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INSIDE

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The keys to being prepared for Y2K: Planning, planning, and more planning

Check medical equipment; set up a contingency plan

Editor's note: As the clock ticks toward the new millennium, physician practices should make sure their information systems and medical equipment will be working in the year 2000 (Y2K). Last month, we examined the steps you should take to ensure that your computer software and hardware will survive the transition from New Year's Eve to New Year's Day. In this issue, we take a look at medical equipment and supplies, payers, and what other practices are doing to prepare for Y2K.

If your practice hasn't started getting ready for the year 2000, you'd better start now. Come the millennium, you could lose access to your patient records, experience medical equipment failures, face a shortage of critical supplies, or be held accountable for harm to your patients.

A U.S. Senate committee report released Feb. 28 estimated that 80% of the nation's 800,000 physician offices had not yet upgraded their computers and other equipment to make them Y2K-compliant.

"It does appear that doctors are a bit late in the game. The message we are trying to send is that being a little later than other industries isn't the problem, but failing to get started can have dire consequences," says **Jim Kalyvas**, JD, a partner in Foley & Lardner law firm in Los Angeles and a speaker at the American Medical Association's Year 2000 Advanced Regional Seminars, held earlier this year.

Small glitches can cause large problems

Even if you feel your practice is totally in compliance for Y2K, you still need a contingency plan to deal with unexpected problems, says **Joel Ackerman**, chief executive officer of RX2000, a nonprofit clearinghouse on the millennium bug for health care providers in Minneapolis.

"Any kind of glitch in the system, even if it involves small items, can have significant ramifications for your practice," he says. **(For tips on what to consider when designing a contingency plan, see p. 52).**

The bad news is that if you haven't already started planning for the year 2000 and implementing those plans, you're already behind. The

good news is that because of the work already done on this issue in other industries, there is a lot of accumulated knowledge that will allow you to jump-start your efforts, Kalyvas notes.

"However, I want to emphasize that the key is to jump-start it now and get the effort under way. If practices haven't started, they're going to have to aggressively push it," he adds.

How much the Y2K problem will affect your practice — and how much it will cost you — depends on how much you rely on technology.

"Corporations are spending millions of dollars, but I don't see that in the cards for any doctors' offices. They could spend $50,000 for staff time and upgrades, or it could go much higher," Kalyvas says.

Expenses can mount up

But if a practice relies on a practice management system that's not Y2K-compliant, it probably will have to outsource the billing and record keeping until a new system is installed. That's simply because there may not be enough time to shop for a new system and have it installed. This expense could run in six figures, Kalyvas adds.

"It can get expensive very quickly depending on what your practice is and how responsibly the vendors you work with have responded," he says.

Even if your practice uses paper records, documentation, and billing, you still need to take steps to make sure you're not at risk in the new year.

"There are emerging standards of care in year 2000 compliance. If a physician doesn't take those steps, it's just like performing surgery without taking all the proper steps. If something goes wrong, the doctor will be held accountable," Kalyvas says.

For instance, if a piece of equipment you use for diagnosis, monitoring, or treatment fails, you could be held liable — even though you aren't the equipment manufacturer — unless you have been diligent in checking the equipment for Y2K compliance**. (For a list of some medical devices and other equipment that may be affected by the millennium bug, see box, above right).**

That's why you need to establish a diligence trail including paper and other documentation showing you made every effort to ensure the equipment is Y2K-compliant. **(For steps you should take to ensure compliance, see related article on p. 51.)**

Door locks to vents: The problem is everywhere

Here's a list of some of the critical equipment you should check or have checked for Y2K compliance.

- Infusion pumps in intravenous drips
- Critical care equipment
- Ventilators
- Heart defibrillators
- Pacemakers
- Intensive care monitors
- Fetal heart monitors
- Medical lasers
- Treadmills that are hooked into computer monitors
- MRIs, CT and PET scans
- X-ray equipment
- Dialysis equipment
- Chemotherapy and radiation equipment
- Monitoring equipment such as telemetry and electrocardiograph monitors
- Laboratory equipment
- Elevators
- Health and cooling systems
- Communication systems such as telephones and pagers
- Fire alarm systems
- Timed-control lighting systems
- Electronic door locks

If you sign any new contracts with insurers between now and the first of the year, you're going to have to assure the payers your systems are Y2K-compliant, reports **Robert Goldstein**, chief executive officer of the Browne-McHardy Clinic in Metairie, LA.

"All the contracts that are coming across my desk require us to warrant that we are compliant and to indemnify the plans against the risks associated with not being compliant," he says.

