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INSIDE

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American Health Consultants® is A Medical Economics Company

Fostering good on-the-job health can boost your practice's visibility

Getting involved with local employers pays dividends

As the health care market becomes more and more competitive, practices have to do more work to differentiate themselves for patients and prospective patients as well as employers and payers. One way to achieve that goal is by making your practice more visible in the community.

Lyne Chamberlain, RN, BSN, MEd, MBA, MHA, manager of marketing and new business development at the 80-doctor Physician Associates of Florida, felt one way to do that for her eight-office Orlando practice was to participate in work site health programs. The practice specializes in primary care, obstetrics, and gynecology and has about 130,000 commercial managed lives on its patient rolls, out of about a million in the Orlando area. "We've been doing health fairs in offices, screenings at the work place, and classes on issues such as stress management and body mechanics for a long time," she says. "But recently it has become a part of our marketing strategy. We used to do them when we got requests from a company or payer. Now we are more proactive."

> **"The goal has been to get employers to insist to their payers that we be included in their health plans."**

The results have been mixed, says Chamberlain, with little measurable impact on the number of patients coming to the practice. But she says the goodwill such programs foster — with employers, patients, and payers — makes the time and expense worth it. **(For more on running a successful program, see story, p. 87.)** "The goal has been to get employers to insist to their payers that we be included in their health plans," she says. "And to get employees to either select us when they start with a company or change to us. That is the theory, although we haven't proved it yet."

Ken Goldberg, MD, a physician with Texas Urologists in Lewisville, started his practice's work site health program 10 years ago. "Men make 130 million fewer visits to physicians than women," he explains. "They are more comfortable in a nonthreatening environment like a work

place. That's why we started reaching out."

Goldberg started by approaching area occupational nurses for guidance on which companies to target. The first programs featured a discussion on health issues, followed by some offering exams or screenings. That initial discussion has evolved into a 12-minute videotape. The screenings take about 30 minutes each.

To conduct the program, Texas Urologists uses nurse practitioners, physician assistants, and one physician who is on maternity leave and likes the part-time aspect of the job. The screening program, which includes employers such as American Airlines, has taken off. Goldberg's practice travels around the country putting on programs, advertising them through posters and payroll stuffers. It has become so large that the practice has hired a coordinator whose main duties include handling all the logistics.

Set your sights locally

Chamberlain has a list of all the employers in her area that have at least 1,000 patients with the practice. Those are the ones she calls on. While getting through to the right person is often difficult, once she has the right name, Chamberlain doesn't have a hard time convincing them to take part in a program. "When I say, 'We take care of 23,000 of your employees,' they don't have a problem working with us."

Most times, the employers are very interested in working with the practice. "They see it as a benefit they can offer employees," she says. Costs are shared — and the costs are actual costs without any mark up — and include nurse time and any lab fees. Among the programs that sell best to employers are flu shot clinics. "That means the employee doesn't have to leave work, travel to our office, set up an appointment. It also means they are less likely to be out sick later in the year."

Goldberg had a harder time selling his program to companies because it focused on men. However, because a number of his target businesses already had work site programs for women — such as mobile mammogram clinics — he was able to push his idea as being fair to the other half of the workforce.

When a program is coming up, Chamberlain sends out e-mail requests to the various offices for volunteer physicians to attend. "I tend to contact the offices near the employer in question, and I concentrate on particular specialists, depending on the topic." For instance, a family practitioner or internist would be better able to address stress management issues than a pediatrician. Nurses also are asked to participate.

Getting physicians involved is one of the keys to success, Chamberlain says. "Meeting the doctors is a really positive tool for building relationships," she says.

With some of her physicians, such as family practitioners and internists, the sheer volume of patients they have makes it hard for them to participate. "They're just swamped right now and aren't thrilled with my requests. But we have had some extra capacity among pediatricians and obstetricians."

Selling physicians on the idea can be difficult because they are already busy and have increasing pressures on their time. But Chamberlain says you can convince them to participate by letting them know that physicians who take part in community activities tend to be the physicians whose panels grow the most. More patients mean more income, she adds. Such programs also can benefit the entire practice through the free advertising that such events provide, both on the site of the event and through local papers, which often provide coverage. If the event is big enough, you may even get a photograph and a news story out of it.

