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Can your office be perfect? Maybe not, but 'ideal' is possible

Open access, strong leadership are key elements

Envision the ideal medical office, a place where patients can call for an appointment and come in the same day. It's an office where staff morale is high and patients feel like partners in their care. There is a steady flow of information allowing physicians to discover inefficient or faulty processes and fix them.

Medical groups around the country are trying to turn that vision into reality through a project sponsored by the Institute of Healthcare Improvement (IHI) in Boston. Rather than seeking to address a narrow quality improvement goal, 42 quality improvement (QI) teams at 23 health care organizations are working to become prototypes of a patient-centered and quality-based practice through the "Idealized Design of Clinical Office Practices" project. **(For a list of the principles for clinical office practices, see box, p. 146.)**

"It really is daunting," says **Frank Littell**, MD, an internist with Peacehealth Medical Group in Eugene, OR, and a faculty member with the IHI project. Yet the dangers of not acting were even greater. "The challenge we faced is that like many other integrated delivery systems, the medical group has lost money ever since the development of the integrated system. We had an opportunity to look at the redesign of the medical group."

The first sites began examining their processes in January 1999. They are collecting data every six months and anticipate having significant improvements to reveal within three years, says project manager **Mora Babineau**, MHP.

Some benefits are readily apparent, Littell says, pointing out that initial changes have boosted the morale of staff and physicians and increased patient satisfaction.

Scheduling and access are areas that plague staff, physicians, and patients alike. So the "Idealized Design" practices began by trying to improve patient flow and scheduling, often moving toward open

access that allows same-day scheduling and attempts to match physician supply with patient demand.

"What are the one or two areas that people are disgruntled about on a daily basis? Their schedules," says Babineau. "People felt they had no time."

So practices greatly reduced scheduling types and, in some cases, added hours. "It also helps you when people are in for an appointment to 'max-pack'" by addressing preventive needs even though the patient came in for an acute problem, she explains.

For Peacehealth, open access went hand in hand with another innovative change — care teams. The medical group moved schedulers and clerks to the back of the office into the doctor-nurse care teams. Each team now has a dedicated scheduler who answers a separate phone number for one team. The nurses and medical assistants have been cross-trained to handle patient phone calls and paperwork.

The changes correspond to a business model called "Lean Thinking," based on a book by the same name written by James Womack and Daniel Jones.

"Most clinics have a lot of inefficiency," says Littell. "Nobody in the front knows what the people in the back are doing. Nobody in the back knows or appreciates what the people in the front are doing. "We decided to combine the front and the back office, to create three teams with three or four providers per team," he says. "The people involved in the delivery of health care should all work together, and that includes the front office."

The change improves patient flow because the cross-trained staff can now support each other.

Test new ideas with leaders' support

Peacehealth has just begun considering other changes using a rapid cycle process of quality improvement that allows the medical group to test ideas and expand or discard them. For example, Peacehealth is creating a software-based registry of diabetic patients to help the medical group track their care.

"Some of us in the group are experimenting with audiotaping the visit and giving it to the patient to improve compliance with instructions," says Littell, who adds that written instructions also are provided.

The medical group also may add some lab capabilities that would allow for "real-time" results to increase efficiency in patient care.

Other IHI project participants are adopting other innovations, but it's still too early to capture many lessons from the practices that seek to redefine how they provide care, says Babineau. "It takes a long time to make change. We're facing that reality as we're heading to our second year."

Yet one fact is clear: Success relies largely on the commitment the project receives, she says. "It's important to have leadership from the CEO

Principles for Clinical Office Practices

What are the components of the ideal office practice? While no two offices will be exactly the same, these are the guiding principles identified by the Institute for Healthcare Improvement (IHI) in Boston as medical groups began shaping the "Idealized Design of Clinical Office Practices." The IHI defined the components as "a foundation for our vision of what clinical offices should be."

