

# PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

May 15, 2002

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## Physicians Squeezed as Malpractice Rates Rise

**F**or many physicians, medical malpractice rates have risen 6% to 10% for policies in force this year, and some physicians are paying as much as 70% over what they paid last year.

"This is the hardest market I've seen since the 1970s, and the worst of a 25-year cycle," says Lee Miller, marketing manager for The Medical Protective Co., a medical malpractice insurer in Fort Wayne, Ind. Medical Protective, which provides insurance to 6,000 physicians in Ohio, raised its rates about 8.5% last year and 8% in 2000. Another rate increase may be filed later this year, Miller says.

In other areas of the country, physicians are paying much more. In St. Louis, for example, doctors are paying 40% more this year than they paid last year. Officials in Pennsylvania predict increases this year will reach as high as 70%.

### Market Forces

Some medical groups in the Keystone State are forgoing surgery entirely, according to *The Philadelphia Business Journal*. Premier Orthopedic & Sports Medicine Associates of Havertown, Pa., an 18-physician practice, initially received a quote of \$140,000 per physician for medical malpractice insurance coverage for this year, an increase of 233% over last year's rate of \$60,000 per physician. At the time, group members feared they would need to stop doing surgery. Instead, they negotiated an increase of 40%

over last year's rates. Four surgeons did leave the group, however, for other states and lower insurance rates, group officials say.

Several factors affect insurance rates, and this year a combination of market forces are working against physicians. Insurance rates typically move in cycles that rise and fall. In effect, the factors that helped to keep malpractice insurance rates low in the past are no longer present and the opposite factors have taken hold, forcing rates to rise.

The simple reason rates are rising, says Jim Berry, president and CEO of Seibert-Keck Insurance Agency in Akron, Ohio, is insurers' premium income is insufficient to cover the losses and loss adjustment expenses that physicians are incurring. The losses are high for many reasons, and chief among them are court awards against physicians and the costs to defend them in malpractice cases, Berry says. Whenever a physician is sued, regardless of the merits of the case, an insurer must pay for lawyers' fees and court costs.

"I don't believe that doctors realize that loss-adjustment costs, which are the fees to provide legal assistance, have been as much as or more than what insurers pay out in indemnity payments," Berry explains. Only 2% to 3% of suits filed against physicians go to trial, he says, but every suit requires an insurer to assign an attorney to the case and pay for certain expenses, such as expert witnesses

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**Will Cost or Choice Prevail When Selecting HMOs?**

The movie, *John Q*, was rated among the top box office hits soon after it opened this winter. In the film, a black father played by Denzel Washington holds hostages in a hospital because his dying son needs a heart transplant. The HMO, the hospital, and the surgeons deny the transplant because of the father's inability to pay for the surgery. Critics have said the movie provides a one-sided, villainous, over-dramatized portrayal of health care, but it appears to have struck a chord with the public.

The real issue behind the movie, of course, is the high cost of health care and the fact that more than 40 million Americans have no health insurance, leaving them with little or no choice when they need care. Recognizing the issue, the American Association of Health Plans, a trade group in Washington, D.C., says this about *John Q*: "It's not just a movie. It's a crisis for 40 million people who can't afford health care."

Brian Klepper, executive director of the Center for Health Care Reform in Jacksonville, Fla., and a perceptive health system critic, says the movie is effective at exploiting anti-HMO sentiment.

But more important is the movement of HMO members themselves. Perhaps in reaction to a low public opinion of HMOs, and almost certainly in response to negative word-of-mouth stories by friends, relatives, and other workers, some HMO members are choosing other forms of health systems when selecting care plans. In California, HMO enrollment has dropped from 55% of all workers in 2000 to 48% last year, according to *The Los Angeles Times*. The decline, the *Times* reports, reflects growing demand for more choice, fewer restrictions, and more access to specialists. Instead, consumers are choosing PPOs (in which enrollment rose from 25% of all workers in 2000 to 27% last year) and point-of-service plans (in which enrollment rose from 19% to 25%).

Walter A. Zelman, president and CEO of the California Association of Health Plans, in Sacramento, explains these shifts by saying, "Sometimes the public wants to have its cake and eat it too. Our concern is that we not wipe out the low-cost options because for too many people those are the only option."

The question now for health plan executives and for workers choosing health plans is this: As employers shift more premium costs to employees, will workers continue to select more expensive plans? Or, will they shift back to low-cost HMOs? In other words, will cost or choice prevail?



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This newsletter is published by Premier Healthcare Resource, Inc., Parsippany, NJ.

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# Ten Steps Groups Can Take to Improve Financial Performance

By Joel Weinberg

**S**ome 43.2 million HMO members are enrolled in capitated health plans, according to figures from InterStudy, an HMO data collection organization in Minneapolis. Given this number, it is a fact of life for most physician organizations that they must be involved in managed care contracts in order to be economically viable.

Since almost all medical groups today participate in managed care plans, the operations and finances of most physician organizations are therefore influenced by rising costs, labor shortages, questions about the quality of care and access to care, and compliance with new regulations.

## Risk Management

Yet it is the task of managing the risk inherent in managed care contracts that is the biggest challenge for most physician organizations. An inability to manage this risk has been blamed for much of the financial instability that has led to the demise of more than 150 medical groups over the last five years, according to an article, "Downstream Without a Paddle:

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State Legislatures That Tackle Medical Group Insolvencies Have Come Up With Strategies That Sometimes Shift Accountability to HMOs," in *Managed Care*, December 2000. Despite many notable failures, however, some physician groups have done well in predominantly managed care environments. The reasons some physician organizations fail while oth-

## Technology and Automation

One characteristic that almost all provider organizations have in common is that they are undercapitalized. Therefore, building or purchasing the appropriate information technology systems represents an expense that they often find they can ill afford. Consequently, many physician groups have problems obtaining

**The reasons some physician organizations fail while others in the same or similar markets are successful can provide a blueprint for physicians seeking to navigate the potentially treacherous waters of managed care.**

ers in the same or similar markets are successful can provide a blueprint for physicians seeking to navigate these potentially treacherous waters.