Despite her commitment to the program, Chamberlain questions whether the work site health strategy has any concrete cause-and-effect benefits. "We had one insurance account that was fairly new, and we did a number of programs with them. They had 700 patients who could sign up with us, and 350 did. But after our programs, those numbers didn't grow. We thought that with as much as we were doing, with all that visibility, the number would jump."

But there are other benefits that are less visible,

Chamberlain explains. "It can be hard to tell how people make decisions on choosing a doctor. The fact that they have seen us out there and met our physicians sends a message to them that we are interested in promoting health. When they go to their insurance companies, we hope they will insist that we be on their provider list. And while they may not use us, they may recommend our practice to others."

There may also be a cumulative effect when the screenings and seminars are combined with other marketing efforts Physician Associates has. For instance, if they hear a radio advertisement, prospective patients might remember that the practice held a program at their office.

There is a true community service aspect to the programs, Chamberlain says. "We have identified diabetics and people with dangerously high blood pressure through these. The screenings help patients."

Like Physician Associates, Texas Urologists has spotted problems during the screenings. "Picking up disease breeds a lot of goodwill," Goldberg says.

"Even if we don't find a direct relationship between these events and getting more patients, I think we will keep up with it," Chamberlain says. "I think that there will be a demand for this from both employers and payer. And it creates a positive impression that will pay off in the end." ■

Tips for improving work site health programs

Start by knowing your market

If you are planning to use work site health fairs, screenings, and seminars as part of your marketing program, consider the tips from two practices who know. **Lyne Chamberlain**, RN, BSN, MEd, MBA, MHA, marketing and new business development manager at Orlando, FL-based Physician Associates of Florida and **Ken Goldberg**, MD, of the Lewisville, TX practice Texas Urologists say that to be successful, you must:

1. **Know your patients and who they work for.** Chamberlain says demographic studies will give you this information.

2. **Concentrate on local employers, at least initially.** "If you are around the corner from a big company, it makes sense to go over and talk to them," Chamberlain says. "After all, you are their neighbor."

3. **Find a champion in the company.** "If you find someone in human resources, especially if they are a patient or former patient, you are more likely to be successful," Goldberg says.

4. **Choose events that make sense.** Chamberlain explains that this means screenings and seminars that either make use of your practice's expertise or connect with passions of your staff. For instance, some of the staff at Physician Associates are involved with the American Diabetes Association. Doing blood sugar screenings builds on this relationship and gives the practice a chance to team with a national organization. If you have obstetrics, team up with the March of Dimes.

5. **Stay on schedule.** This is important not just to the patients, says Goldberg, but to the employers who want to limit the time their employees spend off the job.

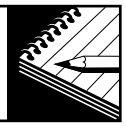
6. **Make your efforts appropriate to your size.** If you have a two-physician practice, don't commit both doctors to a large event; that means you will abandon existing patients.

7. **Be efficient, but provide education.** Goldberg explains that work site screenings have to include more than a "drop your pants, bend over" exam. "You have to provide education and take advantage of the opportunity to interact with people." ■

SOURCES

- **Lyne Chamberlain**, RN, BSN, MEd, MBA, MHA, Marketing and New Business Development Manager, Physician Associates of Florida, 2301 Lucien Way, Suite 230, Maitland, FL 32751.
- **Ken Goldberg**, MD, Texas Urologists, 541 W. Main St., Suite, 150, Lewisville, TX 75067. Telephone: (972) 420-8500.

GUEST COLUMN



Bad debt can be a bottom-line buster

Here's a quiz to gauge your effectiveness

By **Reed Tinsley**, CPA

With what seems like a continuous decline in physician reimbursement, it is imperative that practices collect every dollar they are entitled to. But we all know that doesn't always happen, so mechanisms and systems need to be in place to avoid bad debt situations as much as possible. The following is a bad debt control checklist you can use to assess whether a medical practice is prepared to minimize its bad debts. Any "no" answers should be investigated immediately, followed by recommended solutions.

1. **Do written guidelines exist on the collection of self-pay accounts?** ❑ yes ❑ no

Every practice should have written guidelines to show its employees how to collect self-pay and patient-pay accounts. Those are accounts for which the patient might not have insurance or the amount shown is the figure the patient owes after his or her insurance has paid.

2. **Are collection guidelines reviewed and revised periodically?** ❑ yes ❑ no

Medical practice in today's environment does not remain constant, and neither should the internal policies of a practice. This is especially true of collection policies, which should be reviewed and revised periodically. For example, many practices formerly refused to press patients for payment of their overdue accounts for a variety of reasons; but with insurance reimbursement declining, that type of policy may have to be reconsidered.

