

# PHYSICIAN PRACTICE OPTIONS™

June 15, 2000

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

## CONTENTS

### Features

**Information Systems**  
Computer Network  
Saves Time, Money 3

**Organizational Options**  
Merged Groups Seek  
New Efficiencies 6

**Interview**  
Health System Needs  
To Be Redesigned  
To Accommodate  
Aging Baby Boomers 12

### Departments

**Editorial**  
Web Site Designed  
To Ease Access To  
Editorial Content 2

**Strategy**  
Local Publicity  
Builds Patient  
Volume 10

**Newsline** 15

## Experts Say Telephone Is the Most Important Customer Service Tool

It takes more than clinical skills to succeed in most managed care markets. In the race to grow patient volume, catering to customers has become as important as caring for them, meaning physicians must work to build relationships with patients by continually focusing on customer service. And most often, the customer relationship begins with a phone call.

"That first phone call sets the tone of the patient's experience with you and your practice," says Neil Baum, MD. "There is a world of difference between 'Doctor's office, please hold,' and 'Good morning, this is Dr. Baum's office, Kimberly speaking, how may I help you?'"

A urologist who is also an authority on practice management and physician marketing, Baum has written two books: *Take Charge of Your Medical Practice...Before Someone Else Does It for You: Practical Practice Management for the Managed Care Market* (Gaithersburg, Md.: Aspen Publishers, 1996) and *Marketing Your Clinical Practice: Ethically, Effectively, Economically* (Aspen Publishers, 1991). Three days a week he sees patients in his solo practice in New Orleans, and the remainder of the time he speaks, consults, and writes on practice management.

Before managed care became commonplace, patients found physicians with the help of family and friends, who vouched for the doctor's reputation. "Today, patients don't have any knowledge about the doctor," says Baum.

"Their HMO gives them a directory and they make a phone call. When that phone is answered with rudeness, brusqueness, and inattentiveness, patients move on to the next name on the list. The patient thinks, 'If the office staff is this hassled and this distracted on the phone, how will they be when they have to take care of my medical problem?'"

"The phone call is the first chance that the doctor has to create a good first impression," emphasizes Baum. "You don't get a second chance to make a good first impression."

### A Powerful Connection

Too often staff and physicians view the telephone as just another aggravation. "There has to be an attitude shift," says Nancy Latady of Latady & Associates in Bedford, Mass., a strategic marketing consulting firm specializing in practice development. "With increasing demands on physicians' time, staff must assume a greater role, as representatives and communicators, with patients and referral sources. Pressures on physicians to increase productivity dictate that office staff members move from message taking to skillful handling of the telephone process to decrease physician interruptions and save time."

Latady believes that by paying close attention to telephone customer service, physician practices can do a better job of retaining current patients and referral sources and attracting new

(Continued on page 8)

## Web Site Designed To Ease Access to Editorial Content

By now, it should be obvious to all that the Internet has become a significant factor in health care. Just recently two of the largest managed care organizations named executives to newly created positions in charge of building links between physicians and patients over the World Wide Web.

On April 24, Humana Inc., in Louisville, Ky., named Jonathan T. Lord, MD, the industry's first "e-chief medical officer" and asked him to link physicians and health plan members electronically. Humana's goal is to enable consumers to exchange health information securely over the Internet.

The same day, Oxford Health Plans, in Trumbull, Conn., appointed Jay J. Levin to the new position of executive vice president of e-commerce and strategy. Oxford plans to have its Web site address the health care information needs of members, providers, and benefits administrators, among others.

At the same time, *Practice Options* has been building a Web site (see page 16 for the address) that is designed to provide easy and unlimited access to our editorial content. Physicians now can view, download, or print any article in current or past issues of *Practice Options*.

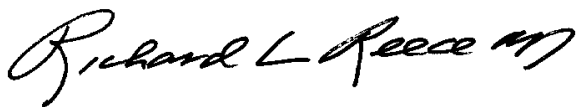
Harris Interactive, an Internet research firm, reports that 89% of physicians use the Internet at home or in their office. While many doctors are still most comfortable with the printed word, they also are like consumers today. They want fast and easy access to information.

I receive many phone calls over our toll-free line asking about information from articles in recent issues of *Practice Options* that callers have read but can't find. In the past, I have scrambled to find such articles for readers and often have had to call them back because searching through back issues can be time-consuming. Now I can quickly find articles of interest and related articles as well and deliver the information in one call.

It's not unusual, for example, for a physician to ask what he or she can do about selling a practice. Readers will inquire, "What is the value of goodwill when I'm selling my practice?" My short answer is that goodwill might total about 30% of gross annual revenue, but for a more in-depth response, I suggest that readers go to our Web page and, type in "goodwill." Some 10 articles will appear, each with a brief summary of the contents. For example, on Sept. 30, we had an article, "Goodwill Complicates Buy-In Pricing," by Daniel M. Bernick, JD, MBA, in which we reported on the issue in some detail.

It is not unusual for readers to call with questions about clinical trials, a topic important to physicians seeking new sources of revenue and new professional challenges. If you type in the words "clinical trials," you will find several articles, including "Clinical Trials Research Offers Physicians Potential New Way To Increase Revenue," an interview that was published June 15, 1999.

You name the topic, and if it is related to practice options, it is likely that we have covered it in the past five years and the article will be in our vast database. For those who enjoy searching in this way, this site is ideal. If, however, you prefer to speak with me directly, feel free to call 888/457-8800.



Richard L. Reece, MD  
Editor-in-Chief  
Toll-free phone: 888/457-8800  
E-mail: rreece@moptions.com

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

Thomas M. Gorey, JD  
President and CEO  
Policy Planning Associates  
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA  
Executive Vice President, Director  
Center for Clinical Innovation  
Premier, Inc.  
San Diego

Harold B. Kaiser, MD  
Allergy & Asthma Specialists, P.A.  
Minneapolis

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

Paul H. Keckley  
Chairman  
Personal HealthMaps  
Nashville, Tenn.

Peter R. Kongstvedt, MD  
Partner  
Ernst & Young  
Washington

Richard Liliedahl, MD  
Health Care Consultant  
Milliman & Robertson Inc.  
Seattle

Lee Newcomer, MD  
Senior Vice President for  
Health Policy and Strategy  
UnitedHealth Group  
Minneapolis

James G. Nuckolls, MD  
Medical Director  
Carilion Healthcare Corp.  
Roanoke, Va.

Brooks G. O'Neil  
Managing Director  
Piper Jaffray Inc.  
Minneapolis

Bernard Rineberg, MD  
Physician Consultant  
BAR Health Strategies  
New Brunswick, N.J.

Carl Schramm  
President  
Greenspring Advisors, Inc.  
Towson, Md.

Jacque Sokolov, MD  
Chairman  
Sokolov Schwab Bennett  
Los Angeles

W.L. Douglas Townsend Jr.  
Managing Director and CEO  
Townsend Frew & Co., LLC  
Investment Banking  
Durham, N.C.

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

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

**Publisher**  
Premier Healthcare Resource, Inc.  
888/457-8800  
E-mail: publisher@moptions.com  
Publishing Address: Premier Healthcare Resource, Inc.  
Suite 300, 99 Cherry Hill Road  
Parsippany, NJ 07054

**Editor**  
Joseph Burns  
508/495-0246  
E-mail: editor@moptions.com

# Computer Network Saves Time, Money

To date, incorporating electronic medical records, voice recognition software, and other medical information systems into private medical practices has been spotty due to many factors, including the high cost and reluctance among physicians to change practice patterns.

