

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

June 15, 2001

CONTENTS

Features

Commentary
New Systems
Will Help Improve
Care Quality, Says
Health Futurist 3

Strategy
Coding Plan Brings
Positive Results 6

Interview
Health Plan Seeks
a Return on
Investment in
Consumer-
Driven Care 12

Departments

Editorial
Will Public Opinion
Help Spur Health
Reform? 2

Information Systems
Group Finds Value
in a New System 10

Career Options
Gene Research
Creates
Opportunities 15

E-Mail Use Grows Despite Some Resistance

E-mail is a communication strategy that many physicians are now using in their personal and professional lives. But many physicians are reluctant to interact with patients by e-mail, even though patients are interested in communicating with their physicians online. A survey reported in the April issue of the *International Journal of Medical Informatics* found that, while 65% of active e-mail users wish to communicate with physicians by e-mail, only 6% do so, primarily due to lack of physician interest.

Yet the trend is moving toward greater patient e-mail communication with physicians and physician offices. Medem, an e-health network founded by the AMA and several medical specialty societies, says recent surveys show about 40% of responding physicians use e-mail with patients and just under 10% of respondents do so daily.

Convenience and Quality

"Three years ago, physician use of e-mail to communicate with patients was almost nonexistent," says Edward Fotsch, MD, CEO of Medem, in San Francisco. "We see the numbers grow with each new survey we do." More physicians are adapting to the idea, and more employers are demanding e-mail access to physicians, reflecting consumer desires. Furthermore, a report in March from the Institute of Medicine in Bethesda, Md., *Crossing the Quality Chasm: A New Health*

System for the 21st Century, recommends that physicians be accessible 24 hours a day, 7 days a week by telephone or e-mail.

With so many patients demanding e-mail access to physicians, the physicians who offer such access may have an advantage in terms of retaining a loyal patient base. A consumer survey last year by Laurushealth.com revealed that 46% of consumers wanted to be able to e-mail their physicians, and 35% would be more likely to choose a physician who offers electronic communication options over one who does not. LaurusHealth is a health information company in Irving, Texas.

"Physicians who have loyal patients know that the key is making their patients feel important by paying attention to them," says Susan Keane Baker, a physician consultant in New Canaan, Conn. "E-mail correspondence can create that feeling of focused attention, and, as a result, is a practice builder."

After using e-mail for about a year, Joseph Scherger, MD, found that his relationships with patients had changed fundamentally. "I felt closer to them, as in the early days of my practice," he says. The chair of the department of family medicine at the University of California Irvine Medical Center, in Orange, Scherger has been practicing for 23 years.

E-mail greatly reduces phone tag, and allows for the easy transmittal of test results, pre- and post-operative or

(Continued on page 8)

Will Public Opinion Help Spur Health Reform?

Recent actions in two court cases may have lifted the spirits of physicians who follow such matters. Last winter, six Connecticut physicians filed lawsuits against six Connecticut HMOs—Aetna US Healthcare, Oxford Health Plans, Cigna Healthcare, ConnectiCare, Anthem, and Physicians Health Services—for denial of critical services. The physicians were joined by the Connecticut State Medical Society, which brought a class action lawsuit against the six HMOs for care abuses and for illegally withholding millions of dollars of payments to physicians. The AMA and the Connecticut Attorney General backed both lawsuits. Aetna and Cigna said the suits were unwarranted.

Less than a month after the suit was filed in Connecticut, a federal judge in Miami ruled that 20 wide-ranging lawsuits filed against HMO business practices could proceed. He rejected HMOs' calls for dismissal, but set tough standards for the physicians' lawyers to prove racketeering by HMOs.

Finding a clear winner in these legal battles is difficult. The HMOs may win in federal courts because it will be extremely difficult for physicians to argue successfully that the nation's HMOs have conspired under the federal Racketeer Influenced Corrupt Organizations Act. Many physicians may find the practices of HMOs onerous, but proving a pattern of criminal activity amounting to an organized conspiracy will be difficult.

Conversely, physicians might win in Connecticut state court because the six physicians have poignant examples of HMO horror stories.

Regardless of the outcome in either venue, the real winner will be chosen in the court of public opinion. Managed care covers 86% of employed Americans, and no system of care that is so pervasive can sustain itself if it consistently draws negative media attention. Recent polls by the Henry J. Kaiser Family Foundation and the Harvard School of Public Health say Americans are very or somewhat worried that managed health plans put profit before care. When choosing among 12 industries, Americans rate managed care companies as next to last (above only tobacco companies) as doing a "good job," one survey shows.

Such polls may encourage physicians to continue suing HMOs, but lawsuits are likely to bring only limited changes. More widespread reform is needed from Washington, where the HMO industry's lobbying efforts are powerful.

While physicians complain about HMOs, other problems in health care, such as rapidly rising costs and increased concern about medical errors, draw attention away from the problems physicians face. Lawsuits against HMOs may be necessary to help point out some of the inequities confronting physicians as they try to deliver quality care, but those suits are not likely to fix the bigger problems of the health system.



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New Systems Will Help Improve Care Quality, Says Health Futurist

By Richard L. Reece, MD, editor-in-chief

Today's health care environment is characterized by several rifts, which are leading to inefficiency and instability. An electronic communication chasm among managed care organizations, physicians, and hospitals, which is creating inefficiency in information sharing and adding cost to the system, is one prominent example. A credibility gap between hospitals and doctors has developed after years of unsuccessful integration efforts and poor financial results. The rupture in the assumptions of most Americans about the quality of care they receive is highlighted by front-page news accounts of medical errors. These rifts have been caused or exacerbated by outdated or misguided health care models; yet the health care model that will bring stability to the industry remains elusive.

Technology and Quality

"The chasms we now need to cross involve information technology, quality of care, and trust, which are a result of attempts to implement health care models that have been largely discredited," says Russell C. Coile, Jr., MBA, a futurist specializing in health care. "But the industry does not yet have a sense of what the new solutions will be. We need to define a model that will satisfy demanding physicians (who are concerned about their dwindling economics) and consumers (who are becoming alarmed about what appears to be a significant safety problem in the industry)." Coile is the national strategy adviser at Superior Consultant Co., health care consultants in Southfield, Mich.