Those who have had the advantage of working with dozens of provider organizations, hospitals, and health plans to manage the administrative components of managed care contracts efficiently have learned that there are specific best practices that groups that are successful in this area deploy. These best practices involve two aspects of operations. One practice is the appropriate use of technology and automation to streamline the primarily manual process of care delivery and administration. The other is management practices that provide appropriate incentives to physicians. It is instructive, therefore, to identify and examine these best practices and review why they are so effective.

timely, accurate, and meaningful data to monitor the organization's financial health and to make good management decisions.

Another expensive but necessary investment is the automation needed to manage efficiently the many transactions involved in the practice of medicine, particularly tracking and serving managed care populations. Unfortunately, health care is still conducted primarily through paper transactions. The labor costs and inefficiencies that result from attempting to manage a practice without automation or electronic transactions are extremely high, both in direct expenses and potential lost revenue.

If the group cannot verify the eligibility of a patient in real-time, for example, the services that patient receives can essentially be uncompensated. If a provider is unaware that it is referring patients out of the

(Continued on page 4)

**Information systems allow provider groups to identify financial weaknesses and utilization patterns that may affect the bottom line, meaning a physician organization can monitor the adequacy of capitation rates, for example, by comparing the claims payments it would have received under fee-for-service with the actual monthly capitation payment.**

(Continued from page 3)

network, the group could be paying significant expenses on specialty and ancillary services.

To resolve this dilemma, provider organizations should be sure that they address the following points.

1. *Find and implement the right technology from the right vendor.* The right system can improve a group's financial outlook through streamlined operations, efficient workflow, and sound business decisions. The technology vendor that is selected should possess two important characteristics. First, it should have a proven track record and expertise in managed care business processes. Second, it must have the ability to build a technology infrastructure that seamlessly integrates mission-critical administrative and management functions.

2. *Take advantage of cost-effective ASP technology.* An application service provider (ASP) allows customers to access software over the Internet, and avoid the expense of buying, licensing, and installing costly programs in-house. A medical group would pay a fee based on the number of patients it serves and thereby avoid the fixed costs of internal installation and regular maintenance.

With an ASP, systems are updated immediately when upgrades become available. In this way, a physician organization can avoid not only significant implementation expenses, but also the costs of hiring and paying internal information technology personnel to maintain the system. ASPs afford a group a considerable cost advantage over other physician organizations that do not have such capa-

bilities. In particular, ASPs allow small and medium-sized organizations to have access to the same state-of-the-art systems and efficiencies as their larger counterparts.

3. *Get online.* The ability to access vital real-time information online will reduce the administrative burden in physicians' offices. Over the Internet, staff and physicians can submit claims, access updated lists of physicians and specialists in the network, and verify patient eligibility.

It is only a matter of time before

which they will achieve desirable economies of scale.

Since low capitation rates have been blamed for the financial woes of many groups, it is critical for physicians to understand the relationships between the cost of delivering health care and the rates being offered. Physicians also need to be able to predict demand that will enable them to determine if a contract is financially viable. After the contract is signed, expenses and income must be tracked on an on-going basis.

**Automated claims processing and timely reports give management information to identify problems before they reach a crisis.**

virtually all physicians will be comfortable using the Internet. In just three years, the number of physicians using the Web more than tripled, from 20% in 1997 to 70% in 2000, according to a study by the AMA, the *2001 AMA Study on Physicians' Use of the World Wide Web*. The cost efficiencies of making such information available online in physicians' offices more than outweigh the cost of training staff and doctors in new systems.

4. *Use upgraded data systems to create meaningful reports and analytical tools.* Sophisticated reporting and analytical tools can transform raw data into the business intelligence that organizations need to make sound business decisions. For instance, organizations can use data analysis to understand the level of contracting and capitation rates at

The best data systems also allow provider groups to identify financial weaknesses and utilization patterns that may affect the bottom line. A physician organization should be able to monitor the adequacy of capitation rates, for example, by comparing the claims payments it would have received under a fee-for-service arrangement with the actual monthly capitation check it receives under the contract. Given that utilization can vary from month to month, a sophisticated reporting system should allow this comparison for different periods, including quarterly, semi-annually, and annually.

5. *Outsource noncore functions.* The expertise of provider organizations is in delivering health care. Rarely do these organizations have core competencies in technology, administra-

tion, or management. As a result, outsourcing these functions may make more sense than creating the infrastructure internally and funding the human capital and systems to handle these areas in-house. Outsourcing allows medical groups to leverage another organization's expertise and spread their costs in these areas across a broader customer base. As a result, they can receive more services for less money.

6. *Use automation to reduce administrative overhead.* Research shows that physician organizations providing care under capitated contracts tend to have higher overhead costs than groups with little or no capitation. In order to manage efficiently all of the administrative tasks that are delegated to the group under managed care contracts, the organization must employ technology to automate paper-based and manual processes. Instead of submitting a paper referral form and waiting two days for authorization, an Internet-based software system can approve referrals that meet criteria the group establishes quickly and efficiently.

Such systems can automate the authorization of as much as 90% of all claims, saving significant costs, and staff time. This type of automation also will improve patient satisfaction and reduce frustration with the notorious hassle factor of managed care.

7. *Use information technology and analytical reports to develop an early warning system.* Many medical groups do not realize that they are in trouble until it is too late to save the organization. If physician organizations do not have early warning systems in place to detect potential risks, they will not be able to take the necessary corrective actions promptly. With automated claims processing and timely reports, management will have the information and the tools to spot and remedy problems before they reach a crisis.

8. *Safeguard the group against losses.* Web-enabled technology can prevent

the drain on resources that occurs when administrative tasks are not handled quickly or correctly. Real-time eligibility verification, for example, provides immediate notification to a practice from a health plan when a patient has left an employer and is no longer eligible for benefits.

Also, physicians can go online to see

within certain financial parameters. The group cannot remain financially viable unless individual physicians are motivated and empowered to control costs and utilization and to achieve quality outcomes and high levels of patient satisfaction. For these reasons, appropriately structured incentive programs provide physicians with a

**A group cannot remain financially viable unless physicians control costs and utilization and achieve quality outcomes and high levels of patient satisfaction.**

what benefits are covered in limited-benefit plans. The right information systems also can eliminate duplicative claims and speed claims processing, another source of lost or delayed revenue. If a provider organization has a risk pool of \$2 million a month and loses 1% to 2% of its revenue providing services to ineligible members, providing benefits not included in the plan, or referring to specialists not in the network, it can lose a great deal of money. In fact, this type of slow leak of resources can mean the difference between a profit and a loss.