The year 2000 problem arose because computer hardware and software use a six-digit field to represent dates, with the "19" in the year being assumed. When the year 2000 rolls around, some computers will read "00" as "1900." Computer software and hardware are likely to be affected if they are more than a few years old. **(For information on how to check out your computer equipment, see *Physician's Managed Care Report*, March 1999, pp. 33-35.)**

However, any biomedical device that has a microchip in it also can be affected. According to

Ensuring your equipment is Y2K-compliant

Here are seven key steps you should take to ensure your practice's equipment is Y2K-compliant:

1. Check your serial numbers against the Food and Drug Administration database to find out if your equipment is compliant or needs a maintenance upgrade between now and the end of the year, advises **Jaren Doherty**, Y2K program manager at the National Institutes of Health in Bethesda, MD. The FDA database is located on the FDA Web site. Address: www.fda.gov/cdrh/yr2000/year2000.html.

Check the equipment by serial number and not by model number. Equipment manufacturers buy microchips from a variety of sources. That means identical equipment could have different microchips.

2. To be sure your practice is not at risk for problems caused by equipment malfunctions, take the extra step of contacting each vendor to get their assurances that their equipment complies, says **Jim Kalyvas**, JD, a partner in Foley & Lardner law firm in Los Angeles and a speaker at the American Medical Association's Year 2000 Advanced Regional Seminars, held earlier this year.

Ask for written certification of equipment compliance. Keep a detailed log of telephone inquiries.

3. Even if your equipment isn't date-sensitive, check it anyway. Some manufacturers use recycled chips, which means your equipment could have a dormant date that could malfunction.

4. Be prepared to replace some of your equipment if the manufacturer declares it's obsolete and will no longer support it.

5. Remember that the closer it gets to Jan. 1, the more difficult it is going to be to get new equipment because manufacturers are going to be backlogged with orders.

6. Don't test your biomedical equipment on your own before checking with your attorney to make sure you are not taking on the manufacturer's liability in case a piece of equipment fails, warns **Gayle Finch**, director of the office of information technology analysis and investment for the Department of Health and Human Services in Washington, DC.

"Typically, manufacturers' testing protocols are considered to be proprietary information. Most of them are still covered by a nondisclosure agreement, and even if you want to test, you may not be able to do it," Finch says.

7. Make sure any new equipment you purchase includes a written guarantee that it is year 2000-compliant, Finch adds. ■

the Food and Drug Administration, more than 100,000 medical products in more than 1,700 categories could be affected by the Y2K problem.

Only a small percentage of biomedical equipment has an electronic component, and only a subset of that will have any problems, says **Gayle Finch**, director of the officer of information technology analysis and investment for the Department of Health and Human Services in Washington, DC.

"Most biomedical equipment tends not to have a Y2K compliance problem, but for the machines that do, it can be a big problem," she adds.

If your equipment is 10 years old, you can assume that the embedded chip won't be Y2K-compliant, adds **Jaren Doherty**, Y2K program manager at the National Institutes of Health in Bethesda, MD.

With more recent equipment, you need to check it out and get assurances from vendors that it is compliant, he adds. **(See above for a list of steps to follow when checking equipment compliance.)**

The experts predict that some small equipment manufacturers may go out of business rather than going to the expense of making their products compliant. You should be prepared to deal with this contingency.

Kathleen Quinn, RN, MBA, director of practice management services for the Health Service Foundation of the University of Virginia in Charlottesville, reports that some of her vendors of used equipment were unable to verify Y2K compliance for their products. The health system was forced to find other suppliers for those products.

Utilities, elevators, communications equipment such as interoffice telephones and pagers, and fire alarm systems in your office building all can directly affect your ability to practice medicine.

After you have checked and rechecked everything, consider an audit by an outside agency.

"The next step for us is going to be having an outside firm come in and double-check our compliance," reports Goldstein.

Don't confine yourself to checking only the systems in your own office. Make sure the vendors and payers you rely on will be able to function on Jan. 1. **(For more about payers and their Y2K readiness, see related article on p. 53).**

The AMA recommends setting up a triage system for dealing with Y2K issues. Here are some steps to take:

- **Evaluate everything you do on a daily basis that relies in any way on a product or service that might not be Y2K-compliant.**
- **Decide which failures could cause the most harm to your patients or could cause the most harm to your business.**
- **Put them in order and start working down the list.**
- **If an item isn't compliant, decide whether you're going to get it repaired or replace it.**
- **Save noncritical items until last.**
- **Come up with a contingency plan in case a particular piece of equipment or system doesn't work.** ■

Contingency plans smooth transition to the New Year

Check out all your potential points of failure

The contingency planning you do today will make your practice run much smoother when the year 2000 rolls around, the experts say.

"A contingency plan is a key issue, because there are a lot of potential points of failure that should be addressed," says **Joel Ackerman**, chief executive officer of RX2000 in Minneapolis, a nonprofit clearinghouse on the millennium bug for health care providers.

Leon A. Kappelman, PhD, a University of North Texas in Denton professor and co-chairman of the Society of Information Management Year 2000 Working Group, suggests a communitywide contingency plan to make sure all patients are not in danger.