Yet one physician has not only built many of these applications into his practice, but has networked them into an integrated electronic information system. David Bright, MD, a family practice physician in Stuart, Fla., has developed a computer network for his practice that has enhanced efficiency in significant ways.

## Forty Patients a Day

"I have taken two existing information technologies—an electronic medical records program and a voice recognition program—and successfully integrated them into my practice to change the way my staff and I enter patient data and compile medical records," Bright says. "Our ancillary integrated software includes an integrated drug reference program and patient education software." The practice's hardware is built around a fully integrated network with a dedicated server and a laser printer.

The networked system helps Bright, who works with a physician assistant, to handle a patient load of approximately 40 visits a day. After using this system for two years, Bright has found it to be relatively easy to incorporate into his daily workflow.

"When a patient comes in, he or she completes a written two-page registration form," he explains. "A staff member enters the information from that form into an electronic database, helping to create an electronic chart. Then, a medical assistant interviews the patient and updates the chart information and the reason for the visit."

When the medical assistant is finished, Bright enters the exam room. "Every examination room has an integrated client computer," Bright says. "I quickly review the patient's reason for coming in online. I interview the patient and perform whatever physical

examination and treatment is necessary. Then, while the patient is present, I use a combination of speech recognition technology, timesaving templates and macros, and a minimal amount of typed data entry to create a detailed, organized record of the visit."

Using the system in this way encourages patient participation and education. "The patient is actively involved to help ensure that the data I'm entering are correct," Bright says. "At the same time, the patient is receiving important information and education regarding his or her medical condition. Prescriptions, medication information, patient handouts, laboratory orders, and disease management algorithms are all available in real-time on the computer screen and easily printed to a networked printer at the checkout station."

**The electronic medical record system allows easy recording and retrieval of patient data from the reception area, the physician's office, or any of six exam rooms.**

## Enhancing Efficiency

The administrative hassles common with paper-based charts spurred Bright to integrate information technology into his practice. "I was experiencing the typical frustrations all physicians face with regard to the problems inherent in using paper-based charts," he says. "Paper charts are extremely cumbersome. In addition, keeping paper charts up-to-date and accurate is almost impossible. We seemed to face never-ending battles to create and maintain perfect medical records with complete, up-to-date information, find these paper charts quickly, and have them available for reference both within my office and externally for specialists and hospitals."

In contrast, Bright's electronic medical record system allows easy recording and retrieval of patient data from the reception area, his personal office, or

any of the practice's six examining rooms, each of which has a computer linked to the network.

Another significant benefit of Bright's system is that he no longer needs to pay for transcription.

With transcripts, delays and technical problems were inevitable. "No matter how hard we tried to troubleshoot the system, a problem would occur about 1% or 2% of the time," Bright laments. "That may not sound like much, but the frustration was fairly significant."

## Cutting Transcription Costs

"When I started this project two years ago I was spending approximately \$12,000 a year for transcription and my costs were increasing about 20% yearly," Bright says. "Since we implemented this system, I have spent nothing on transcription."

The system also improves medication prescribing. "I linked a pharmaceutical macro application to the system to generate and record prescriptions," Bright says. "For most of the common medications I prescribe, I can simply state the name of the medication into the voice recognition system, and hit a button. With that one keystroke I can bring up on the computer screen a template for a prescription form that includes the medication with its standard dosages and instructions. Then all I have to do is specify the quantity and the strength of the prescription and hit another button to print it, and the prescription form is generated."

Medication template forms enhance efficiency by facilitating the process of issuing prescriptions for refills. "Patients often telephone their doctors for prescription refills, generating a given

*(Continued on page 4)*

(Continued from page 3)

amount of work for physicians and the staff," Bright says. "Since we may have between 15 and 20 such requests daily, staff members use prescription template forms to record the requests. Then the physician assistant and I review all the request forms near the end of the day. At that time, we look at each requester's medical chart on the computer, which includes several useful screen formats including a file of all the medications that we've prescribed for each patient in date order. Without ever having to pull a paper file, we can review their medication and can decide whether to approve or amend the prescription. The medical assistant then calls in the prescriptions to the pharmacy and at the same time updates the patient's electronic chart with the new prescription information."

Physician referrals are also handled easily. "The system maintains a variety of report forms as well as a database with the names and contact information of almost all of the physicians in town," Bright says. "For example, the system can generate a referral letter. I hit a button and it's done. I don't have to reinvent a new dictation in order to make a referral. The system parses the information from the current chart."

For Bright, the efficiencies as a result of using the system have had tangible financial benefits. "My net income increased a solid 20% since I started using this system, and that to me is, of course, very satisfying," he says. "The hardware and software paid for themselves within the first 12 months of purchase."

## Quality of Care

In addition to cost savings, Bright has incorporated a number of applications that enhance the quality of care. He added a pharmaceutical reference application into his system, for example, to ensure that medications are prescribed safely. "The pharmaceutical application provides drug interaction information, dosage ranges, and even prices," he says. "The application helps me ensure that the medications I prescribe are safe for the patient. In addition, I can print that information for the patient, who can then check to ensure

**"My net income increased 20% since I started using this system. The hardware and software paid for themselves within 12 months."**

**—David Bright, MD, family practitioner**

that the medication he or she receives is the correct dosage and form and can read a patient-friendly summary of the drug information. I can also copy the drug information into the electronic patient chart to document important information about that medication."

Patient education software linked to the system provides guidelines and educational information for a number of diseases. "For common problems that I treat—such as diabetes, hypertension, and coronary artery disease—I developed standard care management templates that I can retrieve as needed," Bright explains. "I use these templates as guidelines to ensure that I cover all the bases for a patient with a particular disease. The templates prompt me to review particular risk factors, request blood work or other laboratory tests, consider particular medications, and provide patient education materials. By pulling these materials up on a computer in the examination room, I have information right at my fingertips to help me treat my patient. In addition, the templates can be modified very easily if I need to individualize information for a particular patient."

Since obesity is a significant disease and obese patients often develop serious conditions, such as diabetes and heart disease, Bright uses his information system to provide weight management materials to patients. "I have 20 different diets available depending on whether patients want to or need to lose weight," he says. "I can easily retrieve and review the one most relevant for the patient."

All information can be printed for the patient before he or she leaves the office. "After I review the information with the patient in the examination room and answer all questions, I press my print button and that information goes to the printer at the front desk," explains

Bright. "The patient can pick up the materials on the way out."

## An Adaptable System

Bright insists that the system is not difficult to learn for a motivated physician. "We are currently hosting a physician assistant student for a six-week rotation," he says. "This has been a good opportunity for us to determine how easily someone might learn this system. In fact, the student has learned the system fairly quickly: He received training on his first day, and was dictating on day two."

But Bright is quick to note that becoming a sophisticated user of the system requires much more time. "I don't want to mislead anyone," he cautions. "Someone cannot learn the finer points of this system in a day or two, because it's fairly complex and therefore it requires a process of accumulated knowledge and experience. But the more effort someone puts into learning it, the more he or she will get out of it in terms of efficiency over the long run."

Despite the learning curve, Bright is confident that other practitioners could adopt this system within their practices. "The system is flexible and adaptable to any physician's unique practice, as a physician can incorporate his or her own templates," he says. "But a physician would have to invest the time and energy to learn the core applications. Also, a physician would need some assistance in setting up the hardware and the software. And because of the interaction among multiple programs, computer glitches arise from time to time, so some computer assistance might be required on an ongoing basis. But we're trying to make it as error-free and user-friendly as possible."