**Management Goals**

In addition to lacking the capital to invest in technology, provider groups often find themselves strapped to invest in the level of management experience they need to run their organizations effectively in an increasingly complex environment. Yet experienced management, like technology, is essential to succeed in managed care. Groups that are thriving in today's marketplace have management that has addressed and answered such objectives as those discussed below.

9. *Provide incentives for physicians.* Risk-based contracts change the way providers are paid, but also extend their roles and responsibilities in delivering care and managing care

financial stake in improving care, quality, and outcomes.

10. *Get support from physicians.* At the onset, providers should be included in the development of all medical management plans so that physician administrators can create a sense of ownership among all members of the group. This early buy-in also identifies and cultivates physician leaders who can then advise other physicians and providers on how to make behavioral and practice changes to help the group succeed. Peer support and communication are powerful tools to reinforce cooperation in achieving the group's overall managed care objectives.

In conclusion, finding and implementing up-to-date and Web-enabled technology specifically designed for managed care processes are critical to the success of provider groups today. Distribution mechanisms such as ASPs can make this technology available to large and small groups alike without requiring the investment of licensing, installing, and upgrading software. Early warning systems, experienced management, a buy-in from all providers in the medical management approach, and appropriate incentives for physicians are also key to success and survival in a turbulent environment. ■

# Making a Business Case for Quality

**W**hen managed care began toppling the traditional practice of medicine more than 20 years ago, physicians who thought the Hippocratic Oath was the bedrock of their medical education and career were suddenly encouraged to focus on patient care in terms of costs, risk, and the bottom line. As physicians nationwide struggled to adapt to the demands of the new health care system, many thought that earning an MBA was the way to keep some semblance of control over their practices, their patients, and their lives.

Today, as the current system of managed care seeks new bearings (or is itself toppled, as some would argue) in the face of escalating costs, demanding consumers, and potentially more regulatory oversight, there's a growing segment of the industry calling for physicians and other health care providers to deliver quality—not simply cost-efficient—care. These quality advocates argue that providing quality care is both good medicine and good business. But for physicians to persuade health care consumers and purchasers that they deliver quality care, they need the tools to collect and measure the data to prove their claims.

David Shulkin, MD, is among those who argue that quality care needs to be a pivotal focus in the nation's health care system. Shulkin is founder and CEO of DoctorQuality, a Web site (at [www.doctorquality.com](http://www.doctorquality.com)) that provides services to help users select, improve, and monitor quality of care.

Prior to founding DoctorQuality in November 1999, Shulkin, who is a board-certified internist, was chief medical officer of the University of Pennsylvania Health System in Philadelphia.

## Aligning Incentives

"Patients, physicians, and managed care companies are frustrated by the health care system," Shulkin says. "Their discontent stems from the fact that there is no economic alignment with clinical quality. Health care is the only market that we know of where, for example, consumers don't know in advance what they are purchasing in terms of the quality of the product. The incentives are not aligned in today's health care environment to foster the practice of high-quality medicine, or to foster the widespread adoption of best practices. The universal recognition of quality and the reward of high-quality practitioners are simply not happening in today's health care environment."

Shulkin argues that quality will be advanced in health care only when there is a business case to measure quality, and it is the purchasers, he says, who are in the logical position to set this course because they can offer a financial reward for quality. "In the ideal health care system," Shulkin explains, "the providers must be financially rewarded depending on their compliance with evidence-based best practices and their ability to deliver high-quality care."

If the current health system evolves into the ideal system that

Shulkin envisions, it behooves physicians to adapt their practice patterns so that they can be financially rewarded for the reason they became doctors in the first place: practicing good medicine. "All constituencies should focus on doing what has been clinically proven to be the best thing for the patient," Shulkin says. "And the economics should reward that type of behavior. Once we have economic alignment—measurable quality, the best practices that accompany it and produce it, and the economic reward for achieving quality—doctors, hospitals, purchasers, and patients will make the proper decisions regarding health care."

## Filling a Void

The goal of DoctorQuality is to address the frustrations of health care providers nationwide with regard to quality, Shulkin says. "DoctorQuality fills a void," he contends. "To date, managed care has not had a major impact on quality differentiation, nor has organized medicine. The whole system is moving too slowly toward improved quality of care. In fact, there have even been some backward steps in the commitment to quality as providers have come under greater economic pressure. They feel that they are unable to put additional resources into care, even if that care would be of higher quality.

"At DoctorQuality," Shulkin continues, "when we talk about a business case for quality, we're not talking about feel-good relationships, or altruism, or independent profession-

**"The universal recognition of quality and the reward of high-quality practitioners are simply not happening in today's health care environment."**

**—David Shulkin, MD, DoctorQuality**

alism. What we promote is real economic alignment—financial incentives for quality practices.”

But in order to measure quality, it first has to be defined. Shulkin’s definition of quality is simple: compliance with best practices. “From a clinical perspective, the reason I use compliance with best practices as our guiding definition is it’s measurable; it doesn’t take much time to determine whether or not it exists; and it is the single most important milestone toward improving patient care,” Shulkin explains.

There is, however, another aspect to quality that’s not clinically quantifiable, Shulkin concedes, an aspect in which quality is defined by consumers. “Every patient should have a chance to define exactly what is important to him or her,” he says. “In the patient’s world, quality may be convenience, quick access to care, and satisfaction with service levels. For patients, these aspects are more important than strictly clinical quality.”

### **Creating a Market**

The first step in affecting the quality of care is to create a market for quality, Shulkin says. Creating this market involves giving purchasers information they can use to discriminate among providers on the basis of quality, he explains.

“Most of the principals in our company are doctors, and we believe that physicians and hospitals should be the constituencies that determine quality,” Shulkin says. “We promote the identification and reward of providers who offer high-quality care because without the right economic alignment, a focus on quality will not occur.” Even so, Shulkin admits that getting providers to commit to quality is difficult because increasing economic pressure forces them to focus on survival instead.

To help users determine quality of care among providers, DoctorQuality offers a Quality Rating section that

allows them access to quality ratings, as well as to rate the quality of their own physicians and hospitals. “This function facilitates informed selection of doctors and hospitals,” Shulkin contends. “We have 630,000 doctors in our database, and more than 5,000 hospitals. Our quality ratings are enhanced through the continued incorporation of numerous data resources, including state and administrative databases, consumer satisfaction surveys of doctors and hospitals, and clinical quality data provided by health care providers.”