1. Paramount focus on the clinician-patient relationship.
2. Individualized access to care and information at all times.
3. Knowledge-based care — standard.
4. Opportunity for patient to customize his own care to the extent that each individual desires.
5. Minimal waiting for all involved in the processes of care.
6. Seamless communication of information and coordination of care based upon cooperative relationships.
7. Financial performance sufficient to ensure unhindered viability.
8. Patient and practice management based on real-time data, including measures of process, satisfaction, finance, outcomes, and epidemiology.
9. Continual improvement and waste reduction in all processes and services.
10. Individual health linked to broader community health.
11. A model work environment.

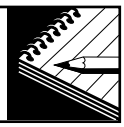
[Editor's note: For more on the "Idealized Design of Clinical Office Practices" project, contact the Institute for Healthcare Improvement, 135 Francis St., Boston, MA 02215. Telephone: (617) 754-4800. Fax: (617) 754-4848. Web site: www.ihi.org.]

level and leadership at the site. We're seeing success where the leadership is coming from the physicians. Putting them back in charge of this work is the right way to go."

IHI also requires the sites to devote a half-time or full-time employee as a project manager. Each quality improvement team sets specific aims, and the project manager coordinates monthly data collection and a monthly report to senior leadership, staff, and IHI.

"If you're really serious about doing this, you need someone who is collecting information, getting your data walls up [to track trends using charts], making sure everyone is staying focused," Babineau says. ■

GUEST COLUMN



If your practice ready for the new tax year?

What you do, or don't do, may haunt you

By **Ted Feher**, MBA, CPA, Senior Manager
Horne CPA Group, Houston

Remember during last year's accounting closeout problems when you said: "We'll fix it next year." Well, next year is here. If last year was fun, this year should prove even better.

The new year is fast approaching with all the attendant distractions, and one that often fails to get the attention it needs is year-end closing. Many of the decisions made, or not made, before year-end have long-suffering consequences. It is hard to make something happen once the clock has chimed midnight. Added to those concerns is the need to contend with the Y2K bug.

Let's look at Y2K issues first. Perhaps you have been through enough Y2K by now, but to omit it from any year-end article would be foolish. Even if you don't have or use a computer system, you need to realize how dependent your business remains on them. Can you think of associates you deal with who provide you with critical products or services that depend on a computer? Have they provided assurances that they have gotten all their Y2K shots? If you don't know, then you are just as susceptible to a Y2K disaster as anyone else. What is your Plan B? If you do nothing else, you should have a list of viable alternatives in case what can go wrong does go wrong.

If you have a computer system, I presume you have had a Y2K checkup by now. Any consultants you use should have given you a bill of good health and developed a plan and timetable so you will be able to survive if something does go wrong. At a minimum, you should have a backup or two of all your information through year-end — all of it, because even if you got a clean bill of health, much like any other inoculation, it is not 100% foolproof. Multiple backups should be stored in separate off-site areas. Make sure one of your backups is not computer-dependent.

At the low end of the technology spectrum, revisit last year's closing process. Take a few minutes and sit down with your administrative staff and have them come up with a wish list. The list should include items they wish they had thought to do differently last year. They may deny there are any, but experience has taught us there are always some. Don't take no for an answer unless you had the smoothest running year-end and lowest accounting ever.

If your staff can't seem to come up with a list, ask your outside accountants. That should make work easier for your accountants and lower your accounting bill. Let them review what they did for you last year and tell you how to do a better job this year.

Tax planning

Jan. 15 is the due date for the final estimate for calendar-year returns. Anything paid after that date is not credited until the due date of the return.

You don't need a plan per se, but you will never know if you got where you were headed without one. Do a year-end projection as soon as possible. **(See related story, p. 149.)** The process of doing the year-end projection will raise questions and stimulate discussion of the schedules and reports you need to prepare the current year's tax return. It also will help prevent those surprises taxpayers seem to hate.