"There are bound to be glitches in the system, no matter how much checking everyone does. Nobody is going to have the time to fix everything. We should focus on where we can do the most good in terms of taking care of the community," he says.

It's not enough to make sure your computers, biomedical equipment, communications systems, and other technology are Y2K-compliant. To be prepared, physicians must anticipate what can go wrong with all their outside vendors, Ackerman and other experts say.

"Contingency planning is important even if you think you are going to be ready," says **Jack Gribben**, chair of the President's Council on Year 2000 Conversion in Washington, DC.

Gribben suggests making a list of all the outside organizations on which you depend and identifying what you can do if each of their systems fail. This includes suppliers, utilities, communication equipment, payers, and contractors.

Think it through

For example, think through what you will do if certain kinds of medication or equipment can't be delivered because of a disruption in the transportation or manufacturing process.

Here are other tips for contingency planning:

- Decide how long you will wait after an equipment or system failure before your contingency plan goes into effect.
- Consider what you will do if you have an influx of patients because other practices or hospitals are experiencing difficulties, suggests the American Medical Association.
- Prepare now for a rash of worried telephone calls from patients and their families who are concerned about what may happen in the year 2000. The RX2000 Web site is already getting e-mail messages from patients who are concerned about their insulin supply or pacemakers, Ackerman says.
- Make paper copies of your patients' files ahead of time, particularly the following:

— those who have appointments in the early part of the year;

— those scheduled for hospital admission;

— those who are likely to need hospitalization;

— those who have chronic illnesses and are likely to seek treatment.

- On Jan. 1, 2000, or before your office opens for business on Monday, Jan. 3, be prepared to check all of your equipment to make sure it is operating correctly, advises **Gayle Finch**, director of the office of information technology analysis and investment for the U.S. Department of Health and Human Services in Washington, DC. ■

Line up financial goals to stay solvent in 2000

Y2K could wreak havoc on your cash flow

The year 2000 could have a dire effect on your practice's financial health unless you take steps now to set up a cash reserve to cover lapses in reimbursement, says **Michael Zimmerman** of Zimmerman & Associates, a health care receivables consulting firm in Hales Corners, WI.

Zimmerman and other health care industry executives predict that it could be April 2000 — or later — before health care providers see regular payments again from payers because of the millennium bug.

A General Accounting Office report concludes that "because of the magnitude of the tasks ahead and the limited time remaining, it is unlikely that all of the Medicare systems will be compliant in time to guarantee uninterrupted benefits and services into the year 2000."

The firm recommends that providers have three to four months' worth of operating expenses in a contingency fund to fill the payment gap.

Your practice may already be feeling a reimbursement pinch if your own billing data isn't Y2K-compliant, Zimmerman adds. The Health Care Financing Administration (HCFA) has instructed carriers and fiscal intermediaries to return as unprocessed any electronic and paper claims that are not Y2K-compliant as of April 5.

Beginning on that date, claims need an eight-digit date to be processed, according to the HCFA directive. For instance, May 1, 1999, would be 05/01/1999. If you still use a six-digit date field in your computerized records, your computer won't be able to distinguish the year 2000 from the year 1900.

"This means that many hospitals and medical group practices could see the disastrous effect of Y2K as early as April 5," Zimmerman says.

This is only a taste of what could happen when the new year rolls around, he adds.

"Medicare historically is one of the best payers. Medicare claims are usually paid in 14 to 21 days. If a practice relies on Medicare for half its business and that is shut off or delayed, it could have dire financial effects," Zimmerman says.

A Zimmerman & Associates survey of nearly 1,000 chief financial officers in the health care industry showed that 83% of respondents expect a slowdown or temporary suspension of claims payments from major payers when the new year rolls around.

All the financial officers surveyed indicated that some part of their internal financial systems are not ready for the millennium, and nearly half reported that their business offices are not taking steps to work with payers to optimize cash flow after Jan. 1, Zimmerman says. **(See chart, p. 54.)**

The health care chief financial officers rate HMO and private-sector payers as slightly better-prepared for the year 2000 than federal payers. However, some private payers have been slow to start Y2K compliance efforts because doing so involves increased operation expenses without the prospect of an immediate return, Zimmerman says.

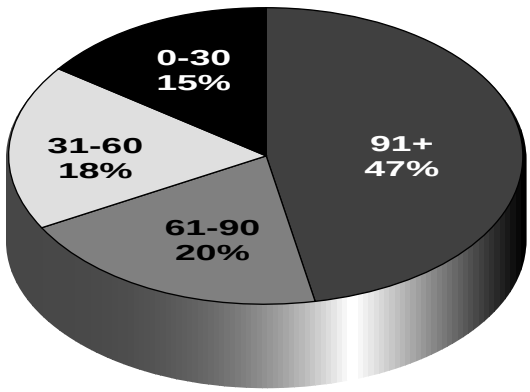
Robert Goldstein, FACMPE, chief executive officer of the Browne-McHardy Clinic in Metairie, LA, doesn't anticipate much of a cash flow problem in the New Year. About 60% of his practice's business is capitation.