DoctorQuality also provides an online resource called My Quality

Practices ensures that patients know whether they are getting proper treatment and enables them to become more active participants in their care.”

### **Marketing Quality**

In addition to informing patients, DoctorQuality is seeking to inform corporate America by taking its message to benefits managers. “Those are the folks who want to see and use quality standards,” says Shulkin.

“Right now, purchasing health care benefits is based solely on fee schedules,” Shulkin explains. “It is a cost-only game. Instead, we believe that benefits should be purchased on the

**“In the patient’s world, quality may be convenience, quick access to care, and satisfaction with service levels,” Shulkin says. “For patients, these aspects are more important than strictly clinical quality.”**

Coach, which helps patients navigate through the entire health care system. “My Quality Coach supports users in understanding and managing their care, including selecting a provider, where to obtain quality care, and personalized health information so that they can obtain best-practice-based care,” Shulkin explains.

Another DoctorQuality patient-oriented tool is called Quality Practices, which are workbooks focusing on clinical best practices for more than 50 common ambulatory and hospital-based conditions. “This type of service is needed because, although there have been tremendous advances in medicine, quality practices are still spotty,” Shulkin explains. “For example, 40% of patients who have been told they suffer from asthma have been misdiagnosed and only 33% of post-heart attack victims who would benefit from beta-blocker therapy are treated with this medication. Quality

basis of value, a combination of cost and quality. Defining value so that purchasers can use this measure in health care purchasing decisions is the purpose of our company. We have a team of people who contact professionals in corporations who are interested in ensuring quality medical care for their employees.

“The focus on quality is crystallizing, and consumers and employers are becoming more interested,” he continues. “And with the Internet, we can measure quality better than we did in the past.”

There is a consensus among physicians that the current system is not working, Shulkin says. “Physicians are looking for alternatives, and many are anxious to get out of clinical practice,” he says. “We are trying to address this dissatisfaction.”

—*Edited by Paula Grant, in Lincoln, Va. More information on physician practice strategies is available on our Web site (see page 16).*

# New Technologies Ease Burdens

**P**hysicians have myriad new technologies to enhance the quality of care they provide and the efficiency with which they work. Some of the best technologies are developed by physicians.

Many physicians believe that for technology to fit easily into the care delivery process and to be adopted by physicians, a device or system has to be created by—or with significant contributions from—other physicians who understand the nature of medical practice. These are often the technologies that best address the needs of physicians in practice.

In particular, physician-developed technologies that help doctors increase the efficiency and accuracy of documentation offer a simple, practical approach to burdensome tasks.

## Seeking a Good Fit

“Basically, physicians are willing to adopt new technology solutions if these solutions do not complicate their work processes on a day-to-day basis,” says Mark Lucas, founder of ProVox Technologies Corp. in Roanoke, Va., creator of TalkNotes software. “In other words, they want software that will fit into their practices’ existing platforms or existing systems, and that will mirror their daily routines.”

“Federal regulations mandating computerization of health care processes have been one factor prompting the expanded use of medical records software,” says Angel M. Garcia, MD. “Second, physicians have realized that a lot of time and

money are wasted in manual processes. Because the cost of health care keeps rising and reimbursement keeps falling, the only way to make the practice of medicine more efficient and put more dollars in our pockets is to eliminate waste.” Garcia is founder and chief executive officer of Data Med Forms and Software, in Deerfield Beach, Fla. Data Med Forms has developed a documentation program called Dr. Notes.

Lucas believes that voice recognition will be a central element of future clinical information systems. “Microsoft Windows has been successful because it mirrors what workers already do in their offices by replicating the desk top,” he says. “Voice recognition is doing something very similar. Voice recognition is here to stay, and the technology will keep getting better.”

In addition, Lucas believes that access to the Internet using handheld computers will result in the Internet being used much more widely among physicians. “Some physicians feel that the Internet is still very unsecured,” he says. “They express particular concerns with handling medical charts over the Internet. But new technologies will absolutely create a more mainstream physician acceptance of the Internet. However, we are probably still a few years away from a completely secure Internet environment for medical records. The privacy issue cannot be overstated. After all, hackers enter into secure databases on a regular basis. So there is obviously reason to

be concerned about security.”

The Internet can revolutionize medical practice by making it more efficient, Lucas adds. “The key is access to records on a global format,” Lucas says. “Everyone is enthralled with the concept of having centrally located electronic records, so that medical professionals who need to see a record can immediately have access to it. The electronic record is a very attractive concept. All physicians who treat a given patient will have access to the same information, which obviously enhances quality of care. The Internet can play a substantial role in moving the health care industry toward that goal by making the information needed to make critical medical decisions easily and affordably accessible.”

Garcia agrees. “As wireless devices become more powerful and the Internet enables transmission of electronic information, the computerization of clinical processes becomes more attractive,” he says. “Doctors are willing to computerize as long as they can save time and money.”

## Facilitating Dictation

While in the recent past, voice recognition technologies have been somewhat cumbersome and imprecise, the TalkNotes product (at [www.provox.com](http://www.provox.com) or [www.talknotes.com](http://www.talknotes.com)) provides voice recognition and enables physicians to create an electronic patient record that can be used with other office systems.

“TalkNotes is a PC-based software application that allows medical pro-

*(Continued on page 9)*

**“Physicians want software that will fit into their practices’ existing platforms or systems and mirror their daily routines.”**

**—Mark Lucas, ProVox Technologies Corp.**

**“Because the cost of health care keeps rising and reimbursement keeps falling, the only way to make the practice of medicine more efficient and put more dollars in our pockets is to eliminate waste.”**

**—Angel M. Garcia, MD, Data Med Forms**

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professionals to create electronic patient chart notes using state-of-the-art voice recognition technology,” Lucas explains. “We have automated the medical documentation process by allowing physicians to dictate directly into customized forms. By using TalkNotes, physicians gain all the advantages of an electronic medical chart, including the ability to search, track outcomes, and recall sections of previous documents.”

The product provides two basic functions: a dictation and documentation function, and an electronic chart. “Some physicians are interested in the product primarily because they want to simplify and otherwise improve on the turnaround time and efficiency of transcription,” Lucas says. “Others are more interested in creating electronic records. They want a better way to manage paper charts and better access to patient chart information. Of course, a number of our customers want both functions.”