3. **Are collection guidelines clear, concise, and sufficiently detailed to serve as a working reference to personnel?** ❑ yes ❑ no

You want an understandable document that clearly outlines employees' duties. This not only minimizes training time but provides employees with a guide they can refer to on an ongoing basis.

4. **Do business office personnel receive formal training on collection guidelines before beginning work?** ❑ yes ❑ no

Upfront training can prevent and even eliminate many of the day-to-day problems that occur within the practice. Don't just throw employees into the water and assume they can swim. The good practices take time to train their employees as soon as they start work and then on an ongoing basis thereafter.

5. **Do employees receive formal training on collection guidelines after any revision or, otherwise, at least annually?** ❑ yes ❑ no

Here is the main point about a guideline: Do the employees follow it? Employees are almost always going to tell you that they do, but what are the actual results? Are the guidelines really working? There must be a continuous assessment to ensure they are working and effective.

6. **Does management solicit employee suggestions for changes in policies and procedures?** ❑ yes ❑ no

The best practices constantly solicit employee feedback. Listen to your employees — they often have good ideas on how to improve various aspects of how the practice operates.

7. **Do exceptions to approved guidelines require the approval of management on a case-by-case basis?** ❑ yes ❑ no

If a guideline is implemented, it should be followed to the letter. However, there may be situations where the policy cannot or should not be followed. But this is not a decision for employees to make. Exceptions should be reviewed and approved by management before such action is undertaken. Make sure the exception is properly documented.

8. **Do self-pay guidelines allow monthly payments on certain accounts?** ❑ yes ❑ no

A sound bad debt policy will allow patients to make installment payments on their accounts. Just make sure there is a review mechanism in place to ensure the patients allowed to make payments are actually making them every month.

9. **Do self-pay guidelines specify the maximum number of payments that will be accepted?**

❑ yes ❑ no If so, how many?

The installment policy should be fair to both

patient and practice. Allowing patients to pay $5 a month until their balance is paid off really creates collection hassles for the practice. Set a reasonable length of time for time for patients to pay off their accounts.

10. **Do self-pay guidelines specify the minimum monthly payment amount that will be accepted?** ❑ yes ❑ no If so, how much?

The minimum amount to pay should tie in with the maximum allowed length of time patients are allowed to pay off their accounts. Of the two, the maximum number of payments allowed is the most important. Fit and set the payment amount within this guideline.

11. **Do collection guidelines specify what action should be taken if a patient misses a payment?** ❑ yes ❑ no If so, describe the policy.

The point to be made here is to set a policy and stick to it. If the policy is to turn the patient over to collection if two consecutive payments are missed, then make sure this policy is adhered to. If exceptions are made, make sure they are made with management's approval.

12. **Does management support the collection guidelines, even when a patient complains?** ❑ yes ❑ no

It is useless to implement a policy and then have the doctors not follow it. There must be a buy-in to the guidelines by every doctor within the practice. In other words, they must support them. If not, policies and guidelines end up becoming a joke.

Employees also get confused about how to implement policies and guidelines when the doctors and administration tell them different things.

Reed Tinsley, CPA, is shareholder in charge of Horne CPA Group's Houston office and an editorial advisory board member of Practice Marketing & Management. *He can be reached at (713) 975-1000.* ■

Focus on special needs improves geriatric care

Interdisciplinary teams target high-risk elderly

As the U.S. population ages, medical groups face the dilemma of providing cost-effective geriatric care that allows patients the best possible quality of life. Successful solutions have emerged that target high-risk elderly with an interdisciplinary, team-based approach to diagnosis and treatment.

In a study of a geriatric evaluation and management (GEM) program at the University of Minnesota Medical School in Minneapolis, functional ability declined less rapidly than that of a control group. The GEM patients also reported greater patient satisfaction,[1] and their informal caregivers were less likely to experience increasing burden over time. Health care costs were similar in the GEM and control groups.

However, researcher **Chad Boult**, MD, MPH, notes that Minnesota is a state with heavy managed care penetration in which overall health care costs already are minimized. In other areas, GEM may produce substantial savings, he says.

"You're preserving function at no cost with GEM," says Boult, who is an associate professor at the University of Minnesota Medical School. He presented the GEM results at the May meeting of the American Geriatrics Society. "Ten percent of the people cost 70% of the money. If you can find those 10% and work closely with them, you have a potential to make a big difference."