The tax projection also allows you to review year-end transactions to make sure they are accomplishing what you expect them to accomplish. It is difficult to re-characterize a transaction after the 31st. The harsh result of unintended consequences can be painful.

The typical tax strategy is to defer income, and presumably taxes, to a future year. On rare occasions, a taxpayer may need or want to do the reverse. Sticking with the typical strategy, the taxpayer will accelerate deductions and decelerate income. Since taxpayers can be on a cash basis or an accrual basis, it's important to understand the difference in how the goal is achieved.

On a cash basis, you pay bills early and slow down collections and deposits. If you use an accrual system, you buy, book, and deliver late.

For cash-basis taxpayers — typically the majority of us — the way to reduce taxes is to write those checks and pay for every deductible item you can before Dec. 31. Similarly, deposits made after Dec. 31 will not be included as income this year. Apply good sense regarding deposits, though. If the Internal Revenue Service believes you stuffed all the checks in your bottom drawer during the last two weeks of December, its agents can be pretty successful at arguing the money should be reported as current-year income.

Inter-company/related-party rules

If you control more than one company, you are subject to the related-party rules of the Internal Revenue Code, section 267. Your financial statements may be correct, but they may not reflect tax realities. To the extent there are differences, it's important to understand the relationship between the items on your financial statements and those on your tax return. The rules are designed to make sure one related party's deduction is another related party's income.

Retirement planning is your only true remaining tax shelter. If you don't have one open yet, you should open one by year-end. The cost to open a plan is usually nominal. Funding and many of the other administrative expenses occur much later — usually not until you file your tax return. That can provide you with an eight- to nine-month delay between taking the deduction and paying the bill.

If you do have a retirement plan, make sure you understand all the idiosyncrasies. It's certainly not illegal and surely no secret that plans are installed/created to benefit the owner as much as possible. However, when there are personnel changes, the funding formulas often fall apart.

Section 410b of the Internal Revenue Code presents a formidable unequivocal test. Plan funding formulas are designed to pass the test under normal circumstances. But when there is a lot of employee movement in or out of a plan (or both), the funding formulas may not pass muster. The plan administrator is usually not informed of such matters until well after the year-end — well beyond the period when something can be done about it. Under the wrong set of circumstances, one person participating or not being covered by the plan can undermine the entire planning process. Clearly, if there is any item one needs to discuss before year-end, this is it. The consequences of noncompliance can be so severe.

Check with your tax preparer about getting information to him or her as quickly as possible. Make sure the preparer will review it and alert you to any potential problem areas — some preparers get very involved in year-end payroll tax procedures and will ignore incomplete data if other work is pressing in on them. However, most will welcome the chance to review your circumstances during December. Typical documents should include your last financial statement and bank reconciliation, a list of fixed asset acquisitions and their invoices for income tax and property tax considerations, and the value of inventory, if relevant. If you are on an accrual basis, an accounts receivable and accounts payable report is a must.

If company cars are used by employees, it is important to determine how much will be deductible and how much will be included in the employees' compensation, if any. Your accountant can supply you with a worksheet so you can list costs associated with the vehicle and the required mileage information.

Prepare a list of periods covered, amount of bill, and amounts paid for all the insurance coverage you have. Officer life insurance is not tax deductible and would be one of those differences previously mentioned. Review your meals and entertainment expenses. Typically, only half of meals and entertainment are deductible. However, when the meals are for the convenience of the employer, you can get a 100% deduction. You also want to check the expenses for misclassifications of business gifts into the entertainment category.

Make sure your staff get the latest changes to the payroll tax tables for the beginning of the new year. The Social Security ceiling increases, unemployment tax rates usually change, and income tax tables are adjusted for inflation.