Lucas notes that by building an electronic medical chart, TalkNotes documents an electronic history for each patient, which can be available to any clinician at any time. Through TalkNotes, physicians can search for patient information using key words or other search criteria. TalkNotes can display a patient’s chart as individual documents or as a single, running chart. In addition, templates can be designed to transfer data from previous visits to help complete new documents more quickly.

Because Lucas wanted to make the product user-friendly, he solicited and incorporated physicians’ opinions when designing the program. “I

spent about three years just talking to doctors and understanding how they felt about dictating and how they managed chart records,” he says. “Using the feedback we received from these doctors, we designed a prototype product and started hiring developers. We continued to go back to these physicians frequently to get their input and designed the product completely based on what physicians told us they wanted.”

What physicians wanted was a product that is easy to use, would not slow them down, and would fit into their existing practice environment. “Basically, physicians want software that will fit into their practices’ existing platforms or existing systems and that will mirror their daily routine,” says Lucas. Since the product is designed to work within physicians’ current workflow, users have reported little change in their work practices after adopting TalkNotes, he adds.

### **Documentation by Exception**

Many physicians find that paperwork is the least rewarding part of their job and as paperwork increases, so does their frustration. “After practicing for about five years I realized that my time was maxed out,” Garcia explains. “I was spending 8 to 10 hours a week either handwriting or dictating my patients’ medical records, and 80% to 90% of everything I documented was basically a repetition of the norm. I created Dr. Notes to standardize all of the normal descriptions for conditions in numerous specialties, so that physicians can just type in the notes on the abnormal.” This methodology is called

documentation by exception.

Normal data are already in the Dr. Notes program for all of a patient’s bodily systems. Lists of the most common abnormalities are included as well. “When doctors are documenting a physical exam, they need to look only at the list of abnormalities, and click on the ones that they find,” Garcia says. “They can add additional text to further describe the abnormality if they wish. The software fills in all the normals. The doctor can also omit a certain area if part of the physical was not done.”

Dr. Notes (at [www.drnotes.com](http://www.drnotes.com)) allows a physician to spend less time documenting and more time talking with a patient, which helps the doctor come to a more accurate diagnosis, says Garcia. To ensure compliance with Medicare evaluation and management requirements, the software follows the format from the federal Centers for Medicare and Medicaid Services. The proper code for any given procedure is embedded in the software. Dr. Notes has developed software for multiple specialties, such as family practice, internal medicine, gastroenterology, general surgery, cardiology, allergy and immunology, pulmonary medicine, and neurology.

What’s more, the program offers different views for different staff members. “For example, clicking on the front office view allows the front office staff to gather patient demographics and insurance information,” says Garcia. “The nurse’s view allows the nurse to document the chief complaint and reason for consultation, medication allergies, past medical history, family history, social history, and

*(Continued on page 12)*

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and depositions. All of these costs have risen in recent years.

"Doctors often tell us they haven't had any claims paid on their behalf, which may be the case, but that does not mean that significant amounts of money haven't been spent in their defense," says Berry.

### Settlements Rise

The frequency of claims has leveled off in recent years, but the size of settlements has risen. "In the insurance industry as a whole, we're seeing continued increases in severity," says Miller. "Before, a bad loss might be \$2 million, now it's \$30 million. We are continuing to see larger single-verdict awards."

Many physicians who were not sued in years past now find themselves

the target of plaintiff's attorneys, Berry explains. "This trend is affecting family practice doctors, internists, and non-invasive specialists," he says. "They are either gatekeepers for managed care organizations or the diagnosticians who are supposed to accurately identify medical problems. Misdiagnosis is a huge area of concern."

One specialty targeted for suits is radiology, Berry notes. A radiologist may be named in a suit even if he or she makes no medical mistakes, he says. "Nevertheless, we incur expense in defending them," Berry adds. "Insurers realized that due to the frequency of claims from this group of specialists, they no longer wanted to insure them."

Ron Gillaspie, an agent and insurance broker with Boynton &

Boynton in Fair Haven, N.J., agrees that radiologists are among the physicians insurers have targeted for rate increases or nonrenewals. Other targeted physicians are obstetricians and gynecologists, family practice physicians, and neurosurgeons.

### Competitive Pricing

Competition, as in most businesses, is a significant factor in the medical malpractice insurance business. When insurers want to enter certain markets, prices drop; when they pull out, prices rise. The St. Paul Companies, a multiple-line insurer in St. Paul, Minn., announced in December that it would leave the medical malpractice insurance business. Physicians with policies underwritten by the St. Paul Cos. will need to find a new insurer when it is

## Broker May Help Keep Costs Down

**S**teep rate increases may spur physicians to call several agents and brokers in search of a better price for their medical malpractice insurance. But doing so may not be in their best interest, says Ron Gillaspie, an agent and insurance broker with Boynton & Boynton in Fair Haven, N.J. Rather, physicians should select one broker, who represents several insurers, and let that broker find the best rate, he suggests.

"All brokers are not created equal," Gillaspie explains. "Some get better pricing from insurers than others." Also, some brokers with long-standing relationships with insurers, or those who have a high volume of business with a particular insurer, may get coverage for a physician when another broker might not, he adds. "You need a good broker who has markets, and one with clout," he says.

Each insurer can provide a quote on a physician's medical malpractice insurance through one broker only, and that is usually the first broker who requests the quote, Gillaspie says. If a broker does not do much business with a particular insurer and therefore does not have a strong relationship with it, the physician may get a higher premium rate quote than would be the case with a broker who does a lot of business with the insurer.

Richard Vento, an insurance broker and consultant with Medical Risk Management Services in Jamison,

Pa., agrees. "There is a lot of judgment in medical malpractice pricing by insurers," he says. "They have as much as 60% swing in price at their disposal. Therefore, doctors do not serve themselves best to go to everyone who is out there."

When insurance prices are high, physicians should seek insurance from the best companies, advises Jim Berry, president and CEO of Seibert-Keck Insurance Agency in Akron, Ohio. "All we and any physician can reasonably do right now is to find the best price and service available for a given coverage from insurers that are highly rated for financial strength," he says. An insurer's financial strength is important because a policyholder wants to be sure that the insurer will be in business in the event of a loss. "This is something physicians need to be cautious of right now," Berry adds.