To Err Is Human, a report pub-

lished last year by the Institute of Medicine, in Bethesda, Md., is driving hospitals to reduce errors and install computer systems and has been effective in getting the industry to bridge the information technology gap. "The IOM study has prompted both discussion and action on the use of information technology in health care," Coile says.

Nevertheless, the limited use of computers among physicians is hindering advances and contributing to

the Internet, it has connected all physicians and hospitals in a system that covers Alaska, Oregon, and Washington. "Distance is not important anymore," Coile notes. "A system like Peace has rural constituencies that are harder to reach, as well as facilities spread across multiple states. Not surprisingly, it has been one of the early adopters of information technology."

Another example is Sacred Heart Hospital, in Spokane, Wash., part of the Providence Health System in

As a result of implementing unsuccessful delivery models, the health system is struggling with issues involving information technology, quality of care, and trust.

substandard safety of care, Coile believes. "While many doctors may not be, by nature, technologically inclined, they will be quick to adopt new technologies that are practical and easy to use," he says. "The computerization of medicine may, in fact, come more rapidly than past progress would suggest. The challenge for the information industry is to develop tools that are affordable for medical offices, not just hospital settings."

Investment in information-driven companies that offer practical clinical solutions will speed up the computerization of the industry. "Such investment will move us much more quickly toward the so-called digital hospital," notes Coile. "But we also need digital medical offices that are linked. Such linkage will probably occur via the Internet."

One example is the Peace Health System, in Bellevue, Wash. By using

Seattle. "This 300-bed hospital estimated that it experienced a 1% error rate across 1.7 million medication transactions annually, at an average cost per error of \$95," Coile states. "As a result, it purchased computerized medication management technology, recognizing that it had an opportunity to improve quality and cut costs significantly."

Despite advances in information technology, the health care industry is facing "the innovator's dilemma," Coile continues. "We are experiencing a period of discontinuous change, when old solutions no longer work. Even so, exciting and potentially powerful new technologies are on the horizon. However, this change is disruptive to both those that have invested heavily in existing technologies and that have learned how to use them and now will have to learn new technology."

(Continued on page 4)

(Continued from page 3)

The government's role in moving the electronic revolution forward will eventually force users to overcome their reluctance. In particular, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires and regulates the use and safety of electronic

medical data, will change the health care landscape. "HIPAA regulations, once approved, will transform the industry," Coile says. "So far, there has been a wait-and-see attitude among practicing physicians, while hospitals and health systems have focused on HIPAA's potential impact. However, HIPAA's effect on practicing physicians could be huge. Many physicians will look to another organization, most likely their local hospital or health system, to give them a HIPAA compliance system that they can implement within their practices."

The effect of HIPAA on practicing physicians could be significant. Yet, to date, physicians have adopted a wait-and-see attitude about the law and its regulations.

ability gap between administrators of health systems and practicing clinicians. "Several years ago, I predicted that the health care industry would experience an acceleration of people with clinical expertise—namely, physicians and nurses—moving into management positions," Coile notes,

"which has occurred to a significant extent. Although important cultural issues involved when clinicians become full-time managers remain, nonetheless that shift has created a bridge between administration and medicine."

Clinician executives can foster organizational success. For example, academic medical institutions in Boston—many of which are run by physicians—are taking market share from suburban hospitals. "Physician management aligns constituencies," Coile says. "Today, physicians manage with true authority, and they make product and process changes in the context of clinical expertise."

Currently, hospitals are struggling to establish sustainable relationships with physicians. But only limited progress has been made, Coile says. "Strong physician groups make strong hospitals," he says. "Most of the best known hospitals in America achieved their status because of the excellence of their medical staffs."

The physician-owned specialty hospitals that are developing in some markets will enjoy mixed success, Coile predicts. "That strategy can work in some markets in which truly excellent physician organizations have aligned themselves with the private specialty hospitals rather than with one of the local community hospitals or the acad-

emic medical center," he observes. While that strategy can be successful, it will not revolutionize the field simply because the sheer number of centers of excellence limits the market share of any one institution.

In addition, Coile cautions that developing a center of excellence to attract physicians and patients must be done strategically. Citing one example, Coile says, "We haven't seen the same level of attention to developing diabetes centers of excellence as we have seen with heart disease centers of excellence. The perception is that some diseases pay better than others. Because diabetics, for example, consume a huge amount of resources, a diabetes center of excellence could potentially become too successful in terms of attracting patients. When an organization treats only extremely sick, high-cost patients, it must have an extraordinarily efficient model of care in order to succeed financially."

Patient-Physician Disconnect

Coile also notes the growing chasm between patients and their physicians. Many health consumers use the Internet to get health information, which they then use in an attempt to participate in decision-making, a role that some physicians do not welcome. In addition, many consumers have expressed an interest in e-mail communication with their physicians, but many physicians are wary of this method of physician-patient communication.

"Ideally, the public would like to be in continuous touch with health professionals by using a variety of media," Coile says.

It is likely that the baby boom generation will drive the trend toward electronic physician-patient communication, Coile notes. "Baby boomers are the ones who hate to wait for service," he says. "They were the first group to bring the Internet revolution to medicine. What's more, they

Bridging the Gap

Until all of its related regulations become effective, HIPAA will be yet another chasm to cross in health care. "But HIPAA will be a bridge to a new model of health care because it will compel medical offices to standardize their network linkages and move to a digital world," Coile suggests. "As that happens, better records for physicians and patients—and better quality of care—will result." Coile adds that HIPAA also opens up the possibilities for e-commerce, as lack of standardization has been a major barrier to allowing health care organizations to communicate electronically.

Another chasm to cross is the cred-

Managed health plans may need to develop models of selective purchasing that influence patterns of care.

have changed the physician-patient relationship by becoming 'empowered patients,' who are at least partially informed through research on the Internet."

In the long term, the rise of Internet consultation is a positive development, Coile opines. "Physicians may initially feel that e-mail communication with patients is simply a new hassle they must cope with," he says. "But I believe it is going to change—and improve—the practice of medicine."