Geriatric outcomes are becoming increasingly important to payers. The Health Care Financing Administration is monitoring the health status of elderly Medicare managed care patients through the Medicare Health Outcomes Survey. The National Committee for Quality Assurance in Washington, DC, has several health plan performance measures that relate to health of older people, including those for pneumonia and flu vaccination.

"One way to [comply with standards and produce better outcomes] is to monitor the population with some sort of screening tool and to implement comprehensive action plans for those who are high-risk," says Boult.

Participation in the GEM program began with a screening questionnaire, the Pra, an eight-item questionnaire that identifies high-risk elderly patients.[1]

"When we tested the Pra, we found out that when you follow people it identifies as high-risk over the following year, they go on to use about twice as many health services and spend about twice as much on health resources as those below

the [cut-off]," says Boult, one of the developers of the screening tool. "It's simple and inexpensive to administer."

The tool has a scoring algorithm to determine whether patients are high- or low-risk. An expanded version, the Pra Plus, contains questions that can lead directly to interventions.[2] For example, the Pra Plus asks patients how many medications they are taking. That became one focus of the Geriatric Evaluation and Management program at the University of Minnesota.

"One of the most frequent things we did was to reduce the number and dose of medications people were taking," says Boult. "Older people with chronic diseases tend to accumulate medications from different doctors."

GEM teams of a geriatrician, nurse, social worker, and gerontological nurse practitioner managed the care of GEM patients, beginning with a home visit to assess their psychosocial and environmental needs. Each patient had treatment goals and a plan of care, and in addition to comprehensive medical treatment, they received counseling, education, and necessary referrals.

GEM was designed as a short-term program in which patients would return to their primary care physicians for routine care, says Boult.

"GEM is intended to be self-limited," he says. You bring people in and get them on the path to where they need to go." However, some very high-risk patients may need periodic GEM care to maintain improvements.

Group Health Cooperative of Puget Sound in Seattle also is creating links between primary care physicians and geriatricians. But its "action plan" ultimately involves every older patient, with a special focus on those at high risk. Group Health has provided a special comprehensive assessment program for elderly patients for 10 years. Primary care physicians referred patients with complex care needs to the program.

The program, however, didn't affect ongoing care and helped only a small percentage of seniors, says **Chris Himes**, MD, director of geriatrics and long-term care at Group Health Cooperative. Instead, Group Health is beginning a program that links geriatric physicians and nurses with primary care doctors.

This new model includes a "care road map" with key indicators based on geriatric health needs. Eventually, all patients 65 and older will receive assessments. It is patterned after a similar program designed to improve care for diabetics. "If a diabetic comes in for an office visit, the medical receptionist presses a button that prints out that person's registry," says Himes. "Anything that's out of date comes up."

The geriatric program will strive for a similar system, although the care goals are more difficult to define. "No one can agree what are the appropriate measures for geriatrics," he says, "not the federal government, not even the U.S. Preventive Services Task Force."

Group Health has developed assessment tools and interventions based on the issues that research shows most affect geriatric health. "There are three things that overall have been shown to make a difference [in care]," Himes says. "The first one is exercise. Second is social activation. Third is overall good geriatric care with focus on the geriatric syndromes."

The geriatric syndromes include urinary incontinence, depression, and memory and cognitive changes. The geriatric program also deals with advance directives, prevention of falls, and other preventive health measures.

Seniors get a prescription for exercise

Seniors generally enter this program when they schedule a "health maintenance visit." Before their visit, they receive a screening tool that incorporates those major areas of concern. For example, the tool asks patients if they have lost interest in daily activities or if they have been feeling sad or blue. If they answer yes, they receive another questionnaire that is a screening tool for major depression.

Group Health Cooperative has developed an array of interventions. For example, patients with urinary incontinence can be referred to the physical therapy department's new Kegel exercise classes. Urologists agreed on guidelines determining which patients should be referred to them. And primary care doctors received a refresher course on medications and other interventions to address the problem.

Group Health also has determined that it can obtain a score similar to the Pra Plus by reviewing medical records. "We're being proactive with high-risk folks and trying to put them into the system," says Himes.

Lifestyle issues present the greatest challenge to Group Health's program. But Himes is convinced exercise is a key to improving the quality of life for older patients. Group Health worked with the University of Washington and local senior centers to develop a strengthening, fitness,

and aerobics program for seniors called Lifetime Fitness. The MCO also offers seniors an independent program called Silver Sneakers.