When all that is done, you can relax, and have a happy new year. ■

Your year-end projection in four easy steps

What you should know now about the future

There are very sophisticated forecasting tools, and there are quick and dirty ways to do a year-end projection. Typically, the more effort you spend on the forecast, the better the results, remembering that you are still fundamentally guessing at the future, even if it is in a somewhat scientific manner. Here are four key points to remember, says **Ted Feher**, senior manager for Horne CPA Group in Houston:

1. **Gather your data.** Eschewing the sophisticated tools to do a reasonable year-end forecast only requires that you have some detailed historical data (at least the past two years). Most accountants will usually try to look at 10 or 11 months of year-to-date data for those past two years and compare them to the 10 or 11 months year-to-date data for the current year.

2. **Assess your position.** Once you have the data, ask yourself how to compare this year to last. Then look at the remainder of the year and see how it compares to the year as a whole, how it compared to the end of the prior year, and how it compares to the past few months. There is no correct way to do an analysis. The more questions you ask, the more likely you are to discover the correct relationships. You are really just looking for a pattern.

3. **Consider your specifics.** You might have some factors that are unique to your own practice or perhaps unique to the particular period at which you are looking. For instance, the vacation pattern may differ from year to year. Maybe there were weather-related phenomena in a prior year. There may be fewer or more employees during the remaining months this year than in prior years. The mix of services being offered may be different. All of those things become part of the judgment about how the year-end may look.

4. **Estimate your year-end position.** After you have analyzed your data, estimate a range of what the profit picture may look like. Given the ranges, you can consider some alternatives: What is the impact if you buy more equipment before year-end? Should you put more into a retirement plan? Should you pay bonuses? Should you buy more supplies? Should you close during December? The list is endless, limited only by one's ingenuity and imagination. ■

Common tax mistakes can be expensive

Some examples not to follow

What is the law of unintended consequences? Here are three examples of how that law operates in the tax world, according to **Ted Feher**, senior manager for Horne CPA Group in Houston:

• A typical tactic used to reduce income tax liability is to purchase equipment and elect to write it off quickly. But if you have already purchased a great deal of equipment, you may not qualify for the election or your accountant already may have figured this in to the tax strategy.

• You may believe you can contribute the maximum to retirement plans but find out differently once you have all the demographic data for the current year. In one case, an employer believed the liability for her employees would be very small because they did not work much of the year. But once the calculations were done, the choice became: a) no retirement plan contributions for the employees then none for the owner, or b) pay some of the employees and former employees even though they would normally not be covered.

• Many cash-basis taxpayers believe that just because their cash balance is zero they have no tax problems to worry about. The cash-basis taxpayer must become acutely aware of which expenditures yield immediate tax deductions and which ones don't. The purchase of a large piece of equipment may eliminate the cash balance, but it is not likely to give you a dollar-for-dollar tax deduction. The year-end Christmas party can be expensive, but it will only yield a deduction of 50 cents on the dollar. Officers' life insurance will use a lot of corporate cash, but it won't yield any tax deductions. Estimated tax payments deplete your cash balance also, but they don't impact taxable income.

The only way to ensure you don't suffer from those unintended consequences is to sit down with your tax advisor before executing any alternatives. He or she can even prepare a simulated tax return, one of the best ways to nail down the potential tax liability with the fewest surprises. ■

Survey: Administrators, marketers doing well

Most managers gain from hot economy

If you think you've been doing well financially during the economic upswing of the 1990s, you now have some data to back up your gut feeling. According to the *Management Compensation Survey: 1999 Report Based on 1998 Data* released by the Medical Group Management Association (MGMA) in Englewood, CO, most administrators in group practices have seen their incomes rise during the past year.

The latest survey, released in October, shows that administrators of small practices (six or fewer full-time physicians) had a 5.26% increase in median compensation to $60,000. Those who manage larger practices earned $80,000, an increase of 3.4%. **(For more information on the salary changes, see table, below.)**

Physician chief executives saw their salaries rise more slowly between 1997 and 1998 than other positions — up just 2.08% to $259,231. Nonphysician CEOs also saw a slower increase — just 1.22%. However in both cases, the survey's trend data shows large gains over the last five years — 20.41% for physician CEOs and 26.52% for their nonphysician counterparts between 1994 and 1998.