The lack of widespread reimbursement for consultation over the Internet is the most significant barrier to greater physician-patient e-mail communication, Coile says. In general, physician reimbursement ranges from \$25 to \$40 for e-mail consultation. "These fees will have to increase and once that happens, e-mail consultation will become widespread, although often it will be the office nurse rather than the physician who will respond to most online queries," Coile says.

To win physician support, new technologies must increase profit, decrease hassle, and improve the physician-patient relationship. If they gain physician support, new technologies could have a profound effect on the practice of medicine in the 21st century, Coile says.

Reinventing the Model

Currently, one barrier preventing change is a lack of vision in health care, Coile states. "Managed care has reached the practical limits of its intellectual model," he says. "Increasing premiums to cover inefficiencies is not a sustainable business model, and it's certainly not a sustainable marketing model. The industry will have to develop some model of selective purchasing that actually influences the pattern of care."

A new care model will work only if incentives and disincentives are aligned to promote effective decisionmaking. "To date, health plans haven't been creative about incentives," Coile explains. "The only incentive they've come up with is capitation or variations on the theme of capitation." Health plans must develop other incentives that will drive cost-effective decisionmaking.

"We are facing an important transition point in health care," Coile concludes. "But we have a long way to go before we can resolve the issues we currently face."

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

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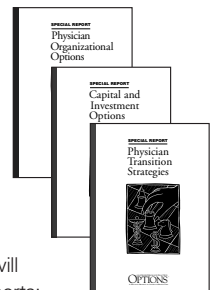
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Coding Plan Brings Positive Results

For Mike Dobrovich, DO, the process of developing and putting in place a coding-compliance plan for his 18-physician primary care practice in Cleveland began with a strong feeling of paranoia and fear of a government audit.

The president and managing partner of Westshore Primary Care Associates, Dobrovich, 49, recently completed the installation of the practice's coding-compliance program. Westshore Primary Care Associates has six offices and works closely with St. John's Westshore Hospital, in Cleveland.

Legal Advice

"Paranoia and fear played a role in getting us involved in developing the plan," Dobrovich explains, but his lawyer had also alerted him to the importance of addressing this issue. "Part of why this was a positive experience for us was due to the guidance of our attorney, Mike Coyne, of Waldheger Coyne, in Cleveland," Dobrovich says. "In addition, we are closely affiliated with a local hospital that was saying the same thing, so we decided to pursue it and started doing so early last year."

Even before the process began, most physicians in the practice agreed that a compliance plan was needed. Therefore, the decision to move ahead was made without much discussion. "The one problem we faced was that once we started developing the compliance program, we had to change our ways of doing things that we had once regarded as sacrosanct," Dobrovich says.

For many physician groups, the issue may not be so clear. The Office of Inspector General (OIG) of the federal Department of Health and Human Services (DHHS) says that all physicians who receive reimbursement from third parties, and particularly those in the Medicare and Medicaid programs, should adopt a plan to comply with the government's voluntary compliance guidelines issued last year. Adopting a compliance plan is an effective form of insurance against a fraud investigation, say consultants and lawyers. The AMA House of Delegates, however, has voted to recommend that physicians ignore the OIG's voluntary guidelines, saying they are cumbersome and compliance regulation is too punitive. Many physicians agree, saying they believe the government's requirements are too intrusive and detract from their primary function: patient care.

Changing Procedures

"Physicians and staff often see this as a very intrusive, government-imposed process," Dobrovich explains. "We all understand the fraud and abuse issue and that the government is trying to contain Medicare spending. But most physicians believe that it is because of the actions of the few physicians who have been greedy and irresponsible that the government has imposed an onerous process on all physicians."

Despite this government-imposed intrusiveness, Westshore Primary Care Associates has found that overall the results of its coding-compliance

plan have been positive, even though many procedures in place before the plan was adopted had to be changed once the compliance plan became operational.

Checks and Balances

Once the group realized that even innocent mistakes could result in serious consequences, the members decided to get their attorney involved. Doing so meant that Coyne, who was knowledgeable about the government's requirements, would have attorney-client privilege in dealing with any questions the government might have about their compliance plan.

Many attorneys who specialize in health law believe that when practices are involved in coding audits, they should seek legal counsel to help resolve issues raised in the process. "Also, the ramifications of some of these compliance issues are broader than you think," Dobrovich says.

The extreme complexity of the task was also a factor in the group's decision to seek the counsel of a health law attorney. "Developing a compliance plan requires that you review everything that your organization does," Dobrovich says. "Do you have adequate and accurate documentation? Are you using the right codes for services? Are you making sure that you are billing for the services that were actually rendered?"

Coding for primary care medicine can be particularly complex, Dobrovich explains. "Sometimes small billing mistakes can make you liable for large amounts of money, and so

While many physicians believe the coding-compliance issue has been thrust upon them unfairly, one group established a plan and reaped a number of benefits in the process.

“Sometimes small mistakes from billing people can make you liable for large amounts, and so you need a system of checks and balances to be sure you are doing things correctly.”

—Mike Dobrovich, DO, Westshore Primary Care Associates

you need a system of checks and balances to be sure you are doing things correctly,” he says.

In addition to reviewing coding and compliance issues, the physicians began reviewing other areas that they originally did not define as being related to compliance. For example, they began to look more closely at whether the physicians they were considering to hire had any Medicare-related sanctions in previous positions. They also started reviewing their vendors, including equipment suppliers, to ensure that none had previously been targeted for Medicare violations.

A Compliance Officer

One of the first tasks for the group was to choose the key personnel who would be involved in all phases of the project. This process involved naming a compliance committee and assigning a compliance officer. “We chose a nurse practitioner as the compliance officer because she is articulate and very good at laying out programs in action and in writing,” Dobrovich explains. “I felt that the compliance officer needed to be someone other than me, because as the head physician, there is the potential for conflicts of interest. The compliance officer should be someone who has an arm’s-length relationship with the physicians and other staff members.”