The three largest insurance rating companies are A.M. Best Co. in Oldwick, N.J. (at [www.ambest.com](http://www.ambest.com)), Standard & Poor's in New York (at [www.standardandpoors.com](http://www.standardandpoors.com)), and Weiss Ratings Inc. in Palm Beach Gardens, Fla. (at [www.weissratings.com](http://www.weissratings.com)). Each insurer gets a rating based on its financial strength and ability to pay. Also, state laws specify the minimum amounts that insurers must hold in reserve, and state oversight agencies can be useful in determining how much an insurer has in reserve for paying claims.

—DK

# Tort Reform Not Always the Answer

**M**any physicians are working with their state medical societies to support tort reform legislation that they hope will help keep medical malpractice rates from rising too sharply.

But tort reforms can erode over time when court decisions limit the scope of intended reform or eliminate a reform, says Ed Kupcho, president of Medical Risk Management Services, an insurance broker specializing in hard-to-place risks, in Akron, Ohio. In 1996, the Pennsylvania Supreme Court struck down elements of a 1975 tort reform bill, finding that limiting lawyers' fees was unconstitutional, and it overturned rules requiring that expert witnesses be certified.

In some states, physicians want certain tort reforms, such as provisions that require an expert witness to determine wrongdoing before a case can be filed, that set caps on the amount of money injured patients can

recover for pain and suffering, that require malpractice awards to be paid over time, and that impose limits on plaintiff lawyers' share of awards. Physicians also are working to establish insurance programs that would ensure that any doctor can get coverage, regardless of the state of the medical malpractice market.

In Ohio, the state medical association is seeking limits on noneconomic damages and on rules regarding joint and several liability so that if a physician is found liable, he or she is responsible only for the percentage of damage assigned, regardless of the other defendants' ability to pay, says Doug Evans, director of issues management for the Ohio association. A provision limiting noneconomic damages that passed the Ohio legislature has been struck down by the courts three times, Evan says.

—DK

time to renew, the company said. It also said that its medical malpractice line produced an underwriting loss of about \$940 million last year on premium income of about \$530 million.

In the 1980s, a number of larger insurers entered the medical malpractice market, prompting a price war that lasted until the mid-1990s. "If your intent as a new insurer is to gain market share, you need to discount the other insurers' filings," Berry explains. "There's no sense in charging more than they do. Companies anticipate they can use pricing as a wedge to create market share, with the hope that they can raise rates in the future."

## A Ripple Effect

Problems develop, however, when many companies compete for business and the premium volume is so low that it does not cover the cost of malpractice claims, Berry adds. "This creates an insidious cycle of new companies discounting an already existing rating structure, and driving down the median price of insurance," he says. "In many states, competition drove pricing well below actuarially correct levels." Consequently, insurers lost

money, raised rates, or left the market.

Another problem develops when reinsurance companies struggle. Reinsurers accept a portion of the risk from primary insurers and, like primary companies, are affected by what they pay out and how much

money they make in premium income and investments. After paying \$40 billion as a result of the terrorist attacks on Sept. 11, many reinsurers have become more cautious about the risks they will accept and are more willing to raise rates, experts say. Also, a decline in the stock market reduced the value of reinsurers' investments. The result was that reinsurers raised their rates, forcing primary insurers and insured policyholders to pay more as well.

All of these issues have combined to make it difficult for physicians to find medical malpractice insurance, causing rates to rise sharply. While physicians may be frustrated by medical malpractice rates now, the situation is likely to turn around, Berry

**Insurance rates typically move in cycles that rise and fall. In effect, the factors that helped to keep malpractice insurance rates low in the past are no longer present and the opposite factors have taken hold, forcing rates to rise.**

explains. Rates typically rise and fall for many reasons over five-year cycles, he says. "We're in an uphill situation right now, but it will change," he adds. Given that rates are high now, it is likely that insurers will make a profit in the near future, which will entice more insurers into the market, and rates will decline again.

—Reported and written by David E. Kettlewell, in Akron, Ohio. More information on physician practice strategies is available on our Web site (see page 16).

## Developers See Market for EMR Software

Physicians who are seeking to free themselves from the drudgery of some of the paperwork inherent in today's medical practices will find a number of programs aimed at easing the burden. Software companies have learned that there is a market for software that helps physicians to create electronic medical records (EMRs) and to gather medical information from patients. Some of the companies that offer such programs include the following.

- Primetime Medical Software, a software research and development firm in Columbia, S.C., that markets the Instant Medical History (at [www.medical-history.com](http://www.medical-history.com)). This program developed in part by Allen R. Wenner, MD, a family practitioner in West Columbia, S.C., and is designed to gather the medical history before the patient sees the doctor.
- Datamed Forms & Software Inc., in Deerfield Beach, Fla., markets EMR software called Dr. Notes. The EMR data are gathered by nurses and front-office staff. More information is available at [www.drnotes.com](http://www.drnotes.com).
- 21st Century Eloquence Inc., in West Palm Beach, Fla., markets the Eloquent Physician, EMR software.

Physicians enter data into the system using either voice activation or a keyboard and mouse. More information is available at [www.eloquentphysician.com](http://www.eloquentphysician.com).

- Qmeda Inc., in Arden, N.C., has a patient-based medical information system designed to help physicians and staff gather patient information. The EMR is not patient-generated, and report modules cover specialized areas (such as breast examinations) as well as procedure-specific modules (such as cardiac catheterization). More information is available at [www.qmeda.com](http://www.qmeda.com).
- Physician Micro Systems Inc., in Seattle, offers EMR software called Practice Partner Patient Records. Its EMRs are not based on patient-generated data. PMSI offers other software applications aimed at appointment scheduling and billing. More information is available at [www.pmsi.com](http://www.pmsi.com).
- ProVox Technologies Corp., in Roanoke, Va., provides a speech recognition-based system called TalkNotes that physicians can use to build an EMR by dictating into customized modules. More information is available at [www.provox.com](http://www.provox.com).

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vital signs. The physician can pull up all of that history, and then ask the patient about the condition itself: the onset, the progression, the aggravating factors, the precipitating factors, and everything that Medicare considers the modifying factors of that present illness. Some of these are provided on a list; other information can be entered as free text."