The survey also shows the greater emphasis being put on sales and marketing in practices. The median salary for a director of marketing and sales increased by more than 9% to $48,000 over the year. Part of the increase stems from more highly educated consumers, explains **Jerome Henry**, MBA, MSHA, project manager for the survey. He says another reason is the increasing ability of marketing directors to act for physicians and their practices during managed care contract negotiations.

Directors of planning and development saw a similar gain in their salaries. But by far, the largest one-year gain goes to administrations at physician practice management companies (PPMCs), who saw compensation increase by nearly a quarter, from $75,000 to $92,765 between 1997 and 1998. More interesting will be next year's data, which might reflect the relative decline in the status of PPMCs over the last year to 18 months.

The companion *Cost Survey: 1999 Report Based on 1998 Data* shows that hospital-owned practices aren't faring as well as other medical groups. The survey shows that multispecialty groups owned by physicians, foundations, or businesses broke even in 1998, compared to a loss of nearly $80,000 per physician for hospital-owned multispecialty groups. The MGMA project manager for the survey, **Daniel Jaynes**, MBA, MSHA, says part of the reason may be that production for hospital-owned practices tends to be lower, while salaries remain competitive. The hospitals also aren't as good at managing their receivables as other practices, he says.

[Editor's note: The management compensation survey features data from 1,725 medical practices, while the cost survey represents some 1,300 practices. The former can be purchased for $75 for members, $95 for affiliates, and $115 for others. The cost survey is $200 for members, $250 for affiliates, and $300 for others. Shipping and handling are additional. For details or to purchase either report, contact the MGMA at (888) 608-5602 or visit the Web at www.mgma.com.] ■

Median Compensation for Selected Management Positions

Title	'97 Compensation ($)	'98 Compensation ($)	% Change
Physician CEO/President	253,940	259,231	2.08
Medical Director	186,720	160,000	14.31
CEO	125,000	126,524	1.22
Practice Administrator (≤6 physicians)	57,000	60,000	5.26
Practice Administrator (≥7 physicians)	77,373	80,000	3.40
PPMC Administrator	75,000	92,765	23.69
Director, Marketing/Sales	43,864	48,000	9.43
Director, Planning/Development	55,403	60,502	9.20

Source: Medical Group Management Association, Englewood, CO.

Patient satisfaction soars with happier employees

Mayo Clinic focuses on staff to improve service

Is it possible to have happy patients but unhappy employees? Administrators at the Mayo Clinic in Rochester, MN, don't think so. That's why employee satisfaction became the focus of a special project to improve service at the Mayo Clinic's division of general thoracic surgery.

By addressing everything from workload concerns to the physician-nurse relationship, the general thoracic surgery unit at St. Mary's Hospital improved morale as employee satisfaction soared. Patient satisfaction rose with it to an astounding 100% excellent rating.

"Service, from the patient's and family's eyes, is all the things that happen when someone talks to them, someone helps them. It's a thousand things a day," says **Victor Trastek**, MD, former chairman of the division of general thoracic surgery in Rochester, who is now chairman of the department of surgery at the Mayo Clinic in Scottsdale, MN. "[We felt that] if the staff were well-supported and worked together well, they would have a better chance of providing service."

The project began in 1997 when the general thoracic surgery unit at St. Mary's Hospital set up a quality improvement (QI) team, then joined a collaborative with the Institute for Healthcare Improvement in Boston to improve service. Their aim: "To significantly improve the 'delight' of both employees and patients on Francis 5C."

"If you don't have employees who feel they're valued, that their work is worthwhile, it doesn't matter how many processes you refine and perfect, it's still not going to be the best service to your patients," explains **Stephanie Sveen**, RN, a staff nurse who is on the QI team.