The group’s committee includes the compliance officer, a senior physician, and the group’s internal accountant. “Since our accounts payable does all the financial analysis and bookkeeping, we added the person who was most responsible for our billing department, and we also ad-

ded the practice manager and others,” Dobrovich says. The committee met once a month for one year and plans to meet once each quarter for the rest of this year.

Getting organized to establish a coding-compliance plan took the group between 25 and 30 hours. In this time, the committee drafted a basic plan and established the required organizational structures. Physicians in the practice spent about five hours each month for about a year on compliance issues, and the compliance officer spent about 10 hours each month on compliance-related activities.

While Coyne had previously outlined the steps the group would follow, there were still some surprises. As the head of the practice, Dobrovich met regularly with all personnel involved in the process, guided the group in enacting the components of the plan, and helped explain the plan to other physicians. After being intimately involved in almost every detail, he found the program to be much bigger in scope than he originally believed it would be.

Increased Efficiency

“I learned that it’s okay to find problems that you were unaware of and that if you can stop thinking of the process as being an intrusion but rather a useful tool in helping you find ways to work more efficiently, it can work well,” Dobrovich says. One benefit of completing the compliance plan, he says, is that it gave the group an opportunity to review and improve other aspects of the practice.

For example, going through the process increased communication among the members of the practice.

“In the plan, we put into place a formal interrogative process and we let staff know that if they have concerns, they have the right to report them,” Dobrovich says. “In analyzing charts, or patients, or billing processes, once you start asking questions, you have to follow through. Don’t ask the question if you do not want to deal with the answer.”

Staff might be confused about a certain coding procedure, something most physicians and staff had assumed was understood, for example. “If someone feels that the procedures are not right, it’s best to review the situation,” Dobrovich says. “In doing so, you may find out that the procedure was correct after all, but at least you clear up any confusion.”

Positive Results

In the end, Dobrovich has found that developing a coding-compliance plan was a worthwhile effort. He also learned that Westshore Primary Care Associates is in the minority among physician groups simply because it has a plan in place.

“We are realists,” Dobrovich says. “You can expend a lot of energy on moral outrage, but whether you think it’s right or not, the bottom line is that the DHHS has a valid point. The fact is that changes are going on in health care, and the government is serious about tracking how it is spending its money.”

—Reported and written by David Kettlewell, in Akron, Ohio. Our Web site (see page 16) has more information on practice strategies. Also, the federal guidelines, Compliance Program Guidance for Individual and Small Group Physician Practices, is available on the Web at www.dhhs.gov/progorg/oig under Compliance Tools.

(Continued from page 1)

medication instructions, and referral information. Patients can use e-mail to provide health updates or to pose questions they may forget to ask during an office visit, and physicians can respond when they choose.

"I began exchanging e-mail addresses with patients simply for convenience," Scherger explains. "I knew how frustrating my practice's telephone system had become, and I wanted patients to get back to me quickly with questions and information. I also wanted to share lab results without having to chase them down by telephone."

Many physician e-mail proponents cite efficiency of work flow as another benefit. "E-mail can replace many patient phone calls to physician offices," Fotsch says. "Most patients call with basic questions. E-mail is quick, and does not interrupt the work flow of office staff. Also, it adds value to a practice because it saves staff time and therefore money."

Message-Pad Replacement

Richard Gould, MD, uses e-mail as a replacement for telephone messages. A pediatrician in Sacramento who has been communicating with his patients by e-mail for four years, Gould says, "E-mail offers a tremendous savings in staff time, reduces after-hours calls, and is more efficient for me and for patients. When patients call, they have to push the proper buttons, leave a message, wait for someone to transcribe the message—which may or may not be accurate—and then wait for me to call back. E-mail eliminates most of these steps, and I can include the printed message in the patient file rather than write a note."

Clarity of communication may improve as well. "We've found that patients often explain their problems more thoroughly in a well-crafted e-mail message than in a hurried phone call to the doctor's office or during an office visit," says Scott Smith, MD,

To E-mail or Not to E-mail?

Whether to accept patient e-mails is an important decision. "The factors affecting the decision to offer online access to patients varies by specialty," says Edward Fotsch, MD, CEO of Medem, in San Francisco. "Pediatricians have high patient volumes and are concerned about being overwhelmed, while neurosurgeons have lower volumes but must deal, at times, with complex issues. There is no one-size-fits-all answer." Medem is an e-health network founded by the AMA and medical specialty societies.

When considering whether to use e-mail to communicate with patients, physicians should assess their communication preferences, particularly whether they even like to use e-mail, says Susan Keane Baker, a physician practice management consultant in New Canaan, Conn.

"A physician should visit a colleague who communicates with patients via e-mail to see firsthand how a system can work," Baker says. "I also suggest that an e-mail communication system be tested with a small group of patients for a limited time." After a few months of testing, the physician, staff members, and patients in the pilot group should evaluate the system.

Physicians should also understand the relevant liability and privacy issues and take steps to manage these issues adequately. One way to do so is to review the guidelines for e-mail communication in health care. Both the AMA in Chicago and the American Medical Informatics Association, in Bethesda, Md., have promulgated guidelines.

Physicians who accept e-mail from patients should establish separate e-mail addresses for medical questions and for other practice activities, such as appointments, billing questions, and prescription refills. Also, telling patients who may read their e-mails is essential. Physicians should also set expectations for turnaround time, Baker adds. —DJN

national medical director for First Health Corp., a national health plan in Downers Grove, Ill. First Health has an online physician-patient communication program for its patients with chronic disease.

"Patients with chronic conditions, such as diabetes or congestive heart failure, tend to benefit from regular physician contact, so that early signs of potentially acute episodes can be caught," Smith explains.

Physicians can link their e-mail responses to Web sites that provide patient education. If physicians can address uncomplicated care issues via e-mail, they may reduce unnecessary visits and spend more time with patients who have acute conditions.

Finally, online communication may help to reduce liability risk. By printing e-mail messages, a written

record of communication is available to offer proof of information sent to a patient. "Electronic communication is essentially like the telephone, but with the ability to obtain a written record and the freedom to respond more thoughtfully at a convenient time and place," Scherger notes.