The record is complete by the time the patient leaves the office. "The prescriptions are automatically printed from the doctor's recommendations, and the patient's instructions are also automatically printed," adds Garcia. In addition, the program can create a standard referral letter and attach the medical consultation report.

The printed patient records have turned out to be potent marketing tools as well. "My practice is in South Florida," says Garcia. "Many of my patients return to a northern state for

the summer, so I began giving them their records to take to their doctors up North. Receiving a copy of their medical record impressed them and made them believe they were receiving high-quality care. Because they

request the medical record. That buys them another 30 days. With the Dr. Notes system, physicians can send the medical note along with the claim electronically. Electronic submission of this information is much

**Some physicians have found printed patient records to be potent marketing tools when sent with patients to other physicians.**

were so impressed, my patients also started showing these records to their friends and family. This really promoted my practice."

The system also reduces claim rejections and shortens the accounts receivable cycle. "By law, insurance companies have 30 days to respond to a claim," says Garcia. "So they wait until the 29th day and then

less expensive than sending a paper claim with a paper medical report attached, and initial submission of all the information necessary for claims processing definitely shortens the accounts receivable cycle."

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

# Office Dispensing Enhances Revenue, Compliance, Industry Leader Says



**Warren Moseley** is chairman and president of Physicians Total Care Inc. PTC is a pharmaceutical repackager and wholesale distributor in Tulsa, Okla.

From 1973 to 1988, Moseley was a lawyer in private practice specializing in taxation and business formation. Previously, he served as director of financial services for Medserco Inc., a company in St. Louis that specializes in physician practice management; and in the tax department of Arthur Andersen & Co. A certified public accountant, Moseley earned his BS in accounting at the University of Missouri, Columbia, and his JD from St. Louis University Law School. Richard L. Reece, MD, editor in chief, conducted this interview.

**Q:** Will office dispensing become widely attractive to physicians?

**A:** Yes, for several reasons. First, there is currently a tremendous shortage of pharmacists, which is expected to reach 40% over the next five years. Since the existing system will be unable to meet the market demand for prescription drugs, something has to be done to address that problem.

Second, one solution to medication compliance issues is to force doctors to gather the data needed to demonstrate that they are in compliance (such as data on drug formula-

ries and drug interactions, and for managed care data management). Doctors in almost every practice are spending 30 minutes to an hour each day dealing with pharmacy issues. In fact, for every three doctors, there is one full-time equivalent person devoted totally to pharmacy issues. Doctors get no additional revenue for the time they spend on this activity. Since the doctors are doing the work, they might as well deliver the product and get paid for it.

Third, doctors who use our system become more knowledgeable about the costs of medication and the therapeutic alternatives, and as a result become more selective about the medications they prescribe. Also, with our system, they can track the effect of various antibiotics, for example, to make sure they are getting the results they want to achieve.

**Q:** An article in The Wall Street Journal noted that doctors who know the costs of medications had a dramatic effect on lowering the costs of prescription drugs.

**A:** That makes sense and is our experience. Where the prescription is filled influences the cost too. Pharmacy industry data have indicated that per-prescription costs in 1999 were \$41.04 at retail outlets and \$36 through managed care. The cost was \$18.97 when the prescriptions went through our system, and that cost included an average \$4 profit for the physician.

**Q:** The number of prescriptions being written has skyrocketed in recent years, which is one reason pharmacists are struggling. They simply can't meet the demand. Is that what is driving the change to office dispensing?

**A:** Yes, in part. The work is being shifted to physicians. In fact, by the time the prescription reaches the pharmacist, physicians have cleared the prescription with the insurer—and physicians are not being compensated for this effort. Many companies are coming up with handheld devices that let doctors do all the checking for information in the exam room and then transmit that information directly to the pharmacy. It does not make economic sense for a physician to buy a handheld device and then spend time gathering information without being paid for this work. Gathering information is a clerical task, and it defies logic not to pay physicians and their staff for gathering information to verify insurance eligibility.

**Q:** How do office-dispensing software systems work?

**A:** Some of the best software for office dispensing uses the Windows environment and can be loaded onto most computers without the need for adding incremental hardware. But let me say that doctors who are interested in dispensing must be willing to make a commitment. That is, before a system is installed, they must be willing to have a software

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**“Doctors in almost every practice spend 30 minutes to an hour each day dealing with pharmacy issues. They get no additional revenue for the time they spend on this activity.”**

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company track their prescription writing habits for two or three weeks so that the vendor will know the kind of inventory the office will need.

At the same time, these software vendors have to gather insurance information about their patients. The physician must be willing to make a nonmonetary investment in the background information necessary to put the system in place. After that, the physician will need a two-week inventory of drugs. That's when the physicians start to look seriously at therapeutic alternatives in terms of relative cost. Before this, they never looked at their prescribing habits in this way. Using such systems, virtually all physicians cut the total medica-

change. Now, with the prevalence of computers, pharmacists no longer need to be the central distribution point and that function can be returned to the physician.

**Q:** *Should pharmacy benefit managers, which are essentially an extension of insurers, continue to exist?*

**A:** The business of insurance companies is to collect premiums and minimize claims, which is a legitimate purpose. But in the process of minimizing claims, the interaction between doctors and pharmacy benefit managers and insurance companies has traditionally been adversarial. The companies that offer software for physician dispensing align the purposes of the insurance company

dred dollars. A few hours of training in how to operate these systems is required as well. The best companies in this field will provide telephone and other support during this process, and generally it goes smoothly.

**Q:** *Does the profit per prescription vary?*

**A:** Yes. It is generally \$4 to \$6 per patient. It will be on the low side for managed care patients and on the high end for cash-and-carry and workers' compensation patients. Generally, physicians need to deliver at least five prescriptions a day per site to have enough critical mass to make a profit using these systems and to meet the monthly support fee, which will be about \$175.

**Q:** *What do you think of point-of-care medicine, which encompasses everything that is done during a patient visit, from the physical exam to the coding, billing, and prescribing?*

**A:** There is no doubt about it: Point-of-care medicine is the new model for medical excellence and lower health care costs. For the past 12 years, we have been calling what we do point-of-care dispensing, so we feel good that we were on the right track early.