"We've started to write prescriptions for exercise at all the health monitoring visits," Himes says "It really is the one thing that keeps people from being able to be happy and be able to do what they want to do."

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Keep 'em talking to boost efficiency

Communication gets everyone on board

For a physician's office to run smoothly, it's not enough for people to just concentrate on doing their jobs, says **Jeannette Perich**, CPA. Instead, all staff must work together and understand how what they do affects the rest of the staff, says Perich, administrator of the Fort Collins (CO) Youth Clinic. The practice has a staff of 63, including eight physicians, four mid-level providers, and laboratory personnel.

Along with customer service for patients, Perich stresses internal customer service among staff members to ensure that the service delivery system works smoothly. The clinic has implemented a series of strategies to promote better communication among staff members.

These include regular meetings at which staff share knowledge and ideas, and using flowcharts as a communication tool to allow individuals to see the impact of their actions on the rest of the operations. "So many times, people get caught in their own little area and don't realize the impact they have on other people," Perich says.

That's why Perich uses flowcharts to give the staff an idea of how the business systems work and how their part fits into the entire process. "We were looking at processes and trying to see where bottlenecks happen in the practice. It's helpful for the staff to see where they fit in," she says. For instance, one creation, "Life Cycle of a Fee Sheet," tracks the path of the fee sheet from the time a patient is scheduled for an appointment through the time the account is paid.

"This helped the people at the front desk understand that if we don't have good demographic information and good insurance information, we can't bill out. Our staff has a better understanding of the whole picture and how the entire process works," Perich adds.

For instance, by studying the flowchart, employees can see how benefits are sometimes denied because the patients are no longer covered by a certain plan, Perich says. "Then we have to start all over again and resubmit the claim, and this is bad for the cash flow," she adds.

Another flowchart traces telephone calls, how they are routed, and what decisions need to be made to route the calls. Another tracks the patient visit and details who comes in contact with the patients and how their actions affect the patients.

Off-the-shelf software

For the fee sheet project, Perich started the process by asking a staff person to write the entire process of how a fee sheet moves through the practice. After the process was written down, she went back to each member of the staff who handles the fee sheet to make sure it was correct. Then she used an off-the-shelf flowchart software program to create a document that was easily understandable to the staff. "Putting it in flowchart form makes it much easier to read. People get turned off by long narratives, and they tend not to read them," Perich says.

She meets once a week with all the managers in the office. This includes managers in the business office, nursing, lab, and transcription areas. The entire staff meets for lunch once a month. "We talk about what we need from other staff people and what they need from us in order to do their jobs well. This all ties into communications and customer service," Perich says.

Giving staff an opportunity to communicate regularly has been "a tremendous help" in ensuring the office runs smoothly, Perich adds. For instance, recently one staff member proposed making a change in his department and didn't think it would make a difference to the rest of the staff. "As soon as it was mentioned, about four people here spoke up about how it would impact their departments," she says. ■

Technology increases efficiency, cuts staffing

Staff have more time for patients

Every time **Ruth Lander**, FACMPE, feels overwhelmed by her work as practice administrator at Columbus (OH) Oncology Associates, she tries to figure out how she can automate some of her daily tasks.

As a result, the practice operates so efficiently that its level of full-time-equivalent (FTE) employees per physician is far below the national average for oncologists in group practice with active chemotherapy departments. The national average for oncology group practices is 7.1 FTEs per physician, according to a recent benchmarking session for the Administrators in Oncology-Hematology Assembly, a special assembly of the Englewood, CO-based Medical Group Management Association. Lander's practice, however, has 5.14 FTEs per physician, based on the practice's 1998 numbers.

"The goal of technology is . . . to enhance staff efficiency so they'll have more time with patients."

Columbus Oncology Associates makes use of the latest technology for everything from managing staff time within the practice to marketing the practice on the Internet. One new endeavor is sending letters to referring physicians via fax modem using voice recognition transcription software. **(For more on the technology the practice uses, see story, p. 93.)**

"The goal of technology is not to eliminate patient-staff contact, but to enhance staff efficiency so they'll have time for the patients," Lander says.

For instance, instead of hiring an additional PBX to deal with the large volume of calls at peak times, the practice implemented a partial voice mail system for billing, scheduling, and administrative calls. The system gives callers a choice of using an automated menu and voice mail or speaking to a live person.