To continue to leverage the possibilities of the system, Bright is always seeking new applications to integrate. "I'm constantly trying to figure out newer, better, and smarter ways to use it to

The system gives Bright the peace of mind to know that when he goes home each day, his records are complete and up-to-date.

facilitate my operations," he says. Currently researching Internet sites for specific medical conditions, Bright has added a shortcut on his desktop that gives him access to sites containing information on Alzheimer's. The practice recently started working with an Alzheimer's facility. "We're now developing bookmarks so that we can access some key sites so that if a patient comes in and has a more esoteric problem, we have information that's easily available over the Internet and that can be downloaded," Bright explains. "We are choosing sites that have the best content and that can be pulled up quickly, because during the actual patient visit we don't have a lot of time to waste. Our system incorporates a very fast connection, and we normally can get to whatever site we want within 15 seconds."

One of the most significant benefits of his system is that it gives him the peace of mind to know that when he goes home at the end of the day, his records are complete and up-to-date. "Having all the loose ends all wrapped up leaves me with a feeling of contentment," he says. "On a practical level, the system has truly freed up my time. Now, I work out at the local gym every morning, something I didn't have time for before. So the system has enhanced both my professional and my personal life."

Given the success he's had in his own practice, he now wants to develop a business plan, seek a partner, and get financing to market his office-based medical informatics workflow expertise to other physicians. "I am looking for quality partners with vision and integrity who can provide an important service to physicians who are struggling with a paper-based system," he says.

While many physicians may wait to adopt new computer systems in their offices, Bright will tell you that using new technology has improved his medical practice significantly. "I've read many articles about reengineering medical practices and I'm a firm believer in continuing to seek ways to enhance practice operations," he says. "There have been so many changes in medicine in the last decade that to practice medicine the way we were taught in medical school—I graduated in the early 1970s—is just not going to be successful anymore."

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

# Want to make certain that you receive each month's issue?

SUBSCRIBE TO PHYSICIAN PRACTICE OPTIONS

## OUR ARTICLES FOCUS ON:

- Understanding the dynamics of managed care
- How to strategically position your practice for success in today's health care market
- Effective organizational options
- Maximizing your practice through health care informatics



### 1 year (12 issues) - \$110

A 50% savings off the regular price.

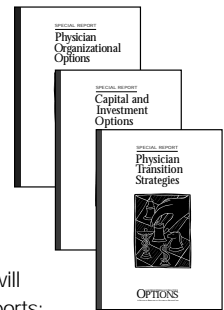
Act now and you will receive one free Special Report of your choice:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES

### 2 years (24 issues) - \$170

An additional \$50 savings off the special 1 year subscription rate. Act now and you will receive a complete set of three Special Reports:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES



Please call 888-457-8800 to order your subscription now, or fax this order form to 973-316-5080 or mail to:

Physician Practice Options  
99 Cherry Hill Road Suite 300  
Parsippany, NJ 07054

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_

Payment method:  Check enclosed  Bill me  Credit card.

If paying by credit card, please fill in the following information:

Credit Card (type) \_\_\_\_\_ Exp. Date \_\_\_\_\_

Credit Card Number \_\_\_\_\_

Name on card \_\_\_\_\_

Billing address \_\_\_\_\_

Signature \_\_\_\_\_

Checks should be made payable to: Physician Practice Options

EXPIRES: 12/00

#FSR110.170

# Merged Groups Seek New Efficiencies

By Thomas M. Gorey, JD

What happens when a medical school's faculty practice plan merges with a community-based group practice? How are differences in compensation, practice style, and contracting to be reconciled? To what extent can a community-based group be expected to support financially the academic mission of the medical school? The University of Wisconsin Medical Foundation (UWMF) in Madison is addressing these and other challenging questions.

For almost 20 years, the practice plan for the University of Wisconsin's faculty physicians was organized as 14 separate partnerships. Although there was centralized billing and collections under this arrangement, the physicians did not speak with a single voice to managed care plans, to the medical school, or to the University of Wisconsin Hospital. Anticipating a growing demand for primary care services as a result of managed care, combined with a growing need for capital development, the faculty formed a single group practice by creating a foundation in 1996.

## New Partners

The most significant event in the four-year history of UWMF occurred on Feb. 1, 1998, when UWMF acquired Physicians Plus Medical Group (one of the other two major medical groups in Madison) and created two divisions within the practice plan: a Physicians Plus Division and a Foundation Division. Since the merger, UWMF and its two divisions have been marketed under the name UW Health—University Physicians & Physicians Plus.

*Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development. More information on physicians' organizational options is available on our Web site (see page 16).*

The combination made sense for Physicians Plus because they were financially challenged and were seeking a capital partner, and it appealed to the foundation and the medical school because they needed to expand their primary care base to enhance teaching opportunities and to increase the attractiveness of the group to managed

facilities. More than 1,550 nonphysician employees provide clinical, technical, and administrative support.

## Complementary Strengths

The combination provides an unusual opportunity for two large physician groups to capitalize on complementary strengths. By integrating the entities and

**The combination made sense because the physicians group was seeking a capital partner, and the medical center needed to expand its primary care base.**

care organizations. Having an expanded base of patients for medical education and a marketable physician pool in a managed care environment were attractive features of the combination.

In addition, with threats that the Mayo Clinic (to the west and north) and the Aurora Health System (to the east) might make serious inroads into the Madison market, there was growing anxiety among all of the key groups in Madison, providing further motivation for the merger. Also, there was a threat that Physicians Plus might become affiliated with an out-of-state physician practice management company or other entity, a move that could have created instability in the market and diminished the foundation's position and influence.

UWMF is now the largest multispecialty group in Wisconsin and one of the 10 largest groups in the country. It is composed of nearly 800 physicians (230 from the former Physicians Plus and 560 university physicians), representing virtually every medical specialty. The physicians serve as clinical faculty for the UW Medical School in Madison and practice at clinics and hospitals throughout the state. In addition to staffing 60 clinics, UWMF physicians provide outreach services at 62 other

hiring Physicians Plus physicians at the UW Medical School, the two organizations intend to develop a system capable of delivering unsurpassed patient care and supporting the teaching and research missions of the medical school. An integration team was established to address the many challenges and opportunities involved in the combination. This process incorporates details of operations, compensation plans, governance, and other organizational activities.

One of the first issues the newly merged organization faced involved the consolidation of duplicate sites and services. Before the merger, the rivalry between the University Physicians and Physicians Plus led each party to open competing clinics in a number of communities throughout Wisconsin. UWMF staff from both divisions worked with the UW Hospital and Clinics and University Community Clinics to develop plans to integrate duplicate facilities. Consolidations began in February 1999, and in June 1999 a new clinic, UW Health-West, opened. This clinic consolidated at a single location the staffs of five separate clinics. Additional consolidations occurred later in the year when the new UW Health-East clinic was opened.

Other important initiatives included

the development of systems to accommodate the "free flow" of HMO members across both UWMF divisions and their primary hospitals, and the adoption of patient access and service standards, now posted in all clinic sites. UWMF also began comparing its clinical work with national benchmarks and developing pilot programs to enhance communication among referring physicians.

UWMF reorganized its administrative management shortly after the merger, establishing organizational assignments, physically relocating employees, and integrating and reorganizing work units. An attempt was made to identify and maximize complementary management skills in the new organizational structure.

### New Skills Required

Recognizing that information systems are the key for much of the administrative integration, the computer departments were merged first, moving to a new location and implementing new systems to drive subsequent consolidations. One of UWMF's goals is for all of its physicians to attain computer skills sufficient to communicate electronically with other staff and to access patient data electronically. UWMF implemented a unified general ledger and human resource system last fall, merged two separate benefit and payroll systems, and installed a new lab information system for the Physicians Plus division.