Fotsch believes online communication between patients and physician offices will soon become standard practice. "As e-mail use by physician practices grows in general, patients will begin to expect online communication with their physicians," he says.

But before e-mail use can become a standard practice between physicians and patients, the issues of confidentiality, security, and privacy need to be addressed. "Physicians express a valid concern that private medical

(Continued on page 9)

(Continued from page 8)

information communicated by standard e-mail may fall into the wrong hands," Fotsch says. "Physicians who wish to e-mail patients should have a system that incorporates some level of user authentication and data encryption so that messages are secure. The use of standard e-mail systems for physician-patient communication is very risky and is not endorsed by malpractice insurers."

Physicians, then, rightly express concern about liability for medical advice provided online, largely because the standards for this type of communication are just now being developed. "Clinical decisions are made according to standards of care," Fotsch states. "But what are the standards for online communication? For example, if a physician provides a patient with information about diabetes and that patient, on his own, decides to change insulin usage with fatal consequences, is that physician liable? These types of issues are of concern to physicians, and malpractice insurers and medical societies have just recently issued standards for these communications."

Mail Call

Another concern physicians have is the excessive use of e-mail by their patients. For example, if patients do not receive any guidance from the physician as to what information is appropriate to send via e-mail, they may send unnecessary or inappropriate information, creating inefficiencies for the physician. Some physicians deny that e-mail communication saves time but rather puts an additional burden on them.

Yet, many physicians who communicate with patients by e-mail say this fear is unfounded. "While physicians typically worry that they will be overwhelmed by patient e-mails, both survey data and anecdotal data indicate that the opposite occurs," Fotsch says. "Physicians are surprised by how little patient e-mail they receive from

E-Mail Guides Are Online

Given the projected increase in use of physician-patient e-mail, the AMA has published guidelines to help physicians manage such communication. They are available on the AMA's site on the Internet (at <http://www.ama-assn.org/ama/pub/category/2386.html>).

The American Medical Informatics Association in Bethesda, Md., also has drafted guidelines, which also are available online (at www.amia.org/pubs/other/e-mail_guidelines.html).

—DJN

their patients, since more than 70% of the e-mail is administrative and replaces phone calls to the office."

E-mail volume would be less of a concern if physicians were reimbursed for their time spent with patients online. Concern about reimbursement is especially acute for physicians who may lose revenue-building patient visits by answering questions online.

Since January, First Health Corp., which has 10 million enrollees nationwide, has been reimbursing physicians \$25 for online consultations with patients.

More than 300,000 First Health enrollees and their dependents who suffer from such chronic conditions as diabetes, asthma, congestive heart failure, and HIV, and who have established relationships with physicians, can participate in the program.

Patients and physicians interact in a designated section of the First Health Web site, Smith says. To make online visits meaningful clinical encounters, First Health physicians developed simple templates to help facilitate communication.

Once the patient submits the information, the physician receives e-mail notification that a visit is waiting at the First Health site.

First Health hopes that the regular physician contact encouraged by e-mail will facilitate the detection of early warning signs of complications for these diseases. "Clinical studies suggest that patients with chronic conditions who communicate with their physicians frequently are more

likely to avoid acute problems and hospitalizations," Smith notes. "Enhanced communication between doctors and patients can help improve outcomes."

New Initiatives

Similarly, the Silicon Valley Employers Forum, an organization in Sunnyvale, Calif., including Cisco Systems, Oracle Corp., Adobe Systems, Cadence Design Systems, and NEC, began a pilot program in April that allows employees to communicate online with their physicians. The program is testing an online system developed by Healinx Corp., a company in Alameda, Calif., that provides Web-based, physician-patient communication services, and will pay physicians \$20 for each online "visit." About 2,000 employees and 100 physicians are eligible to participate in the service, in which patients are encouraged to inquire about non-urgent health matters. Healinx estimates that this system can reduce office visits by 20%.

In the fall, Medem plans to introduce a Web-based consultation service in which physicians can be reimbursed for online visits.

Facilitating online communication by reimbursing physicians for visits may enhance patient satisfaction. "Online visits provide patients with more convenient and meaningful access to care," Smith says.

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

Group Finds Value in a New System

David Wilcox, PhD, and Stephanie A. Clayton, MHSM

Changing to a new practice management or electronic medical record system can be a daunting challenge for any medical group. Implementing such systems can take months, and total costs often drive the average practice into a financial descent. But the physicians at one pediatric medical practice in southwestern Ohio found a way to meet that challenge without experiencing the pain normally associated with such wrenching change.

Like these physicians in Ohio, many other doctors nationwide are seeking to integrate new information systems and the Internet into their practices. High on the list of services physicians are seeking are information systems for diagnostic reporting, claims processing, pharmaceutical information gathering, medical office products acquisition, e-mail communication with patients, and electronic medical records.

Web-Based Applications

Thanks in part to the Internet, digital storage, and retrieval of data, records management has been transformed into content management (see table, "From Records to Data," page 11). With the re-engineering of how content is managed, physicians and practice administrators can use health information technology to help increase practice efficiency. The

David Wilcox, PhD, is the chief information officer, and Stephanie A. Clayton, MHSM, is the regional operations manager, for Pediatric Physician Alliance Inc., in Norcross, Ga. Pediatric Physician Alliance provides Web-based business products and management services to medical groups. More articles on information system are available on our Web site (see page 16).

result is an unprecedented level of access, improved security, and increased economies of scale.

Despite the number of advantages computer systems offer, physician groups have not gotten involved in

A new information system helped a practice get payments from insurers within two weeks, and fewer claims were being denied.

streamlining transaction processing by reducing dependence on phone calls, faxes, and e-mails with the speed some analysts had anticipated.

One Solution

Although the prospect of buying and installing a new system may seem daunting, one practice found the process went smoothly and the new system began paying dividends right away. Early this year, Pediatric Physician Alliance Inc. (PPA) worked with a five-physician pediatric practice in southwestern Ohio that purchased and installed PPA's product, IntegriMed. An integrated suite of Internet-based business products and services, IntegriMed automates processes and business tasks for medical groups. At first, the physicians worried that the new system could take months to install and would incur unexpected cost overruns. Instead, the entire process took only a few weeks and came in on budget. Even better, it solved many administrative problems almost immediately.