Because Lander's practice provides oncology care, she feels it would be risky for patient care calls to go into voice mail.

"We don't let nursing calls go into voice mail. Those patients talk to the receptionist and nursing," she explains.

When new patients are being interviewed, staff tell them they can call a different number that will allow them to bypass the receptionist and go directly to voice mail for the department they are calling. Many patients choose to use this feature.

"We haven't made it a complete voice mail system. Other physicians and older patients don't like voice mail," Lander says.

Lander finds the technology useful for taking care of many business matters. "I'm often away from my desk, and so are many of the people I call. We often take care of things by using voice mail, fax, or e-mail," she says.

In the past, the receptionist often had problems contacting nurses to let them know patients had arrived. The nurses often were on patient phone calls, in the midst of other patient treatments, or talking to one of the physicians. The arriving patient either had to wait, or the receptionist had to leave her desk and let nursing know the patient had arrived.

Now, instead of using the telephone to notify nursing that a patient has arrived, the receptionist just types the patient's name into the computer and it pops up on a computer screen in the nurses' station. This keeps the phone lines free for the nurses to get patient phone calls and cuts down on the time the patient has to wait.

The practice uses an off-the-shelf software product and a personal computer for the notification system.

Automatic results

Before the practice installed an automatic lab result system, physicians often had to walk to the lab to get results before they saw a patient. With the new system, physicians and nurses can retrieve the lab results automatically via computer near a patient exam room or a chemotherapy treatment room. This has saved nurses many trips to the lab for results to check complete blood counts before starting a chemotherapy treatment.

"There's no wasted time. Nobody has to take the results back to them," Lander says.

Before the practice contemplates any major purchase, a cost-benefit analysis is performed. In fact, the practice was highlighted in the Medical Group Management Association's 1998 report, *Performance and Practices of Successful Medical Groups*, for its superior performance,

particularly in "productivity, capacity, and staffing."

Lander started learning about technology when she took her job with the practice in 1987. "I've seen the whole computer revolution in the workplace," she says. She claims no special computer expertise, just "a thirst for learning, efficiency, and organization.

"I believe in doing things the best way possible if it's in my control," she adds.

To keep abreast of the latest technology she might use in managing the practice, Lander attends trade shows and seminars, networks with fellow oncology administrators, and reads numerous periodicals. But she's careful that her forays into new technology don't take up all her time.

Collecting information

To keep from being inundated by phone calls from technology firms, she picks up literature instead of leaving her card or signing up for drawings for prizes at the trade shows.

"And, if the articles in the periodicals aren't helpful to me, I still will look at the ads to see new product offerings," she adds.

She conducts periodic operations audits to find ways to improve the way the practice works. "I feel confident we can figure it out without hiring a consultant," she says.

She encourages employees to make suggestions on how to operate more efficiently and has a suggestion box for those who don't feel comfortable talking to management about changes.

"The way we have fixed a lot of things is by walking the halls and keeping our eyes open. If we see a problem more than once, we look at how it can be fixed," she says.

To manage her own job, Lander has "everything I could possibly forget" in her handheld mini-computer. All the addresses and phone numbers she needs are stored in the mini-computer and can be exported to print out labels for mailings.

"Now I don't have to carry around a 50-pound day-timer, and I don't have to worry about losing it," she says.

Once she did drop her handheld device on the pavement and broke it, but within a couple of days she had downloaded everything from the main computer at the practice and was back in business. ■

How one practice puts technology to work

Systems save staff time, money

Columbus (OH) Oncology Associates, a seven-physician practice, relies on technology to give its staff more time to spend with patients and to make the practice more efficient, says **Ruth Lander**, FACMPE, practice administrator.

Here is a look at some of the ways the practice puts technology to work:

• **Internal pager system.** When a telephone call comes in to a physician or key staff member, the PBX operator pages that person with an alphanumeric message and a two-digit code. The code identifies where the call is "parked." The recipient can dial the code from any telephone in the building and get the phone call.

Before the system was implemented, the operator called around to various locations trying to find someone. This created disruptions and noise similar to an overhead announcement system.

"The system disrupted everyone, physicians, patients, and staff. The new system is wonderful. I don't have to go back to my office to get a call. It saves time and it cuts down on the noise," Lander says.