Another major initiative still underway will replace the central business office's two separate billing systems with a single, unified billing and scheduling system. This undertaking is particularly important given that UWMF processes an average of 12,000 codes and 10,000 payments each workday.

Also, UWMF initiated a new marketing strategy, including an image advertising campaign to promote the combined group to the public, an integrated referring physician directory to enhance referrals into the UWMF system, and new physician and outreach specialty marketing.

Despite the progress that has been made, as UWMF moves forward it will face a number of challenges, including completing the merger process, managing costs more tightly, sorting out the effect of the merger on the medical school, and creating a group mindset and identity.

## Some specialties have been fostering a group mindset, but others have done little.

### Completing the merger process.

Combining a large, community-based, primary and secondary care group with an academic group practice that provides primarily tertiary care presents huge opportunities for the physicians, the medical school, and the community. The integration of UWMF with Physicians Plus has the potential to strengthen both, allowing the physicians to compete more effectively both locally and regionally. In addition to solidifying long-standing referral patterns (which could have been altered overnight had Physicians Plus been sold to another entity), the merger presents opportunities for providing care more efficiently, for important clinical studies, and for enhanced primary care education. Patients stand to benefit from the qualities of both groups in a unified system and from a greater choice of physicians.

The process of integrating the foundation division and the Physicians Plus division into a single organizational entity has not been completed, however. Merging two groups of this size, with significantly different cultures, requires a considerable amount of time and energy. Effecting a full implementation of the merger is the most significant issue the foundation faces.

**Managing costs more tightly.** The underlying financial pressures that motivated Physicians Plus to seek a partner have not been eliminated, because the fundamental clinical delivery cost structure that existed before the merger remains substantially unaltered. One component of the merger agreement is that the foundation will supplement Physicians Plus compensation by \$3 million per year for two years. At the end of that period, the organization will need to implement a permanent solution to the financial pressures on Physicians Plus. While administrative consolidations have already produced meaningful cost savings, more aggressive steps will be needed to reduce costs and achieve true economies of scale.

**Sorting out the effect of the merger on**

**the medical school.** It may take several years to assess the full impact of the merger on the medical school. The benefits of an expanded pool of physicians for clinical education are clear. What is not so clear is how and to what extent the new entity will support the medical school's academic mission of research and education, particularly since the foundation is an economic organization that is not controlled by the dean or the department chairs.

Even before the acquisition of Physicians Plus was completed, the subject of the "Dean's Tax" and other academic assessments paid by the foundation division were discussed. Since financial pressure to meet expenses was a significant reason for Physicians Plus to seek a partner, their operations were not capable of shouldering additional financial burdens.

Reaching a consensus on how the unified group will support financially the academic mission of the medical school will be critical for the future success of both UWMF and the medical school. The funds flow model that the UWMF board approved in principle in November 1999 eliminates the two-division structure. The implementation details of this funds flow plan are politically sensitive and pose a significant challenge.

**Creating a group mindset and identity.** UWMF has made considerable progress in promoting the newly merged group to the external market. There is a high public awareness of the merger and an appreciation of the benefits the merger presents for patients. Work remains, however, in motivating UWMF physicians from the two divisions to act in a more teamlike fashion. Some specialties have been proactive in fostering a group mindset, for example through sharing of call, but in other specialties, little has changed since the merger.

Merging two medical groups is always challenging. The experiences of UWMF in addressing these issues will hold important lessons for other faculty practice plans interested in forging alliances with community-based medical groups. ■

(Continued from page 1)

ones. When patients and referral sources feel connected to the practice, they stay. “Satisfied patients are the key to bringing in new patients—friends, family, neighbors—through positive word-of-mouth,” she says.

Skillful phone service enhances overall practice efficiency, too, and helps keep costs in line by streamlining access to information and services. “Receptionists serve more of a triage function now,” Latady explains. “Rather than saying the doctor is just not available, or simply promising a call back at a designated time, a well-

informed receptionist can get to the heart of the message and connect the caller with the triage nurse, or handle a billing or prescription issue.”

A good telephone triaging system also can save the practice money, Latady says. Certain medical information can be handled as well or better over the phone, saving a visit and making it more convenient for both patient and physician, she explains.

#### Expectations and Risk

The receptionist also plays a key role in managing patient expectations. “Whether it’s the patient’s first or

tenth visit, the receptionist should tell the patient what to expect, outline what a given procedure will entail, identify any special preparations, and explain how long the appointment and any follow-up results will take,” Latady suggests. “Warning patients about frustrating issues, such as leaving extra time to find a parking space, helps give patients some control over their experience.”

Enhancing customer service, of which the telephone is a large part, can also help reduce the likelihood of litigation. “Many malpractice issues are a

(Continued on page 9)

## Steps To Take To Fine-Tune Telephone Skills

**P**roviding award-winning customer service over the telephone is a set of skills that can be learned. Ask the receptionists in your practice to keep these tips in mind when talking with callers.

**Use the patient’s name.** To build a relationship with your caller, use your name and the caller’s name. Greet people with “good morning” or “good afternoon,” and be warm and enthusiastic, recommends Suzanne O’Connor, RN, MS, president of Health Care Satisfaction, a consulting firm in Andover, Mass. “Try to envision what the patient looks like. Use their name, tell them you’re glad they called, and ask ‘How may I help you?’”

**Promote the practice.** “Offer information without always waiting to be asked specific questions,” says O’Connor. “Endorse the doctor they chose. Or, if a new patient is looking for a physician, ask if he or she prefers a male or female doctor, or an appointment during extended office hours. If you have added a new service, such as drawing blood on site, tell patients when they call for appointments. It does not have to be an in-depth conversation, just a brief dialogue so patients feel they are getting a personal response.”

**Get the details.** “Don’t just take a name and phone number, and promise a call back,” O’Connor says. “Put some meat into the message. Receptionists should ask patients to share the nature of their call so they can take a clearer message. Often the receptionist can handle the issue, or pass it along to billing staff, for example, which can provide prompt assistance. Summarize what the patient says, and use phrases like ‘I assure you the message will be delivered.’”

**Get a time to call back.** If the doctor needs to return a call, identify a specific time so an anxious patient does not feel tied to the phone all day. O’Connor recommends that physicians have a set time for callbacks so the receptionist can tell the

caller what to expect. Most offices promise to return all calls within two hours or at a specific time each day.

**Focus the caller.** What about the talkative caller, or the patient who can’t seem to get to the point? “Receptionists should feel comfortable interrupting these callers, because there are other patients in the queue who need attention,” O’Connor counsels. “Interrupt in a pleasant way and use his or her name, saying, ‘Mrs. Smith, how can I be of most help to you today?’”

**Leave with a plus.** The most challenging patients are those who are angry or upset. “Generally, people who are angry feel helpless, and not in control,” says O’Connor. “Step beyond the anger. Don’t personalize it, don’t absorb it, but find out what they are anxious about.” She suggests saying, ‘Mrs. Smith, I very much want to help you. Is there anything you are anxious or concerned about right now that I should convey to the doctor?’ If you interrupt the venting they might start all over again,” warns O’Connor. “Just listen at first, assure them you will deliver the message, thank them for being so honest and direct, and for giving the office a chance to remedy the situation.”

**Take a 60-second vacation.** Eight hours of handling calls, some of them difficult, can be wearing. And receptionists cannot always step away from the phones. O’Connor says a 60-second break is healthy medicine, and like humor, a great energizer. “Between callers, receptionists should look at the pictures on their desk of family and friends,” she says. Display humorous sayings to lighten the mood. Download screen-savers from the Internet that are peaceful and serene. Practice positive reinforcement. “Tell yourself that the irate caller was upset because of a serious illness, and that you did the best you could under the circumstances and handled the situation with professionalism,” O’Connor says.