Before installing the new system, the pediatric practice submitted more than 50% of its claims manually, and the practice estimated that about 20% of its denied claims were due in part to the burden of keeping up with multiple contractual requirements

from insurers. The average payment cycle time was 64 days, and it took from five to 10 days before a paper claim was mailed to the appropriate party. Insurance verification did not occur before the patient encounter,

and a lack of verification was one of the most frequent reasons insurers returned claims unpaid.

A daily claim review process was not in place to ensure that clean claims would be submitted. If a claim was denied after an average of 30 to 60 days from the date of original receipt, significant follow-up was required before refile could occur.

All patient encounter forms were printed the night before, instead of when a patient checked in. This procedure often led to more work due to cancellations or rescheduled appointments. Also, since staff used a paper scheduling system, and the schedule was often misplaced and could be difficult to read, scheduling errors and delays occurred.

Scheduling Conflicts

Another problem the practice faced involving schedules was that the staff did not have a central directory of patient names and telephone numbers. Therefore, if a physician had to cancel or reschedule appointments, the staff had to pull all the charts of the patients involved to get their telephone numbers.

Super bills often were missing at day's end. Staff estimated that about 2% of all paper encounter forms were lost, in part because patients walked out with them. When encounter

forms were missing, staff could not balance out the day's activities. Clearly, the practice needed a new system.

Before any physician group begins the process of selecting software, advisers suggest that the physicians and practice administrators establish specific criteria for the system, and then match the system to the criteria. The practice in Ohio, for example, wanted a system that could:

- Offer immediate online insurance eligibility, verification, referral authorization, claims processing, and payroll management
- Provide instant and sound financial and operational reports
- Allow data migration from legacy systems during installation
- Allow quick and easy staff training with minimal up-front costs
- Upgrade the software continuously and remotely and service the database at no additional cost
- Provide value-added services through direct online links to medical suppliers, pharmaceutical companies, and other services

Financing Options

After reviewing the specifications from a number of information system vendors, the medical practice chose IntegriMed, in part because PPA offered attractive financing options. IntegriMed requires no large capital expenditures for software, hardware, or licensing fees and can be purchased by paying PPA a percentage of collections. The percentage to be paid was much lower than traditional billing service charges of 7% to 10% of total billing.

Once installation began, setting up the hardware, connecting the circuits, and importing and testing data in the new system were completed within two weeks. Training on the system took two days. During the second day, staff began building patient schedules.

In the end, the system was installed

From Records to Data

In the past, most physician groups managed paper records. Today, many groups are using information systems to manage data.

Records	Data
How can I track multiple pieces of paper?	How can I aggregate similar data?
How long does it take to find one document among many?	How can I select data in just a few seconds?
Where can I store all the documents?	How can I integrate multiple systems that are used to store data?
How can I make content available to all staff who need it?	How can I centralize documents stored in different media?

Source: Pediatric Physician Alliance Inc., Norcross, Ga.

on schedule and within budget. The practice now has a system that replaces its old manual administrative processes and automates scheduling, appointment tracking, centralized patient data, eligibility checking, claims submission, and billing.

Today, the practice sends the majority of its claims over a secure online exchange system, and is migrating from a dial-up modem to a high-speed ISDN line. The practice has 12 computers, which allows information to be shared instantly at workstations throughout the office. All of the computers are accessible to administrative staff, nurses, and physicians throughout the practice.

Insurance verification is done online before an office visit—addressing one of the most frequently cited reasons for claim denials—and internal prompts in the practice management system ensure that claims are completed properly.

Staff can now look up patient demographics online so they are not continuously pulling charts. In addition, nurses can see at any time the status of each patient—from registration to check out—from their own workstations.

Staff are responsible for balancing

out their own activities at the end of each day, making it easier to match charges with claims. Physicians and designated personnel also can obtain a snapshot view of the financial and administrative health of the practice off-site as well as at work.

Outcomes Data

The specific financial effect IntegriMed is having on the practice will take several months to determine. Within the first few months of installation, however, payments from national insurers were being received within two weeks and fewer claims were being denied.

The physicians have seen a dramatic change in their day-to-day operations, especially after a local newspaper published an article about how the practice was one of several that moved into a new office building and was using advanced technologies. Within the first two weeks of operating in the new building, the practice had seen more than 15 new patients.

The practice shows clearly how a small group in a rural location can use new information technology to simplify processes and improve the way it does business. ■

Health Plan Seeks a Return on Investment in Consumer-Driven Care



George Halvorson has served as president and CEO for 15 years at HealthPartners, a health maintenance organization in Minneapolis and one of the largest health plans in Minnesota. Prior to that time, Halvorson was CEO of an international health care organization that set up health plans in Jamaica, Chile, and Spain. He was also the founding CEO for Blue Cross HMO in Minnesota, and is immediate past chair of the American Association of Health Plans. Richard L. Reece, MD, editor-in-chief, conducted this interview.

Q: What is HealthPartners, and how big is the health plan?

A: HealthPartners is the result of a 1992 merger of MedCenters Health Plan and Group Health Inc., two of the first HMOs in Minnesota. We have approximately 660,000 enrollees and are the largest HMO in Minnesota based on HMO enrollment. We are the third largest health plan in Minnesota if we include all insurance functions. About 40% of our membership comes to us through self-insured employers.

Our care system includes clinics we own and clinics that we work with under contract. Our HealthPartners Medical Clinics employ 550 physicians, about 60% of whom are doing primary care. The contracted clinics

include about 11,000 physicians.

Q: What is the guiding principle of HealthPartners?

A: Central to our organization and its functions is the belief that consumers and physicians are partners in health care. We believe that partnership is essential to achieving our goal, which is improving health. The original HMO model was intended to improve health, but until recently that wasn't accomplished very successfully and the science of illness prevention has been fairly rudimentary.

HealthPartners is now developing into a new type of health plan that will meet consumers' needs, particularly their demand for choice. We are changing from a more traditional health plan model into a facilitator of consumer choices about health.