• **Room lighting system.** The practice has been using a system that identifies which examining room each physician is to go into next. Each of the seven physicians in the practice is assigned a color, and each of the 11 examining rooms has a light bar with all seven colors on it.

When a doctor enters a room, he presses a button that indicates on a master panel where he is. When he leaves, he presses a button again, turning off his light. The room where he is to go next then lights up. A similar lighting system in the physicians' offices notifies them when patients are ready. There also are panels in key areas that track where the physicians are.

"If a nurse needs to catch a physician, she can find him and not waste any time," Lander says.

Lander is looking into updating the system so it will track how long physicians are in each room, how long patients wait for a physician once they're in an exam room, utilization of each examination room, and lulls in the schedule. There are several such systems on the market, Lander says.

• **Voice recognition transcription.** The practice helped a company develop a voice recognition transcription system for oncology. The physicians speak into what looks like a normal handheld transcription machine. Instead of a tape, it contains a small disk that captures a digital voice recording of the physician's speech. That digital recording is later downloaded into a PC with a voice recognition program, which transcribes the recording into words. The document is edited minimally by the transcription secretary before it is processed. The system includes a fax modem that allows the transcription to be faxed directly to a referring physician. The practice is in the process of implementing this system now.

In addition to saving time, the practice saves the cost of the letterhead and postage, Lander says.

"I love saving money. It costs a lot to send personal letters to the referring doctors, but we certainly want to keep them informed about their patients," she says.

The practice still prints out its progress notes because Lander hasn't found a satisfactory electronic medical records package yet.

• **Education.** Instead of traveling off site for continuing education, physicians and other practice staff often rely on audiotaped seminars, audio conferences, and Internet medical education services to earn their continuing education credits.

Learn while you drive

Lander often sets up audio conferences with the Medical Group Management Association in Englewood, CO, for several staff members at a time. Some physicians listen to audiotapes in their cars going to and from work.

Not only does the technology save travel costs, it helps the practice work more efficiently, Lander says.

"Physicians can complete many of their CMEs this way. When the physicians are away from the office, they aren't making any money. What they really need to do when they are away from the office is take a vacation and not spend that time at educational programs," she adds.

• **Periodicals and books on CD-ROM.** Lander likes these because they take up less space than books and magazines and because they have search capabilities that save the staff time.

• **On-line payables.** Lander pays as many of the practice bills as possible on-line.

"The actual cost is about the same as a postage stamp, but it has saved my time. When I am on vacation, I don't have to worry. The payments go out on the day they are supposed to," she says.

Drug companies still send hard copy, but Lander is working with many of her major suppliers to set up on-line invoices.

• **Automated ordering.** Many items the practice uses, including all its equipment and supplies and much of its drug supply, are ordered electronically. "There's no way I'd ever put anything in the mail," Lander says.

• **Marketing.** The practice maintains an Internet Web page that markets the practice and provides information to patients, including a program that writes out directions from the patient's home. There also are multiple links to major cancer sites.

The Web page includes information on the practice, including physician biographies and photos, clinical trial information, and new forms that patients can print and fill out rather than having to wait for a packet in the mail. ■

Personal touch pays with Medicare HMO patients

Seniors are encouraged to call or drop in

Establishing a personal relationship with Medicare HMO patients has paid off for the Browne-McHardy Clinic in Metairie, LA. The practice has the lowest disenrollment rate with all health plans and among all provider groups in the area, says **Kathy Calahan**, RN, director of health services, utilization management, quality assurance, and provider relations.

At Browne-McHardy, senior care coordinators evaluate the senior citizens, act as a liaison between them and their managed care plans, and encourage them to call or drop in if they have questions or problems. The senior care coordinators are a registered nurse and a licensed practical nurse strictly devoted to Medicare patients who are in a managed care plan, Calahan says.

As soon as the practice receives its monthly notice of patients who have enrolled, the patient care coordinators call the patients, introduce themselves, and invite the seniors to come into the office for an interview and a health risk assessment.

"We want to identify the needs of older patients as soon as we can," Calahan says. The interview and risk assessment allow the practice to get a handle on older patients who have a history of ongoing illnesses, Calahan says.

Patients are scored according to severity of need, and those who are most severe are given an early appointment with a primary care physician.

The senior care coordinators handle durable medical equipment needs and transfer the care to a contracted provider. If the seniors are receiving home health services, the care coordinators evaluate them for appropriateness and transfer the care so there is no break in service.