—LGC

(Continued from page 8)

result of poor communication,” Latady notes. “Patients didn’t know what to expect, or were in the dark about likely outcomes. But giving people clear and concise information and treating them with kindness and respect can go a long way toward reducing potential litigation. Patients generally don’t sue physicians they like.”

The way staff members handle patients on the telephone can help distinguish physicians from competitors, and standout practices capture market share. “It’s difficult to assess quality clinical care, but being known as a friendly, helpful, courteous staff helps set your practice apart from the competition,” Latady says.

### Stickers and Scripts

In Baum’s office, every phone has a two-dollar mirror on it so staff members can see what they look like when they answer the phone. “I want staff members to see themselves smile because a smile can be heard on the other end of the line,” he says. Also, every telephone receiver in Baum’s office has a sticker on it that says, “Telephone equals opportunity.” Baum explains, “It’s a constant reminder that the telephone is the opportunity to create that good, positive, first impression.”

Baum’s staff follows a set script when answering the phone: one, smile and be enthusiastic; two, identify the time of day and identify the practice; three, state who you are; four, offer to be of service; and five, use the caller’s name. “The person calling likes to hear his or her own name,” says Baum. “In my office, we customize the call by encouraging staff to use the caller’s name at least twice during the phone conversation.”

Baum’s staff also is trained to give patients clear, concise directions to the practice, and is well versed in his credentials and areas of interest and expertise in order to handle frequently asked questions. “If a patient calls with a specific urologic problem, particularly if it is in my area of expertise, my staff offers to send copies of journal articles I have published on the subject, and directs

the patient to our Web site if he or she has Internet access.”

### A Supportive Environment

“I tell the individuals answering the phone that they are the most important people in the practice,” Baum says. “They have a chance to make or break the attitude of the patient toward my practice. I emphasize this point at staff meetings, at performance reviews, or at any opportunity I have to interact with them about the telephone.”

Suzanne O’Connor, RN, MS, president of Health Care Satisfaction in Andover, Mass., agrees that the telephone is an important link to patients. “Telephone receptionists are a key link in a practice’s chain of service,” say O’Connor, whose consulting firm specializes in providing telephone training and interpersonal skill building to increase patient and staff satisfaction. “Practices have to respect the importance of the job and its difficulty,” O’Connor adds. “If patients are frustrated or angry, receptionists hear about it, while all the praise usually goes to the doctor.”

Like Baum, O’Connor believes practices should value their secretaries and receptionists, and recognize their contributions with praise or a small token of appreciation. “Even

something as small as a package of Lifesavers can say to a receptionist, ‘You are making a difference today,’ and bring a smile. Laughter is important, and so, too, are occasional breaks so the receptionist can leave the phones briefly to re-energize.

“These are not customers calling to order an item from a mail-order catalog,” O’Connor continues. “Illness can make you angry, pain can make you upset, or a new symptom can scare you. It takes a special kind of person to handle patient callers.”

### Positive Results

Baum believes in ‘moments of truth,’ those interactions between a patient and a practice that allow staff members to create a positive, negative, or neutral impression, he says. “The more moments of truth that you can manage in a positive fashion, the more likely that patient will want to be a part of your practice and will tell others about their stellar experience,” he adds. “The first moment of truth that most patients have with practices is the telephone. It is one of the most vital and important aspects of my practice.”

—Reported and written by Lisa Gilson Clancy, in Hopkinton, N.H. More information on building your practice is available on our Web site (see page 16.)

## Using Patient Surveys, Physicians Can Measure Phone Skills

How skillful is your staff on the telephone? “If your practice does patient satisfaction surveys, make sure you include a question about telephone customer service,” offers Nancy Latady of Latady & Associates in Bedford, Mass., a consulting firm specializing in practice development. For a first-hand assessment of how callers are treated, doctors can call their own practice, or ask a family member or friend, or hire a consultant, to pose as a patient. This type of assessment can be useful in understanding a caller’s first impression.

“Physicians also can enroll staff in telephone customer service training, and then write performance expectations into job descriptions,” Latady adds.

Apart from enhancing customer service and boosting patient volume, effective telephone skills and triaging also can improve staff morale and retention. “Receptionists tend to come and go, and that can take its toll on a practice,” Latady observes. “If your staff members feel valued and happy, they’ll stay. That’s a plus for patient care.”

—LGC

# Local Publicity Builds Patient Volume

By David Kettlewell

Physicians and business owners seeking to get their names out to their local communities often are reluctant to invest the substantial sums required for print or radio advertising or direct-mail promotions. Yet they may easily overlook one of the most cost-effective ways to promote and build awareness of their practices: getting articles published in a daily or weekly newspaper.

Newspaper editors have an insatiable appetite for professionally written news and feature articles. Every day, they face a deadline to produce good material that serves their readers.

But most physicians' experience with the press falls somewhat short of expectations. One physician in Michigan who

asked not to be named complained about the lack of coverage by his local newspaper. "The newspaper never gives us publicity," the physician says. "They never call us, and the one time we asked them to cover the opening of our new satellite office, they didn't even return our call. They never sent a writer and provided no coverage."

asked not to be named complained about the lack of coverage by his local newspaper. "The newspaper never gives us publicity," the physician says. "They never call us, and the one time we asked them to cover the opening of our new satellite office, they didn't even return our call. They never sent a writer and provided no coverage."

This physician is not alone. Many practices have never received any coverage from local media. But with the right approach, it is possible to be one of the few practices to get positive press coverage.

Public relations professionals say a positive

*David Kettlewell is CEO of Medi Medical Consulting Services Inc., a company in Akron, Ohio, that helps physicians develop medical marketing and strategic plans. More information on practice strategies is available on our Web site (see page 16).*

news story is a powerful communication tool, having exceptionally high credibility with readers, typically far surpassing that of ads. If a newspaper consistently publishes articles featuring your practice, you are likely to see an increase in the flow of new patients and the publicity will reinforce your name among your existing patients. For the money, it's one of the most successful medical marketing concepts today.

To get an article on your practice into your local newspaper, you can hire a public relations firm to oversee the entire process of drafting ideas, sending a query letter, preparing a manuscript, and submitting the article. The advantage of using a PR agency is that it will be much less work for

you, but you will pay a higher fee for the time the agency spends working with the press. If you don't have the budget for this option, you can prepare the ideas, write the letter, and hire a writer. In either case, you are likely to get good results.

## Understanding the Editor

Just as if you were beginning any new relationship, it is important to know something about the typical news editor of a major daily newspaper. Given that most have a keen sense of quality writing, you can assume that they will abhor amateurish script. They are always looking for news and feature articles to publish and typically do not have enough staff members to assign a writer to cover your event or write about your practice. They also want copy submitted on time.

Therefore, if you can provide them with well-written articles on topics of

interest to their readers and do it in a timely fashion, your practice will benefit. Once an editor publishes one of your articles, he or she is likely to be willing to accept more in the future. By submitting articles occasionally, you may be able to make your practice the source of definitive medical information in your community so that the editor and staff reporters may begin to call you for local comments on national health news. All of these efforts will raise the awareness of your practice in the community and the result should be more patients.

## Identify the News

The first step in getting published is to identify the kinds of information you have (or can get) that may be newsworthy. An ob-gyn practice, for example, will have a thorough understanding of the issues involved with osteoporosis, hormonal therapy, and ways to identify the existence of tumors through breast self-examination. Each of these is a newsworthy topic.