"My worst-case scenario is that we won't be getting paid the dollar amount for every enrollee, but we'll be paid an estimate, based on December's figures. We've had problems with payers who missed deadlines because of lack of data in the past, but they've always been able to accommodate us at least by an estimated amount," he says.

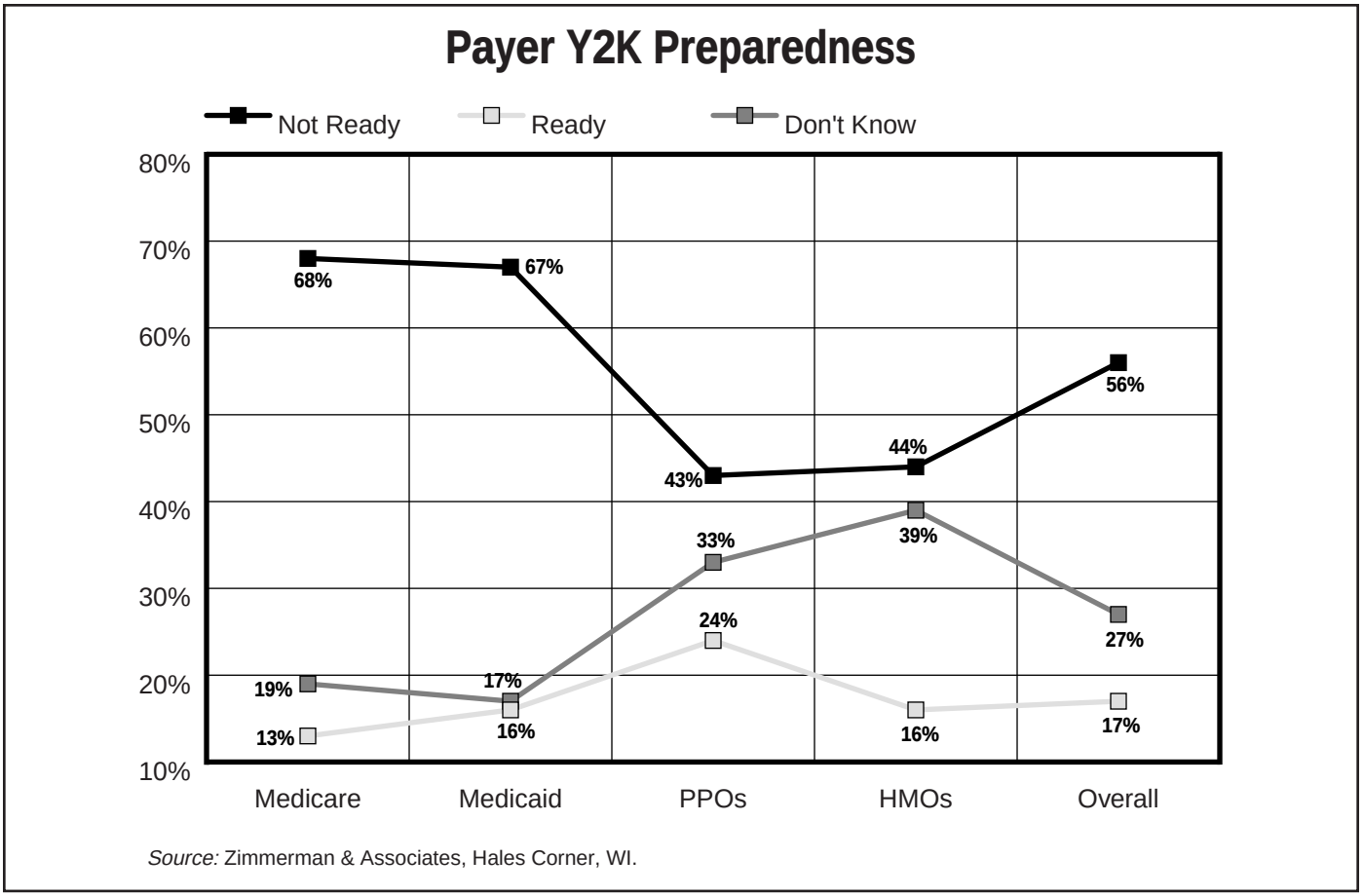
Zimmerman & Associates advises its clients to build up their cash reserves as a cushion against decreased reimbursement in the early part of 2000.

"When businesses look at building up reserves, they usually either sell inventory or clean up

Days of Cash on Hand Planned by Practices



Source: Zimmerman & Associates, Hales Corner, WI.