The effort required a substantial commitment. More than a year after the project began, the team still meets two days a week for at least an hour. "We felt very strongly that this is a part of running our business," says Trastek. "Now it's just part of my daily work. It's just like going to the operating room."

First, the general thoracic surgery team (dubbed Francis 5C for the wing of the hospital) needed to know how employees felt about their jobs. Everyone who had patient contact received a survey: physicians, nurses, patient care assistants, housekeepers, and respiratory therapists.

The surveys asked employees to list both what they enjoy about their work and their frustrations, and answer other questions such as how much independence they felt they had to make decisions for the patient's well-being. They also rated their overall satisfaction with their jobs.

The survey had a response rate of about 50% to 60%. Overall, employees gave the unit a score of 68 out of 100. "When this initiative started, the staff saw this as a flavor-of-the-month type of thing," says Sveen. "They didn't trust that we were going to make any huge changes. There was a reluctance to participate."

Still, the response allowed the team to identify five major areas: workload, relationship building, communication and information, recognition, and physical comfort/environment. The team began to brainstorm about those areas and showed that they were willing to attack even hard problems by conducting rapid QI cycles.

Team tackled workload worries

After about two months, a group of nurses came into one of the team meetings with a concern. The floor had been renovated, and new monitoring equipment allowed the integration of both general care and intermediate care (sicker) patients. The unit cares for lung and esophageal patients, including a large percentage of lung cancer patients.

The nurses complained that staffing was inadequate to deal with the greater needs of some patients and still provide the emotional caregiving they felt was a vital part of their jobs.

While workload is a tough issue, "it was clear that the group had to deal with it, because that's what we said we will do," says Trastek. The QI team, which included the nursing manager, increased the nurse-per-patient ratio, even though it meant the unit would be over budget. After the staff became more accustomed to the new patient mix, the unit was able to regain a staffing level that was within budget.

That swift response brought the QI team a new sense of respect. "It solved the staffing problem immediately, and they got a tremendous buy-in from the nursing group," says Trastek.

The Francis 5C team also addressed the difficult issue of relationships with a "gap analysis." Nurses complained that they didn't feel valued by the surgeons, and the team wanted to know where the communication breakdowns occurred.

They surveyed a sample of 20 nurses with a questionnaire that asked nurses to circle the names of the five surgeons who: "listen to your concerns about patient care," "value your contributions to patient care," "expressed their appreciation of what you do for their patients," and "have made progress in developing good rapport with FR5C nursing staff."

The surgeons received a similar questionnaire, with a yes-no version of the questions, such as, "Do you listen to the nurse who expresses concerns about your patient?" They were taken aback when they received their results. "The surgeons thought they were doing wonderfully when, in fact, there were significant gaps," says Sveen.

The issue was a touchy one, but the effort paid off. Within a week of the surveys, the nurses said they could tell a difference in how surgeons responded to them. Surgeons were more likely to express appreciation for a job well done, and nurses felt like a valued part of the team, Sveen says. "We're the eyes and the ears for those doctors. We're the ones who spend so many hours with the patients. They trust what we're telling them, and they're listening more. It gets to the point where they actually ask for our input. In the past, we were basically not acknowledged at all."

The team repeated the gap analysis between nurses and nursing assistants, the nurse manager and nurses, and nurses and physician assistants.

The team took other steps to improve communication. It placed a white board in each patient room with a dry erase marker. That became a tool for sharing information among the patient, family, doctors, and nurses. Physicians and nurses would write critical lab values and reminders, and patients could write questions. The staff and physicians also now have special forms to jot a note or comment to each other. And the team began a Francis 5C newsletter with employee information.

After the team's actions, the employee satisfaction rating rose as high as 84 out of 100, and 100% of patients gave Francis 5C a rating of excellent.