Ask yourself and your staff members, "What newsworthy topics are of interest to my patients? What issues in the news can I embellish on by adding my particular comments?" Pick up some of the national women's magazines and list the articles they cover. What topics are these publications covering that you know something about? What articles are being published in medical periodicals? Would one of these topics be of interest to the general public, and thus your local newspaper?

Is your practice opening a new office in town? Would the opening be a newsworthy event? In a large metropolitan city, maybe not, but if your satellite office is in a smaller community or yours is the first practice of its type in town, it might be worth an article.

## Send a Query Letter

Once you have a newsworthy topic—or better, a list of ideas—write a letter to the editor outlining your ideas and explaining why each would be of interest to readers.

Include in the letter your willingness to write any of these articles because it is unlikely the editor will assign a staff reporter to write your article. Most newspapers do not have the staff to send reporters to any but the most newsworthy events.

The following are topics pulled from a sample query letter:

- Getting back to basics on medical care: Preventive care, exercise, and nutrition. This article will discuss the simple basic steps each reader should follow to enjoy better health.
- Feeling good about yourself: How a holistic approach to women's health care can include a combination of relaxation and exercise to make a happier and healthier you.
- Five things you need to know about breast cancer. This article will discuss the steps one would follow from diagnosis to treatment options.
- What every woman needs to know about estrogen replacement therapy. In this article, we would help separate truth from fiction about this important women's health issue.
- What you need to know about health insurance. Why are patients confused? What are preauthorization and precertification and why are they important? Where can you go for testing? Why does a patient need to call his or her health plan if an emergency room visit is necessary?
- Incontinence, who suffers from it, and why? A frank discussion of a topic seldom spoken about.
- Patients and medical care. This article will explain the results of a focus group study regarding how patients feel about their medical care, their physician, and their insurance company.
- What patients expect from their doctor in today's tumultuous medical environment.
- Natural treatments and medicine today. How are we integrating natural treatment into our care for all patients?

Each of these article ideas is well-written, clear, and concise. A list like this one in a letter would demonstrate a knowledge about what is newsworthy, and the style is obviously that of a professional writer. Since the writer asked the editor simply to circle the topics of interest, the

letter made the editor's job easy. In this real-life example, the editor accepted the first three ideas and left the others for future consideration.

#### Call the Editor

After you have written the letter, you or your office manager should call the editor. If you do not know which editor to contact, you can simply explain your ideas briefly to the receptionist and ask for the name of the appropriate editor. Tell the editor that you've prepared a list of ideas and that you can provide finished copy, meaning an article ready for publication. Ask permission to fax or send the letter by mail. Offer to call back within a day or two to review the ideas.

When you call the editor back, it is likely that the editor will want you to write up one or more of your ideas in an article. Ask the editor if he or she wants a photo with the story. The newspaper may send a photographer at no cost to you or you may want to hire a photographer to shoot the photos for you. The cost will be \$100 to \$200. At this time, the editor will give you advice on what direction the story should take or discuss areas of particular interest. These requests should be followed explicitly.

#### Writing the Article

Unless you have extensive experience as a writer, it would be best to hire a professional writer. If your material is going to be published, the article must be written professionally. The editor will not even

edit a poorly written story. He or she is likely to throw it away. Hiring a professional writer helps ensure that you will get the best results.

Ask the editor for the name of a retired or freelance news writer, or call other members of the newspaper's reporting staff and ask if they know professional writers, or if they accept freelance assignments themselves. Expect to pay \$500 to \$1,200 for a professionally written article of 1,000 words.

Once the story is written, it is of paramount importance that you submit it on time or ahead of schedule. Since editors work on daily deadlines, they appreciate receiving a story early. Plus, if you help them meet their deadlines, you are likely to make a new friend in the process. Conversely, if you miss a deadline, you could be permanently labeled as unreliable.

After the editor reads and edits the article, he or she is likely to make suggestions for changes. At this point, it's best to be willing and flexible. Editors know what they want and it's useless to argue with them.

Following publication of your article, you may find the editor willing to accept other article ideas from your practice. You may even get calls for quotes from staff writers doing medical articles related to your area of expertise. What's more, the publicity should generate increased patient volume, which is the reason businesses of all sizes are interested in positive press coverage. ■

## Reasons Physician Groups Often Receive No Press Coverage

Many physicians complain that the local newspapers don't write about them. But physicians often fail to follow the time-honored practices of public relations when seeking coverage. Physicians often do not:

- Call the editor before submitting a list of article ideas
- Send a query letter to the editor
- Submit article ideas of interest to readers
- Prepare well written articles
- Send articles on time

By doing what other physicians fail to do, you will be well prepared to secure positive publicity for your practice through your local newspaper.

—DK

# Health System Needs To Be Redesigned To Accommodate Aging Baby Boomers



*David Friend, MD, is a managing director at Watson Wyatt Worldwide, consultants in Bethesda, Md., and has been with the firm since 1994. The author of*

*Healthcare.com: Rx for Reform (New York: St. Lucie Publishers, 1999), Friend earned his undergraduate degree in economics from Brandeis University in Waltham Mass., received his medical degree from the University of Connecticut in Farmington, and earned an MBA from The Wharton School of Business at the University of Pennsylvania in Philadelphia. Richard L. Reece, MD, editor-in-chief conducted this interview.*

**Q:** What is Watson Wyatt Worldwide and what is your role there?

**A:** Watson Wyatt is a large consulting firm, with 5,000 associates in offices in 35 countries around the world. I'm responsible for all of our business in the eastern United States, our largest and most profitable region. I also sit on the Global Management Committee, a group of 10 people who run the company worldwide.

Watson Wyatt is in three major businesses, all of them related to helping companies manage their employees more effectively. First, our employee benefits business involves helping companies purchase health care and retirement benefits for their employees. Second, our human resources technology business assists companies in building information technology systems so that employers can communicate more effectively with their employees. Third, we focus on human capital, helping companies maximize employee performance through compensation and other programs.

**Q:** What made you, as a physician, decide to become a consultant?

**A:** From an early age, I had an interest in combining business and medi-

cine. That's why I majored in economics in college, as opposed to a more traditional pre-med choice, such as chemistry or biology. When I graduated from college, I wanted to earn both an MD and an MBA. That was in the late 1970s, when joint MD-MBA programs were not common. In fact, I was one of the first people in the country to pursue that joint education.

After my education, I ran two health care-related businesses and several industrial businesses. In addition, my experiences as a medical intern opened my eyes to the fact that health care was not particularly well managed. Twenty years ago, it was considered unnecessary to "manage" health care in a businesslike fashion. In fact, 20 years ago, sound business management was seen as detrimental to patient care. Today, it is generally accepted if a business is not well managed, no matter what that business is, the business will not be successful.

In my career, I have taken the training I have had as a physician, namely the ability to learn and understand concepts and applied that ability to solving business problems. Helping patients diagnose and solve their clinical problems is not dissimilar from helping business clients diagnose and solve their problems.

**"Although we have severe problems in the health care system, we have a cure for them. I have tried to diagnose the problems and suggest available information technology cures."**

**Q:** What made you decide to write your book, *Healthcare.com: Rx for Reform*?

**A:** During my medical internship, from 1994 to 1995, I was amazed at how archaic the management of medical information was. I had come from an industrial company in which most key information was computerized. As an

intern, I found that one of my chief functions was to run around and collect information almost all of which was recorded with pencil and paper.