Source: Zimmerman & Associates, Hales Corner, WI.

their receivables. Physicians can't sell inventory, but the practices all have a lot of money tied up in receivables," Zimmerman says. **(See chart, p. 53.)**

He gives the example of an extremely large practice group that produces $1 million a day in revenue. If it takes an average of 100 days to get a claim paid and the practice reduces it to 75 days, that's a 25-day improvement, which amounts to $25 million in extra cash, Zimmerman says.

Here are some tips for setting up a reserve fund:

• Set up a Y2K task force to develop a strategic plan to clean up your receivables.

• Focus first on collecting the high-dollar accounts that are long overdue.

• If certain companies are holding onto a lot of receivables, ask for them.

Don't count on taking out a short-term loan to tide you over. Banks are struggling with their own set of Y2K problems, and there's no way of knowing how lines of credit will be affected.

[Editor's note: Zimmerman & Associates may be reached at 5307 S. 92nd St., Hales Corners, WI 53130. Telephone: (414) 425-2189.] ■

Sources for Y2K help

The American Medical Association has published a book titled *The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice*. The 73-page manual includes information on liability, insurance coverage, medical equipment, and payment/billing issues. Members of the AMA can download the entire document from the AMA Web site. The publication also can be ordered by calling the AMA customer service center at (800) 622-8335. The cost is $25 for AMA members and $100 for non-members.

The AMA Web site is an interactive resource for physicians and provides regularly updated information about Y2K problems and how to solve them. Address: **www.ama-assn.org/**

You can request Y2K compliance from the Food and Drug Administration by writing to: Attn: Medical Devices Coordinator, Center for Devices and Radiological Health, Mail Code HFZ-Y2K, 9200 Corporate Blvd., Rockville, MD 20850. Also, the FDA operates a Web site that is a clearinghouse on information for Y2K compliance

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of medical devices. Address: **www.fda.gov/cdrh/yr2000/year2000.html**

The FDA encourages medical device users and health professionals to report malfunctions or problems with devices under the FDA's MedWatch Program. The program can be used to report devices that are suspected or determined to fail due to Y2K problems. For more information on the MedWatch program, call the MedWatch office at (800) FDA-1088, or visit the Medwatch Web site. Address: **www.fda.gov.medwatch**

Rx2000 Solutions Institute is a nonprofit organization that acts as a clearinghouse for information on issues relating to Y2K in the health care industry. The organization offers a variety of services to providers, primarily through its Web site. The Rx2000 home page includes checklists for Y2K compliance, how-to advice, and links to other Year 2000 internet sites. Telephone: (612) 835-4478. E-mail: info@rx2000.org. Web site: **www.rx2000.org**

For more information on Y2K compliance, contact Jaren Doherty, Y2K program manager at the National Institutes of Health, Center for Information Technology, Office of Information Resources Management, 6100 E/2B-03, 6100 Executive Blvd. MSC7505, Bethesda, MD 20892-7505. E-mail: jaren-doherty@nih.gov. Web site: **wwwoirm.nih.gov/y2000**

You can also contact the President's Council on Year 2000 Conversion, Room 115, Old Executive Office Building, Washington DC 20502. Web site: **www.Y2K.gov** ■

As your risk increases, case manager role grows

They can save money and improve patient care

Your practice is at risk for a patient with congestive heart failure who makes repeated visits for care. How do you control the time you spend on the patient and the cost to your practice?

An elderly patient needs personal care to live independently, but her insurance doesn't cover it. How do you help her tap into community resources?

You see a number of obese, sedentary patients who could benefit from wellness activities, but your patient load doesn't give you time to counsel them. How do you help them stay healthy?

These are all scenarios in which a case manager could help you manage the details of patient care. If your practice is bearing substantial risk for the cost of patient care, you might consider hiring a case manager to collaborate with your physicians.

"When there is an incentive to keep patients out of the office or emergency room and manage their care by phone or by self-care, case managers become quite attractive," says **Kathleen Quinn**, RN, MBA, director of practice management services for the University of Virginia Health Service Foundation in Charlottesville.

In the traditional fee-for-service environment, physicians may not have many incentives for hiring a case manager. But in a highly capitated environment, the incentives for hiring a case manager to work in your practice can be substantial.

The more risk, the more reward

"The more risk the physician bears for the patients' cost of care, the more likely it is that the physician will look toward utilizing a case manager to help manage the care," says **Maureen Cadogan**, CCM, CPHQ, RN, principal of Cadogan Consulting in West Covina, CA. Cadogan helps medical groups put together case management programs.

The first case managers usually dealt with only high-cost catastrophic cases, such as brain injury or spinal cord injury patients, says **Sue Binder**, RN, CCM, principal of Integrated Healthcare Consultants in Caldwell, NJ. Her firm contracts with physician practices to manage patient care.

Now they can help take care of many of the details involved in today's patient care, leaving physicians free to assess, diagnose, and treat patients, she adds.

"The whole practice of medicine has changed radically from being paid for treating the sick to a capitated system which rewards the physician to keep the patient well," Binder says.