**Q:** *Doesn't point-of-care medicine make sense because the patient-physician relationship is the backbone of the health system?*

**A:** It always has been. But the importance of that relationship has been obscured by the fact that doctors and the pharmaceutical industry have become the scapegoats of the health care system. The main reason they are the scapegoats is that many people (including Medicare recipients) do not have pharmaceutical coverage and the cost of their drugs comes out of their own pockets. The payers will not pay \$300 to \$400 a month for drug costs, but will gladly fork over \$50,000 for a coronary bypass, which may not have been necessary had the patient been taking the proper drugs. But because

**“The business of insurance companies is to collect premiums and minimize claims. But in minimizing claims, the interaction between doctors and insurers has traditionally been adversarial.”**

tion costs of their patients in half from what they were before the system was installed.

**Q:** *Lowering drug costs must also benefit the health care system, in which the fastest growing costs are in prescription drugs, correct?*

**A:** Yes, but these systems have been greeted with some external resistance. For example, many pharmacists especially resist doctors taking over this task. Pharmacists often control MCOs' drug policies. Although tremendous savings can be achieved by MCOs with physician dispensing, the politics are sometimes unfavorable.

Remember that pharmacists started by compounding drugs for doctors, not by dispensing drugs. However, with the rapid increase in new drugs, it became impossible for physicians to maintain a complete inventory and pharmacists started dispensing drugs. That is a relatively recent

and the patient with those of the physician. In other words, doctors are encouraged to do the maximum for minimum cost, while the insurance company gets the maximum for minimum cost and the patient gets better, lower-cost health care. It helps everybody by making prescriptions more profitable at a lower cost.

**Q:** *What needs to be done to set up a system for dispensing drugs in a physician's office?*

**A:** The licensing fee may be \$4,000 (plus sales tax) per practice site; which can be paid at the rate of \$1 per prescription. Doctors generally make \$4 to \$6 per prescription, so accounting for the licensing fee means they are making about \$1 less per script until it is fully paid. The only upfront costs are for the two-week inventory, which generally runs \$2,000 to \$4,000 per physician; and for a printer and a barcode reader, which together may run several hun-

## “A layer of management needs to be eliminated, and physician prescribing achieves that.”

Medicare will not pay for the drugs, doctors and pharmaceutical companies are berated for profiteering.

**Q:** *Two obstacles to the dispensing of drugs by physicians are the seven or so state laws that prohibit it and the charge that physician dispensing “for profit” is unethical and leads to overutilization. Could you comment on these obstacles?*

**A:** The New Jersey law, for example, allows doctors to dispense a 72-hour supply of medications and to make no more than a 10% profit from doing so. Therefore, the issue in New Jersey is not whether doctors can dispense with competence, but rather where the profit from dispensing is going. In Texas, doctors cannot dispense if there is a pharmacy within 35 miles. Again, the issue is the allocation of profit. Allocation-of-profit laws are an illegal restraint of trade. Those laws, if challenged, will fall, according to the Federal Trade Commission.

As to the ethics issue: The AMA and some other medical societies have issued opinions that physician prescribing is not unethical as long as it does not exploit the patient for the doctor's profit. But that's also true for practically everything the physician does. A professional license gives a person the right to do for others something they want to have done for them for their own good and to charge for having it done. Everything a professional does presents ethical dilemmas; the issue is how those dilemmas are resolved.

**Q:** *What about the turf issues concerning doctors and pharmacists? That is, the argument that pharmacists are part of a check-and-balance system that catches doctors' errors?*

**A:** That is no longer an issue. First, if it's an argument about who makes the profit, the antitrust

laws take care of that because eliminating physician dispensing is an illegal restraint of trade. As far as the error question, the best office-dispensing systems will check for drug interactions, allergy history, and have extensive data on the patient. Besides, the doctor gathers information from the patient, and that information is always in the system. Doctors have a better database than pharmacists or insurance companies and their PBMs. PBMs have only a record of drugs that have been filled; they don't, for example, have records of the over-the-counter medications a patient may be taking or the patient's allergies. All the data that managed care, PBMs, and HIPAA [the Health Insurance Portability and Accountability Act] folks are talking about getting can be obtained only from doctors.

**Q:** *Some people portray the physician-consumer relationship as a battle for control. Does office dispensing give doctors too much control?*

**A:** Patients know, and usually trust, their doctor. However, if you ask 20 patients the name of their pharmacist, 19 of them won't have a clue. And the pharmacist has no information about them except what is in the record for the insurance company. The control issue, as I see it, is with the payers, who often dictate the health care decision. Patients do not complain about doctors being in control of their destiny, but they do complain about the payers, who want to be at the table when decisions are made.

**Q:** *If physician dispensing cuts pharmacy costs by 50% and if those cuts stem from the physicians' firsthand knowledge of what drugs cost, that knowledge and that cost-cutting threaten the HMOs' and the PBMs'*

*reason for being, does it not?*

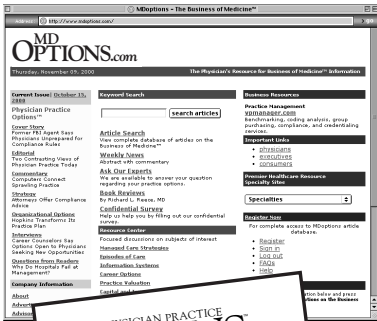
**A:** The payers are brokers and the PBMs are subcontractors to the payers. They served a useful function when the system was out of control in the 1980s and 1990s, and they were needed to correct a system that was in disequilibrium. But now that disequilibrium has gone the other way, and we have more bureaucracy than physician costs. The only place left to cut the cost of health care is in the bureaucracy, which means we have to trim the brokers back or they need to address operating inefficiencies that can result in system cost savings.

One way HMOs and PBMs make money in pharmacy is to recommend drug A over drug B and to receive a rebate for doing so. This focus on the price of a pill, while originally lucrative for the payers, has diminishing results for health care. Payers take a 25% commission in the form of the premium. So the system is beginning to take payers out of the loop because their bureaucracies are too wasteful. A layer of management needs to be eliminated, and physician prescribing achieves that.

The true savings occur at the physician-patient level, where convenience is paramount and where patients and physicians are informed about costs and are responsible and accountable for the true cost of the encounter. By assisting in this process and focusing on distribution efficiencies and total treatment cost, there will remain a very strong market for payers and PBMs to continue accelerating the improvement of health care delivery. These software systems are here to assist them.

—Edited by Paula Grant, in Lincoln, Va. More physician practice strategies is available on our web site (see page 16).

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