This lack of computerization was very frustrating. For instance, in the intensive care unit, we were constantly seeking the patient's medical record, which always seemed to be missing. I'd have to get in early in the morning to grab the record and almost seemed to be in a competition with the nurse, because whoever got the record first could use it and the other person could not use it easily. This seemed a ridiculous way to deal with data in a digital world, where multiple users can view information simultaneously using computer systems. In general, the practice of medicine is an intensive information experience. Physicians spend a tremendous amount of their time acquiring information and trying to dispense that information to patients and other caregivers. As a result, they have less time to focus on clinical work.

When I finished my internship in 1995, the Internet was just beginning to take off, and I believed that the health care system could be made more efficient through intelligent application of information technology. I saw an enormous

opportunity to improve the efficiency and lower the costs of the health care system by reducing the time and cost of acquiring information, by allowing multiple caregivers to view patient records simultaneously, for example, or by allowing information to be transmitted to multiple locations within a health care system.

The book reflects my belief that

**“We have two fundamental choices: We can either come up with innovative plans to ration care, or we can build a more efficient system that can provide more care per dollar spent. The information technology revolution gives us the chance to take that fork in the road toward greater efficiency.”**

although we have severe problems in the health care system, we have a cure for them. So, in essence, in the book I tried to diagnose the problem and suggest available information technology cures.

**Q:** *In your book you outline three current forces that are reshaping the health care system: the aging of the baby boomers, technological advances, and an inadequate financing system. Could you discuss the effect of the first factor?*

**A:** The aging of the baby boomers is a well publicized and much-analyzed trend. Today, three million United States citizens are over age 85. In 20 years, we will have 20 million people over age 85. Those demographics will have a profound effect on the health care system, because the aging population is going to create greater demand for health care. People who are 65 use five times the health care resources of those who are 25 and those who are 85 use 12 times the resources.

Right now roughly 50% of people over 85 have Alzheimer's disease, so the health care system faces the expense and the tragedy of dealing with 1.5 million Alzheimer's patients. If no cure is found, the Alzheimer's population will grow in 20 years to nearly 10 million people, all of whom will need care around the clock. The cost of Alzheimer's care alone will be staggering. This one example of demographic-driven expense should be sobering in itself.

**Q:** *What is the effect of the second factor, technological advances?*

**A:** While technology can provide an opportunity to reduce health care costs, it often also increases costs. For example, health care expenditures can skyrocket as people seek life-prolonging technologies and those that improve the quality of life. We are only at the beginning of what will be an explosion in the ability to produce new drugs that will improve lifestyles in a variety of ways.

New drug developments in general will be significant, such as the new arthritis medicines currently in development. Also, we can expect continual enhancements in devices such as pacemakers and artificial joints.

All that technology is going to be very expensive—and we have a population that is going to demand it from their caregivers and from their politicians.

**Q:** *What is the effect of the third factor, an inadequate care financing system?*

**A:** When Medicare legislation was enacted in 1965, the promise was made that we as a nation would finance the health care of the elderly. But we did that without recognizing that the cost of care 30, 40, or 50 years hence—in other words, today—would be extraordinary. As currently designed, the Medicare system is simply not adequate to handle the financing that will be necessary in the coming years.

**Q:** *How will employers react to these escalating care costs?*

**A:** One effect will be that employers will change the type of health care benefits they offer, from a “defined benefit” to a “defined contribution” plan. A defined benefit means that the health care plan chosen by the employer will largely cover the cost of care, regardless of the price, as long as the care is defined under the employee's benefit plan. In contrast, a defined contribution plan allocates a certain dollar figure, say \$4,000, and if the costs of care exceed that amount the employee must cover the remainder out-of-pocket.

This shift is similar to the shift in retirement planning. In the past, employers offered a pension that provided employees with a guaranteed portion of their income annually after retirement. Today, companies have 401(k) plans, whereby they allocate funds to each employee and the employees control how those funds are invested.

**Q:** *You say in your book that we've moved from “waste care” to “hollow care.” What do you mean by those terms?*

**A:** When the health care system was paid on a fee-for-service basis, there was a huge incentive to do every conceivable test on every patient because that extra care created more income for the hospitals and the physicians. For example, if a man sprained his back, he would not simply be advised to get back rest; rather, he would be advised to undergo expensive MRIs and other diagnostic tests, because the system could generate more profit that way. So we had a very wasteful system, or “waste care.”

The introduction of managed care gave us the opposite incentive. Instead of maximizing profits by doing a lot of procedures and services, physicians and health care institutions can maximize profits by offering less care. Capitation in particular represents a huge financial incentive to do little for a patient. Because profits increase as the actual care decreases, there is a great incentive to “hollow out” the system by promising services and then not providing them.

**Q:** *In your book you tout the advantages of a “virtual health care system.” What is a virtual system, and how can it provide efficient, high-quality care?*

**A:** Here's a useful analogy. A hospital is like a department store, trying to provide all services to all customers but being very inefficient. In the retail industry, entrepreneurs figured out that if they could ‘unbundle’ that department store and create specialty stores within a shopping mall, they could provide a better experience for the customer at a lower cost. In the same way, I envision health care services being split out from under the hospital umbrella. Today, with Internet technology, care can be provided by a network of health care suppliers linked through the

*(Continued on page 14)*

(Continued from page 13)

Internet to deliver services.

For instance, if a patient has diabetes, she will not receive all of her care under one roof; instead, a specialized company will monitor her blood sugar on a continuing basis by providing her with a device that records her blood sugar, transmits it to the company's information system, and alerts her physician if the blood sugar levels are not in a normal range. A separate company might supply the patient with medication. A third entity might ensure that she receives eye care. A fourth entity might provide renal care. All of these entities, much like the shopping mall, will be able to come together in a virtual system and provide the individualized care services each consumer needs much more cheaply and much more effectively than the current hospital-based system.

Developing a virtual system that provides better care at lower costs is the only way the country is going to avoid rationing care, which otherwise will occur due to the great demand of the elder boomers and the great explosion of available technologies. We have two fundamental choices: we can either come up with innovative plans to ration care, or we can build a more efficient system that can provide more care per dollar spent. The information technology revolution gives us the chance to take that fork in the road toward greater efficiency. But we are still at great risk that we're going to go right down the path toward rationing.

**Q.** *How will physicians function under a virtual system?*

**A.** In order to function under a virtual system, physicians will have to have a fundamental shift in their roles. At the moment, physicians are the keepers of information; they memorized information during their training and now they supply that information to their patients. But in an Internet-based world, the patient can go online and access more data than physicians can possibly have in their heads. Now, the physician's role will be to help patients navigate the maze of information, serving as a guide. Physicians also will be resource managers, who make the decisions as to particular prevention and treatment measures that will be the most cost-effective. Physicians

**“Those physicians who are willing to develop their role will have an enormously satisfying career ahead of them. Those who don't recognize the change risk seeing their livelihoods decline and their dissatisfaction grow.”**

will have to change their orientation from treating illness to preventing illness.

As an example, suppose I'm a doctor with 200 patients on pacemakers. All 200 patients come to my office and I examine each of them, finding that 10 out of the 200 have a problem with their heart. Under a virtual system, those 200 patients will have their pacemakers transmit data via the Internet to my server. My computer will read the findings and notify me that 10 patients have a problem. So instead of examining 200 patients, I'll only need to examine the 10, and I'll make sure they receive proper treatment, before their health problems become critical.

Interestingly, under the current system, some of those patients may never come in for the examination, so I would not know they had a problem. Rather, I would have spent 95% of my time with patients who basically didn't have a need for care, and I would have missed some who were truly sick. I might only see them when they present at the emergency room with significant care needs that are horribly expensive to treat. Under a virtual system, I can focus on care for the people who really need it. Because of this new, more efficient focus, doctors will be able to render more care to the people who truly need it.