Because of their experiences with insurance company case managers, some physicians may feel that case managers are trying to second-guess the doctors, says Binder. But that's not true, she says, adding that case managers are collaborators with the doctors.

"The physician has to focus on the clinical aspects, but there are many other areas of patient care where the case manger can collaborate," Binder says. **(For information on the jobs case managers can take on, see article on p. 61.)**

Case management still is fairly rare in physician practices, but some groups are finding it beneficial.

Pediatric home visits

Most of the University of Virginia clinics are still paid on a fee-for-service basis. However, the pediatric office has some risk-bearing contracts and uses case managers for everything from visiting newborns at home to managing chronic or terminal diseases.

Now that new mothers are being discharged from the hospital so quickly, the UVA clinics find that routine well-care visits by case managers can make a difference. The case manager can check on the baby, answer the mother's questions, help new mothers avoid an unnecessary office visit, or make sure they bring the baby in if there is a need for it.

"So many first-time mothers are unsure of themselves and they don't live close to their mothers and grandmothers. If their baby needs to be seen, judgment calls are hard to make," Quinn says.

The case managers also help families manage the care of children with chronic or terminal diseases such as asthma, leukemia, or cystic fibrosis. Their interventions help reduce emergency room visits and admission to the hospitals, Quinn says.

"Our payer mix is still heavily weighted toward fee for service. As the payer market changes, we will be more incentivized to use case managers," Quinn says.

Instead of having its own case manager, Greensboro (NC) Orthopedic Center employs a nurse who acts as a liaison to case managers, particularly in workers' compensation cases, says **John Nosek**, MPA, CMPE, executive director.

"Her role is to make sure the patient care is completed as effectively and as efficiently as possible and to make sure our workers' comp patients don't fall into a black hole," Nosek says.

For instance, Nosek's case manager makes sure patients are getting to therapy, helps get the patients back to work, and notifies the insurance company if patients aren't compliant.

"It has an indirect monetary benefit, because if patients are out of work a shorter length of time than is the norm, we are apt to get more employers to send patients to us," Nosek says.

One of the practice's workers' compensation employers has the lowest out-of-work rate in the nation for his company, Nosek says.

[Editor's note: For more information on standards of practice and credentialing of case managers, contact the Case Management Society of America, 8201 Cantrell Road, Suite 230, Little Rock, AR 72227. Telephone: (501) 225-2229. E-mail: cmsa@cmsa.org. Web site: www.cmsa.org.] ■

Would a case manager work for your practice?

Here's how to find out

How do you know when your practice can support a case manager? It depends on your individual situation.

Maureen Cadogan, CCM, CPHQ, RN, principal of Cadogan Consulting in West Covina, CA, helps medical groups put together case management programs. She knows of one two-physician practice that has hired its own case manager. "Their volume of patients was busy enough that they felt it warranted the intervention of a case manager," she says.

However, she points out that this practice is the exception. Generally, it takes three or more physicians with high caseloads to support a case manager, she says.

Sue Binder RN, CCM, says her experience shows that any group with 100 or more doctors can benefit from case managers. Binder, principal of Integrated Healthcare Consultants in Caldwell, NJ, contracts with physician practices to manage patient care. Practices with a large Medicare population or a busy medical/surgical component are also good candidates, she adds.

Smaller practices have the option of hiring an independent case manager as a consultant, Cadogan says. Independent case managers will work either on an hourly basis or on a case-by-case basis.

Or, you might consider contracting with one of your insurers to provide case management for your patients.

Here are some questions to ask yourself before you hire a case manager:

What a case manager brings to the game

Here's what a case manager could do for you

Case managers can collaborate with physicians in a variety of ways, says **Sue Binder**, RN, CCM, principal of Integrated Healthcare Consultants in Caldwell, NJ. Here are some jobs a case manager can perform:

• **Advocating for the patient.**

The case manager works with the insurer to make sure patients get the treatment they need.

• **Identifying alternative sources of services.**

"When you have benefits that cover A and B but not C and D, you look beyond the insurer and tap into community and church resources," Binder says.

She describes her work as creating a "patchwork of reimbursement." For instance, a lot of senior citizens need custodial care, such as help with meals, light housekeeping, or personal care to live independently. Most insurers won't cover these services. In these cases, Binder looks for Meals on Wheels, senior citizen centers, or church volunteers to fill the gap.

• **Preventive care.**

Case managers can set up wellness programs for your practice or plug your patients into programs that are already operating in the community.

"There's no sense in reinventing the wheel. A lot of hospitals and community agencies are developing health awareness programs. If there's a good program in the community, the case managers can steer patients toward that," Binder says.

• **Utilization review.**

At Brown-McHardy Clinic in Metairie, LA, nurse case managers precertify outpatient procedures any time a physician wants to order a diagnostic study that costs more than $350, says **Kathy Calahan**, RN, director of health services.