Q: How does HealthPartners facilitate consumer choice?

A: We are now, in effect, the equivalent of a 401(k) plan administrator for health. We let employers define the contribution that they would like to make on behalf of their employees, and then we offer their employees a wide range of health care choices. On one end of the spectrum, we offer a plan with an open panel network of 11,000 doctors to which employees can self-refer. On the other end, we offer a closed panel plan, which is a traditional staff-model HMO. We offer diversified choices, including PPOs and traditional HMOs, and as many

as a dozen health plan choices. We are working on a medical savings account option for people who want to take a higher deductible and have more flexibility in their health care spending.

Employees can choose the type of plan they want in this continuum, and also whether to have a \$500 deductible, a \$1,000 deductible, full HMO benefits, HMO benefits for co-payments, or other configurations. In sum, we have created a whole series of choices, and we are finding that consumers are very pleased.

Q: How have you determined consumer needs?

A: Over the past three years, we did several major surveys and held face-to-face meetings and several waves of focus groups. We discovered that several aspects of our plan are highly valued by consumers. We had by far the highest consumer rating in the state as the plan that actually works to improve enrollee health. We also had the highest consumer and buyer ratings across plans for our quality improvement efforts.

However, we found that consumers had several serious issues with our customer service. The primary service issue was access to caregivers. Enrollees were frustrated with delays in getting an appointment. Enrollees also were angry about how customer service calls were handled. They expressed strong dislike for our automated telephone system, which offered a menu of options to the

“It makes a huge difference in enrollee satisfaction when people can get care the day they need it. And, to our surprise, we found that we were saving significant staffing costs.”

“Since we started calling people at risk of death from influenza and inviting them in for a flu shot, our flu deaths have dropped by 50%.”

caller—press one for billing, two for claims, three for referrals, and so on.

I sat in on some of these focus groups and was shocked at the intensity of the anger regarding these issues. We realized we had to develop more consumer-focused systems.

Q: *How have you resolved the appointment-delay issue?*

A: We have made a major commitment to same-day appointments. Now, for all of the 25 clinics we own, we have successfully implemented a same-day patient appointment strategy. We are working with six of our contracted clinics to implement the same approach. The program has been entirely implemented in our HealthPartners Medical Group clinics, and we have expanded it to our mental health clinics so most of those patients can be seen on the day they call.

We took a very systematic approach to achieving this result. To start, we had to burn down the backlog of appointments. So there was a time in which physicians and clinic staff worked longer days, as well as on their days off and on weekends. Then, we implemented the same-day appointment system by using flexible daytime scheduling. We first implemented the approach in several pilot clinics, proved that it worked, and then had physicians from those pilot sites explain the approach to others in the HealthPartners Medical Group.

In our first pilot clinic, before we implemented same-day appointments, only 40% of patients surveyed checked the top two spots on a satisfaction scale of one to ten. After same-day appointments were fully implemented, that percentage was up to 80%. It makes a huge difference in enrollee satisfaction when people can get care the day they need it.

Interestingly, we received an amazing and completely unexpected side benefit from this system. We knew from our surveys that members wanted same-day appointments, and we were prepared to spend a little extra money to achieve this goal. But, to our surprise, we found that we were, instead, saving significant staffing costs. First, fewer receptionists are required because scheduling appointments is much more straightforward. We also need fewer nurses because we no longer need triage nurses to handle patients' issues over the telephone. Third, we closed our daytime urgent care centers, which we had traditionally maintained to care for patients who needed immediate care and who couldn't get in to see their own doctors. Finally, our six nighttime urgent care centers have cut down to half staff because they used to treat thousands of overflow patients—now nonexistent—from the daytime centers.

Overall, due to that unexpected increase in efficiency, we were able to reduce our staff by roughly 220 employees. Amazingly, we had a complete structure in place built around the delay in care. We were so used to it being there that we could not even see it.

Q: *How did you resolve the second issue of concern, regarding customer service calls?*

A: The old automated menu had been required because our billing system was separate from our claims system, and those were separate from the referral system. And our membership system was different and separate from the rest of the systems. Accordingly, the information on each of those systems was available only to a select set of staff members. So, members with problems had to

talk to employees who worked with each system. Furthermore, a service representative who could not answer a question on the first call would research the issue and put the information into the computer. When the enrollee called back for an answer, the enrollee would get the next available service representative, who would then have to become familiar with the enrollee's problem and the information in the computer file. So, a member who called us three times on the same issue would talk to three different people and have to explain the issue each time.

To bring a customer focus to calls, we completely reorganized our internal data systems so that we could have all information available to one person at the point of call. We compiled all information into a single, simple, common system, and then trained member services staff so that they can answer every question. Now, when enrollees call member services, they get a staff member who can resolve 95% of all calls on the first contact. That's more than a 50% improvement over the old system. Since we get more than a million calls a year to our member service lines, that's a lot of people getting a better result.

Even more important, for the 5% of questions that can't be resolved immediately, the service representative gives the enrollee his or her name and a private phone number so that the service representative can help the enrollee until the question is resolved. Customers are much happier with the new approach.

Q: *Can you describe your efforts related to improving health?*

A: Rather than have a generic commitment to improving health, we decided a few years ago to

(Continued on page 14)

(Continued from page 13)

become aggressive with regard to health promotion. Accordingly, we set some specific quantifiable goals. For example, one goal was to reduce the number of heart attacks by 25%. That goal is one of the reasons we have 95% physician compliance on the prescription of beta-blockers, which are part of the best possible strategy for preventing second heart attacks.

We also created a goal to reduce by 25% the number of enrollees who would develop diabetes. And, very recently, we have an objective of

they are walking 10,000 steps each day. This program has been well received—some participants are almost fanatical in terms of keeping track of their activity levels. It encourages people to stay active, and gives them an immediate reward because there is a definite sense of satisfaction in achieving a high number.

In addition, we have identified within a health registry some 100,000 enrollees as being at high risk for one of our targeted diseases. Using that list, we aggressively follow up with these people to provide the

guidelines—never rules—and the focus is on best practices rather than on cost savings. To date, ICSI has developed 50 guidelines. This is a super approach—extremely capable physicians developing evidence-based care guidelines that we then use for our members and patients.