A key to the patient-friendly approach is to help the seniors deal with their HMOs. "We educate them on their Medicare HMO and help them understand how to access care through their primary physician. There is a lot of confusion among seniors as to how their Medicare HMO works," Calahan adds.

SOURCE

- **Kathy Calahan**, Browne-McHardy Clinic, Metairie, LA. Telephone: (504) 889-5234.

If the senior citizens have to have medical care when they are out of state, the senior care coordinators help them negotiate the paperwork when they return. "They act as ombudsmen for the patients. The patients love it. They love having the personal touch," she says.

The practice looks at the Medicare HMO disenrollment rate every month to keep up with trends. Unlike commercial HMOs, where patients have to stay in for a year, Medicare HMO patients can choose to leave the plan as early as 30 days after enrollment.

"We want to bring them in and make them happy. We don't want them dropping out," Calahan says. ■

In brief

Academic practices gain in salary race

The latest surveys of academic practices by the Medical Group Management Association (MGMA) are showing rising salaries among both faculty and management. According to the *Academic Practice Management Compensation Survey: 1999 Report Based on 1998 Data*, department administrators with clinical operations are reaping the benefits of consolidation in the industry. Their compensation rose 4.2% to $79,310. Administrators without clinical operations saw a 4.5% increase to $65,843 over the previous year.

However, executives in academic practices are doing more work for their compensation, says MGMA survey operations department project manager **Jerome Henry**, MBA, MSHA. Institutions are paying more while at the same time trying to lower staffing ratios. Another finding of the survey was that the more experience a manager or administrator had, the higher the pay increase.

The survey costs $75 for members, $95 for affiliates, and $115 for others. It can be ordered by calling (888) 608-5602.

The other academic practice survey, *Academic Practice Faculty Compensation and Production Survey: 1999 Report Based on 1998 Data*, also showed increases that were higher than inflation. Median salaries for primary care physicians increased 4.6% to $120,000. In the private sector, primary care physicians had only a .86% increase. Specialists in academic practices averaged a 2.6% raise, compared to a half of a percent drop for specialists in the private sector.

According to the project manager for this survey, **Jan Krause**, MA, the increasing parity is due to universities trying to build primary care networks that are competitive in the managed care contract war.

Family practice leap

The biggest winners among primary care providers were family practice physicians, who saw a 7% rise in compensation to $128,434. Among the specialists, gastroenterologists had a 15.4% jump in compensation to $149,927. The smallest increases — 0.2% — went to diagnostic radiology and rheumatology doctors.

One interesting finding of the survey: a one-year compensation lag among academic physicians compared to private-sector physicians in primary care. For instance, if private-sector doctors see an increase in compensation one year, academic physicians can expect an increase the

following year. That trend has continued throughout the 1990s.

The survey is available from the MGMA for $200 for members, $250 for affiliates, and $300 for others. ▼

Y2K? No problem, say medical groups

Most medical groups will be year 2000 (Y2K) compliant by Jan. 1, 2000, according to a survey of members of the Alexandria, VA-based American Medical Group Association (AMGA). The association asked its 230 group practice members, representing about 45,000 physicians in 40 states, when they thought their systems would be ready to handle any computer glitches caused by the so-called Millennium Bug. The survey questions focused on awareness and planning, computer systems, vendors and contractors, and overall assessment. Half of the groups responded.

While a few groups are already compliant, the average projected date for compliance is Aug. 11, 1999. Other findings of the survey:

- Virtually all responding groups had discussed Y2K issues with their staff and discussed liability and risk management issues with legal representatives.
- 38% have hired a contractor to assist with Y2K problems.
- 69% have reviewed insurance programs to determine how Y2K occurrences will be covered and/or excluded.
- More than 90% had a strategy for dealing with potential problems associated with billing and financial systems, clinical and medical records systems, biomedical equipment, and facility issues.
- 86% had a contingency plan in development, but only 6% had one completed.
- Renovation and replacement was the most common way practices dealt with Y2K problems — 79% renovated or replaced their billing/financial systems; 62% renovated or replaced clinical and medical records systems; 59% renovated or replaced biomedical equipment; and 55% renovated or replaced other facility infrastructure and equipment susceptible to Y2K problems.

For more on the survey or on the AMGA, contact the organization at (703) 838-0033. ■

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Editor: **Lisa Hubbell,** (thehubbells@earthlink.net).
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)
Production Editor: **Terri McIntosh**.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.