First, they make sure the patients are still eligible for coverage from their health plans. Then they check to see if the request meets criteria established either by the health plan or HCFA guidelines. If it doesn't meet the approved criteria, the request is sent to the Utilization Management Committee, a group of 12 physicians who make the final decision and give the physician alternatives.

"We don't have nurses denying care. If it doesn't fit the criteria, we sent it to the UM committee," Calahan says.

• **Disease management.**

Case managers help patients with chronic or terminal illnesses learn to manage their diseases and avoid office visits, hospital admissions, or emergency room visits.

"Even a reduction in repeated emergency room visits can count as soft savings when you consider that the physician has to be involved every time a patient goes to the emergency room," Cadogan points out.

If you are in a capitated contract, at least a portion of the emergency department costs could come out of your pocket, she adds.

Browne-McHardy Clinic contracts with an outside disease management company to manage the care of their congestive heart failure and diabetes patients, Calahan says.

"They educate the patients on their disease and call them regularly to remind them of what to watch for," she adds.

For instance, the case managers remind congestive heart failure patients to weigh themselves and ask if they have noticed any swelling.

• **Resource management.**

"We want to get the patient to the right place at the right time and at the right cost," Binder says. Seeing that women get regular mammograms and come in for Pap smears and pelvic examinations is crucial.

[Editor's note: Sue Binder can be reached at 29 Cedars Road, Caldwell, NJ 07006. Telephone: (973) 228-2301.] ■

• Do you have substantial financial risk if you don't manage certain cases?

• Do you have a lot of chronically ill or elderly patients with multiple comorbidities who are taking up a lot of your time?

• What are salary norms for case managers in your area?

• What would be the direct costs to your group?

• What would your cost savings be if you were able to better manage patient care? ■

Choose your case manager carefully

If you're considering hiring a case manager, follow this advice from the Case Management Society of America:

• Make sure you hire someone with clinical experience. Depending on your practice's needs, you may hire a nurse, a social worker, or a rehabilitation professional. **Maureen Cadogan**, CCM, CPHQ, RN, principal of Cadogan Consulting in West Covina, CA, recommends hiring someone with at least five years' clinical practice experience.

• Make sure the case manager's experience is related to your practice. For instance, if you serve a large geriatric population, consider hiring a social worker with experience working with the elderly. If you have an orthopedic practice with a lot of workers' compensation cases, consider hiring a case manager experienced in workers' comp.

• Hire only people who have case management experience, advises **Sue Binder**, RN, CCM, principal of Integrated Healthcare Consultants in Caldwell, NJ. Otherwise, it may take a long time for the case manager's efforts to pay off.

• Choose a case manager with whom you and your staff can work. The case manager has to collaborate with a lot of people in your practice. There's no time for personality conflicts.

• Hire someone who is capable of doing multiple tasks without getting stressed out.

• Look for a case manager with good computer skills. Familiarity with information technology equipment is a must in that job.

• Be sure your case manager keeps his or her skills up to date.

• Consider hiring a credentialed case manager. There are six credentials for case managers, including care manager certified (CMC), certified case manager (CCM), certified disability management specialist (CDMS), certified rehabilitation registered nurse (CRRN), continuity of care certification, advanced (A-CCC), and certified professional in health care quality (CPHQ). ■

Henry Ford builds a better managed care doctor

Managed Care College expands on skills

Faced with an increasing number of managed care contracts, the Henry Ford Health System in Detroit started its own continuing education program to help professionals learn to work more effectively, efficiently, and comfortably within today's managed care environment.

Now in its fifth year, the Managed Care College has evolved from a mostly didactic program to a combination of classroom lectures and hands-on projects that teach participants how to improve the clinical care process.

"The only way people are going to acquire and master skills to analyze and improve the way we provide care is to actually do it," says **John Wisniewski**, MD, MHSA, director of the Managed Care College.

The nine-month course is open to doctors, nurses, allied health professionals, administrators, and social workers within the Henry Ford Health System. Each year, the health system invites treatment teams and individuals from across the system to apply for a slot at the Managed Care College. For most terms, there are fewer open slots than applications.

Wisniewski spearheads the teaching, assisted by a group of about 20 core faculty members who do classroom presentation or work behind the scenes.

Participants attend 10 classroom sessions between November and June and work on a project in which they apply what they learn in the classroom to make improvements for their own patients. **(See story, p. 63.)**

"If we just bring them to the classroom and lecture about clinical improvement and new advances in health care delivery, they may walk away with a better understanding, but it by no means guarantees they can do it in the clinical setting," Wisniewski says.

COMING IN FUTURE MONTHS

- How to negotiate and work with pharmacy risk contracts
- The best way you can manage your Medicare HMO patients
- Proven techniques for minimizing claim denials
- Developing and implementing practice protocols

Wisniewski compares learning more effective and efficient care to learning to play a musical instrument.