The physician of the future will have to be an excellent manager of information and resources and a master of technology. He or she will also have to understand the financial implications of care so that optimal treatment decisions can be made cost-effectively. He or she will also have to humanize care, taking all the care resources and translating them into meaningful, compassionate care for patients. Those physicians who are willing to develop their role will have an

enormously satisfying career ahead of them. Those who don't recognize the change risk seeing their livelihoods decline and their dissatisfaction grow.

**Q.** *In your concluding chapter you make a powerful argument that there has to be a partnership between the business community, the payers, and the physicians. What is the best way of achieving that partnership?*

**A.** Finger-pointing exercises are fruitless. On one front, the business community has said that physicians were overpaid and that's why health care expenditures were out of control. Well, physician incomes have fallen for the last four or five years and yet expenditures are still out of control. On another front, the physicians and medical groups are saying that employers don't really care about their employees. But we know in today's world that companies that take care of their employees are watching their stock prices skyrocket, while companies that ignore their employees' needs are seeing their stocks sag. So that myth has been debunked as well.

Both groups should recognize that they need each other, and rather than assign blame, just acknowledge the fact that we have a very inefficient health care system that basically was not designed for the demographics or the technology or the financing mechanisms that we have today. Our system simply was not designed to handle that load. What we have to do is redesign the system to accommodate our demographic and technological and financial realities. If we can work together to accomplish that, then we can provide better care to more people than ever before.

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

## California Public Employee's Retirement System Balks at Higher Co-payments

In a decision closely scrutinized by employers, the board of the nation's largest public pension plan delayed final approval in April of a health care rate increase due to concerns about higher co-payments.

The planned changes would boost average health insurance premiums by 4.9% to 8.6% for more than 1.1 million public employees, retirees, and family members covered by the California Public Employee's Retirement System (CalPERS) plan.

The CalPERS health benefits committee recommended increasing premiums paid to HMOs by an average of 4.9% in

2001 and raising most co-payments.

The CalPERS board of directors, however, said it needs more time to consider the implications of doubling co-payments on office visits and brand-name prescription drugs to \$10. Under the proposal, the co-payments for generic drugs would remain at \$5. "The board deferred action on the co-payments plan for 30 days to analyze its impact," CalPERS spokeswoman Pat Macht said. Without the increase in co-payments, premiums would rise by an average of 8.6%, Macht said.

CalPERS, the second largest public purchaser of employee health benefits after

the federal government and the largest in California, boosted its premium payments an average of 9.7% this year.

CalPERS attributed the latest planned premium increase to rising costs, aging membership, and the cost of making the state's hospitals earthquake-proof over the next eight years.

The proposed rate increases by health plans include: Maxicare Health Plans Inc., 2.9%; Cigna, 2.1%; Aetna US Healthcare, 7%; Health Plan of the Redwoods, 4.7%; Blue Shield HMO, 6.9%; Health Net, 5.4%; PacifiCare, 3.2%; Lifeguard, 7.3%; and Kaiser, 4.8%. Universal Care rates will drop by nearly 1%.

## ACP-ASIM Takes Aim at Misuse of Antimicrobials

The American College of Physicians-American Society of Internal Medicine, in Philadelphia, is launching a major education effort aimed at combating antibiotic resistance.

Herbert S. Waxman, MD, ACP-ASIM senior vice-president for education, unveiled the plan at an ACP-ASIM press conference during the college's annual meeting. Waxman said the federal Centers

for Disease Control and Prevention and the Infectious Disease Society of America are partners in the new campaign.

ACP-ASIM will issue a series of educational messages on antibiotic use and will follow up with a number of studies aimed at gauging the effect of the educational program on physicians, Waxman said. "We want to know if the message is changing the way internists practice and we want to

measure patient outcomes," he said.

In addition to educating its members about infection control and correct use of antibiotics, ACP-ASIM will lobby Congress for support of a variety of initiatives including changes in requirements for labeling of antibiotics. Waxman said that ACP-ASIM wants antibiotic labels to include information about antibiotic resistance.

## Catholic Health Association Conditionally Backs Medical Errors Reporting

The Catholic Health Association (CHA) of the United States said in April that it would support a national, mandatory medical-errors reporting system, but only if certain conditions to protect providers from legal liability are met. The CHA is the first national hospital organization to take a public position in the medical errors debate.

"Catholic health care facilities, as well as the executives who lead them, recognize and accept that it is their moral responsibility not only to ensure quality care and the safety of their patients, but also to contribute to and participate in appropriate efforts to produce this outcome," the Rev. Michael D. Place, CHA's president and CEO, said in a statement announcing CHA's position.

CHA said that its board adopted a pub-

lic policy statement that generally reflects recommendations made by the Institute of Medicine. That organization issued a report on the rate of preventable medical errors last year that set off a fiery debate on the issue.

Several provider groups have blasted a controversial new television advertisement sponsored by the American Association of Health Plans as a thinly veiled attempt to shift the national focus away from holding health plans legally accountable for the care they provide.

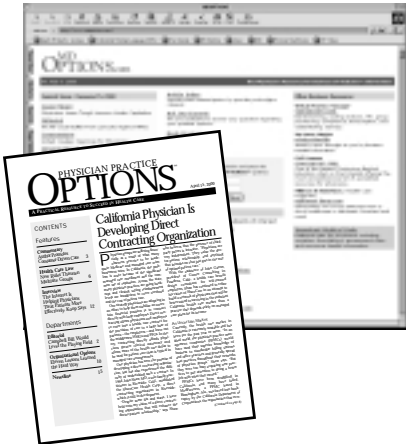
For its part, the CHA said that it is willing to support a national and uniform mandatory reporting system if it will improve clinical care and if it includes legal liability protections and other safeguards. "The focus needs to be on preventing errors and not on finger-pointing

or implementing unnecessary requirements that inhibit and block improvement in the quality of care," Place said.

CHA's policy stipulates nine specific caveats. It says, for example, that the "primary and demonstrable purpose" of a mandatory reporting system should be improving patient safety, not punishing providers. The CHA also calls for immunity for providers, clear definition of the term "reportable events," and appointment of an independent, third party to collect and maintain data reported through the system.

"The commitment to a nonpunitive environment for medical errors reporting is a critical underpinning of this policy to improve quality and patient safety," noted Maureen H. McCullough, CHA's vice president for public policy.

**MD  
OPTIONS.com**



Bookmark **MDOPTIONS.com**  
to your Internet favorites

## Our FREE online resource includes:

- ▶ A complete database searchable by keyword, subject, or issue
- ▶ The top Business of Medicine™ news stories of the week
- ▶ Tools to develop and implement strategies to build your practice
- ▶ Interaction with experts on all aspects of the Business of Medicine™
- ▶ Links to business resources such as group purchasing, practice management, marketing, and CME.
- ▶ E-mail updates on the latest developments in the Business of Medicine™

### E-MAIL UPDATES

Let **MDOPTIONS.com** come to you! **MDOPTIONS.com** can keep you up-to-date automatically on the latest developments in the Business of Medicine™. You can sign up at **MDOPTIONS.com** or fill in your name and e-mail address below and fax it to us at 973-316-5989.

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

E-Mail: \_\_\_\_\_

**TOLL-FREE LINE 888-457-8800**

We are available to answer questions on the Business of Medicine™. This service is free to our readers.

# PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

June 15, 2000



Premier Healthcare Resource  
Suite 300, 99 Cherry Hill Road  
Parsippany, NJ 07054

BULK RATE  
U.S. POSTAGE  
**PAID**  
SMITHTOWN, N.Y.  
Permit No. 15