The good news for Minnesota patients is that all Minnesota health plans—Minnesota Blue Cross and Blue Shield in Eagan, Minnesota Medica Health Plan in Minnetonka, Minnesota PreferredOne in Golden Valley, Minnesota and UCare Minnesota in Minneapolis—are now accepting these guidelines as their standard for care. In the past, physicians who worked with several plans might have had three or four competing sets of guidelines about the care of each type of condition. Now, all physicians and plans are accepting these ICSI care standards, and the ICSI guidelines have received great popular support because they are developed entirely by physicians.

The plans that use ICSI guidelines cover 80% of Minnesota's citizens, who can now visit the ICSI website (www.ICSI.com) to see what to expect for their care. In addition, physicians around the nation can access the ICSI guidelines on the Web if they are interested.

Q: Such a focus on consumer-driven health care seems to be transforming the health care industry. Do you agree?

A: In terms of the pure and rigid form of traditional health plans, that statement is absolutely true. The reason HealthPartners has adopted a consumer focus is that consumers want choices for care and high-quality care. In order to be successful going forward, the health plan model for the future must satisfy these consumer needs.

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

“We will begin to see an evolution to use graduated benefits, so that consumers can pay for the level of care they want.”

reducing the number of people who commit suicide by 50%.

Once we set a goal, we re-examine the overall health system to determine how to achieve it. We have brought together some of the brightest, best physicians, counselors, and other caregivers and asked them how we can change our system to reach our goals. As a result, we are now the benchmark plan in the country for diabetes care according to the National Committee on Quality Assurance, in Washington, D.C. We were one of two care systems in the country recognized last year by the American Diabetes Association for clinical excellence. For our behavioral health patients, we've doubled the size of our care network, increased same-day access, and cut the number of complaints about that care by 75% this year. Because the suicide goal is new, we don't have the results yet, but we've already made major process changes that we believe will help us succeed.

Another health promotion program is called 10,000 Steps a Day. We ask participants to use a pedometer and stay active to the point where

necessary preventive care. For example, we call people at risk of death from influenza and invite them in for a flu shot. Our flu deaths have dropped by 50% since we put that program in place.

Overall, we have created a whole support system of telephone contacts, dietitians, counselors, and other communication tools to help people achieve health. By focusing our efforts, we can now actually have an effect on prevention that we didn't have before.

Q: HealthPartners is also a founder of the Institute for Clinical Systems Improvement (ICSI). How does ICSI encourage quality care?

A: The ICSI was actually co-founded by HealthPartners; The Mayo Clinic, in Rochester, Minn.; and the Park Nicollet Clinic of St. Louis Park, Minn. The mission of ICSI, which is entirely physician-run and physician-governed, is to review the very best science available and determine the most appropriate medical approaches for common conditions such as low back pain, high blood pressure, diabetes, and bladder infections. ICSI creates

Gene Research Creates Opportunities

By Kent Bottles, MD

Even if only half of what is being reported in the media about genetics research is true, the effect of gene research on the practice of medicine will be dramatic. Diagnosis, treatment, and classification of common diseases, such as heart conditions, diabetes, and common epithelial cancers, will soon be transformed by the ongoing research into gene function and gene associations. From *Time* magazine cover stories to questions from anxious patients who surf the Internet, practicing physicians are already being challenged to incorporate genetics into their daily practice of medicine.

Traditional genetics has been associated with specialty practitioners (geneticists) who treat patients suffering from rare diseases often caused by single-gene mutations, such as Huntington's disease, cystic fibrosis, and Marfan's disease. The new genetics, however, will take place in primary care offices and deal with the genetics of common chronic diseases, which are thought to be associated with multiple genes, not mutations.

Diagnosis and Treatment

Based on new genetics research, the methods physicians use to diagnose illnesses will change as genetic susceptibility tests become readily available. These tests will enable physicians to detect common diseases long before the patient even develops symptoms. Some genetic susceptibility tests now being developed use biochips to detect genetic differences in a single nucleotide building block

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of DNA, known as single nucleotide polymorphisms.

The ongoing development and availability of pharmacogenomics also will revolutionize the methods physicians use to treat patients. Pharmacogenomics, which involves examining how genetic differences affect the way individuals respond to various drug therapies, will enable physicians to tailor the drug treatment for each patient's specific genetic makeup and thereby to avoid drugs that will be ineffective or will cause adverse reactions.

Although the new genetics promises much in the way of improvements in health care, many practicing physicians appear to be unprepared for incorporating genetics into their daily practice. In a

tion will help clinicians to communicate clearly the meaning of the results of a genetic susceptibility test for each individual patient. When considering therapeutic options, both patients and physicians need to become more comfortable discussing relative risk compared with that of the general population.

Everyday Genes

Among the other issues involving the new genetics is patient privacy, which must be protected by all health care professionals so that patients can benefit from the genetics research but avoid being discriminated against for insurance and employment opportunities.

Physicians can keep abreast of current genetics research and how it will

Understanding genetic predisposition will help clinicians to communicate the meaning of susceptibility tests to patients.

Georgetown University study of 1,958 health care professionals published last year, researchers found that 70% of physicians and other providers had discussed genetics with their patients, and 30% had provided genetic counseling, but less than 10% had confidence in performing these services.

To provide up-to-date clinical care to patients, physicians need to learn about a variety of issues concerning genetics. Currently, more than 450 genetic susceptibility tests are available, but exactly when to order and how to interpret the results of those tests are questions that physicians are only now beginning to ask. Understanding the basics of risk assessment and genetic predisposition

will affect their practices by reading relevant articles in medical journals and by attending CME conferences, such as those given by Cambridge Healthtech Institute in Chicago (June 8-9) and San Diego (June 15-16). More information on such conferences is available on the Web (at www.genomics101md.com).

Physicians who understand what is happening in this rapidly evolving area of medical research will be ready to take advantage of the types of cutting-edge diagnostic tests and therapies likely to be readily available to them in their treatment of patients in the not-so-distant future.

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

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