"We don't just bring students to the classroom and play recordings or talk about music theory. The way they learn to play the instrument is to receive instruction and practice on their own to discover their own technique," he adds.

Topics in the 1998-1999 sessions include understanding health care as a business, quality improvement, population and disease management, outcomes research, interdisciplinary teamwork, benchmarking, measurement and statistical tools, evidence-based care, and clinical guidelines and decision making.

Hands-on work

The course includes an open discussion about finances and politics involved in managed care contracts as well as the big economic picture in health care today.

"But when you get right down to it, the most important thing to do is to analyze the care process. If you're not doing that, the financing and all the rest is not going to be that critical," Wisniewski says.

Participants in the managed care college are asked to look at the group of patients they care for and to do an honest assessment of how effective their practice is. These are among the questions they must answer:

- Do they accomplish what they want to accomplish?
- Do their practices illustrate the best scientific-based practices for the patients they are caring for?
- How can they improve their own practices' performance?

"We use the rapid cycle improvement model, which is currently demonstrated to be one of the more effective ways of improving care. They don't spend a lot of time analyzing and studying it to death. They gather enough information to make good decisions, try things out on a small scale to see if they work, then move onto the next cycle of learning," Wisniewski says. **(For tips on conducting your own improvement process, see story on p. 64.)**

The Henry Ford program is specifically geared to the needs of the health system. However, staff do conduct programs outside the institution and provide consulting services to a wide variety of health care organizations, Wisniewski says. ■

Improved care, new skills result from 'college'

Participants study their own practices

Each participant in the Managed Care College at Henry Ford Health System in Detroit designs and completes a clinical improvement project within nine months.

"Our aim is not only to improve care for the patients we are taking care of now, but to help our professional work force master a new set of skills and the confidence they need to continually improve care for our members," says **John J. Wisniewski**, MD, MHSA, director of the program.

Typically, an interdisciplinary team that cares for the same group of patients will take on a project to improve care of those patients.

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Editorial Questions

For questions or comments, call **Glen Harris** at

Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Executive Editor: **Glen Harris**, (404) 262-5461, (glen.harris@medec.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.
Editor of **Physician s Capitation Trends: Reba Griffith**, MPH.

Conduct your own care improvement project

You don't need to go to managed care college to improve care in your own practice, asserts **John Wisniewski**, MD, MHSA.

Wisniewski is director of the Managed Care College at Henry Ford Health System, a nine-month hands-on course to teach health care professionals how to better meet the needs of the managed care practice and population they serve.

Having structured lessons that accompany your improvement project may make it easier, but any health care professional can take on a project to improve patient care, he says.

"What you need is confidence and drive, and the ability to focus on the goal of improving your own learning and your care for the patient," he adds.

Start small, Wisniewski suggests. Find some area of your practice you would like to improve, come up with ways to make the improvements, institute changes, and measure your results.

Here are some tips for developing your own projects:

• **Work with your colleagues.** "This type of learning works best when done in a social setting. There is a tremendous amount we can learn from each other," Wisniewski says.

• **Keep your goals moderate.** Don't expect so much of yourself that you become frustrated.

• **Recognize that there is not a right or wrong way of doing things, only consequences of choice.** "If you're looking for the one best way or right way, you'll get frustrated," Wisniewski warns.

• **Find the best solution you can and try it out.**

• **Recognize that learning doesn't stop in the professional school.**

• **Be open to new ideas.** "There is a wealth of new information that comes to us, not just within our own profession but from other disciplines and other industries that have enormous applications inside health care," Wisniewski says. ■

Here are some of the projects the teams have completed in the past:

• A physician and a nurse from an ambulatory primary care clinic looked at how they managed patients with chronic congestive heart failure. They conducted an assessment of their practices and outcomes and found that most of the patients were not getting any real education on how to manage their disease. For instance, patients did not know how to monitor their weight, what symptoms signaled an exacerbation in their condition, or self-management techniques. They found that some medications being prescribed were not always the most effective, and that some of the record keeping and monitoring in the clinic was not as good as they would prefer.

The team set up self-management classes for patients and changed the medication for patients who were not receiving the recommended optimal doses or the right medication.

"In addition to improving care for this set of patients, the physician and nurse learned lessons about teamwork and went from a more passive role of working within existing structures to an active role in shaping processes," Wisniewski says.

• A team from a hospice program found that its use of pain management medication varied among patients and physicians. The team studied the cost and lack of efficiency involved in varying doses as well as the potential for suboptimal patient dosing. They came up with a way to standardize and improve pain management.

• The treatment team at an inpatient geriatric unit found that a large number of elderly patients had active urinary tract infections that were not picked up immediately or not treated adequately. They instituted a whole range of interventions that included improvements in catheter insertion decision making, setting the optimal intervals for medications, and even designating cranberry juice as the default fruit juice on the meal trays. ■