health that will see the first impact of the consumer-driven initiative because it is the first area where consumers will be paying directly for care.

**Q:** *Is there a critical role for information technology in the survival of PCPs?*

**A:** Absolutely. IT can streamline the business of health care. Physicians can use IT effectively to gather and process data. We will still have a highly fragmented delivery system in which cooperation and coordination among independent physicians and other providers will be the key to service delivery.

One reason I believe in chain operators is that it is much easier to organize and coordinate activity within a single organization. However, regardless of whether physicians are in a chain or are independent providers, one key to success will be managing information effectively.

On the business side, the information relates to activities such as billing, processing, scheduling, and procuring supplies. On the clinical side, patients will demand electronic access to medical records.

**Q:** *Will the Health Insurance Portability and Accountability Act present an opportunity for doctors?*

**A:** Yes. I'm not a believer in the status quo in health care.

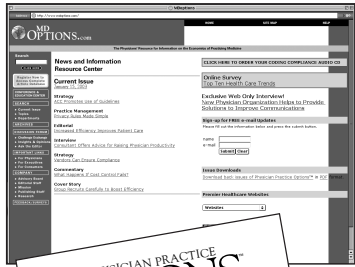
There is a growing realization that the industry is facing significant issues of quality, cost, and access. The doctors who embrace initiatives that have the potential to improve quality, reduce cost, and improve access will be the winners in the long term. The physicians who use IT intelligently, and do so primarily through outsourced providers, will be able to use it to their advantage.

The number one opportunity for doctors is in billing and collections. It is absolutely critical to bill and process accounts receivable electronically. Small independent groups of doctors who are using small billing and collection companies will not be able to compete with the groups using larger, more sophisticated billing companies that use the most advanced information systems to streamline the process.

Many doctors do not realize that paper claims processing is rapidly going to become obsolete, not only at the level of Medicare and Medicaid, but for all health plans too. It's like any other innovation that has occurred in the 20th century. At the outset, an investment is required to take advantage of the innovation, but ultimately a tremendous improvement will result. When people first had an opportunity to buy a car, it was much more expensive than a horse, but ultimately they figured out that they could get from point A to point B a lot more quickly. The IT revolution in health care will have the same impact.

—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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