Other units at Mayo are now looking at the Francis 5C model. And the team continues to meet and address both staff and service issues. "Instead of wondering what they can do about it, [employees] have a place they can go with concerns and issues," says Sveen. "We can't promise to solve everybody's problem, but we're working in the right direction." ■

Coordinating care leads to trust, better outcomes

Patients wonder: Is there a health care 'system'?

An elderly patient comes to the hospital with chest pain. She is immediately admitted and scheduled for bypass surgery. Who is in charge of her care? A cardiologist? A cardiac surgeon? A hospitalist? Or her own primary care physician?

Managed care promised to focus a patient's care with one key provider — the primary care physician. But new specialties grew, including behavioral health "carve-outs" and urgent care centers.

Coordination of care is now gaining attention as an important factor in both clinical outcomes and patient satisfaction. Patients need to know who is responsible for their care, and they have a right to clear information and prompt follow-up, outcomes experts say.

"The absence of a coordinated health system is one of the most important reasons why people don't trust health care right now," says **Susan Edgman-Levitan**, PA, president of The Picker Institute, a Boston-based nonprofit organization that focuses on health care quality improvement from the patient perspective.

"When you ask consumers about their perceptions of the health care system, universally, they start laughing," says Edgman-Levitan, referring to Picker-sponsored focus groups. "Even using the word 'system' is an oxymoron. [They say,] 'There is no system up here. The only person who coordinates care is me. It is not done for me.' There is a tremendous amount of cynicism about health care in general that is, in part, related to that [frustration]."

Keep them in the know

Coordination of care can involve everything from smooth discharge from a hospital stay to prompt communication about test results. "Patients want to know that things are happening that should be happening," she says.

Technology can play a major role in that smooth flow of information. At Kaiser Permanente in Oakland, CA, policies require hospitalists to notify primary care physicians within 24 hours of admission that their patient is in the hospital. The hospitalist is also responsible for sending a discharge summary to the primary care physician who is

Improve coordination of care

Providing better coordination of care may involve a new attitude toward patient care as well as system-level changes. Here are some ideas that emerged from the collaborative on Improving Service in Health Care, sponsored by the Institute for Healthcare Improvement and The Picker Institute in Boston:

To unify and coordinate care in your system as experienced by patients:

- ✔ Identify a spokesperson for the medical team: physician and nurse (give patient card with beeper, e-mail, etc.).
- ✔ Share care plans and clinical pathways with patients so they know what to expect and when.
- ✔ Have a "call return" time service guarantee.

To ensure smooth transitions between care settings and other caregivers:

- ✔ Share map of the entire process of care developed from the perspective of the patient.
- ✔ Check with patient and family for understanding of referral processes.
- ✔ Provide 24-hour prescription refill request lines.
- ✔ Fax orders and clinical information between settings. ■

expected to contact or visit the patient during the hospitalization.

But each physician still generates a new paper record, which isn't readily available to physicians at other sites. Kaiser hopes to rectify problem with an electronic medical record that includes firewalls, passwords, and other security measures to ensure confidentiality.

"As long as things are paper-based, there's going to be a real problem in moving information around, which is a barrier to continuity of care," says **Mike Ralston**, MD, director of quality demonstration for The Permanente Medical Group in Oakland. "As patients move through these different areas of specialty, information about their care has to move along with them."

At Harvard Vanguard Medical Associates in Boston, a computerized medical record allows urgent care doctors to access records, inform primary care physicians of the encounter, and even schedule follow-up appointments with the patient's regular doctor.

"I don't miss a beat," says **Steven Pearson**, MD, MSc, an internist and urgent care physician. "If patients come in who don't have a primary care provider, I can assign one on the spot and arrange for a follow-up."

While technology provides such benefits, coordination of care also relies on simple aspects of communication. For example, nurses or physicians may share the care plan with the patient or even hand over the medical chart for review, says **Diane Miller**, MBA, director of the collaborative on Improving Service in Health Care for the Institute for Healthcare Improvement (IHI) in Boston.

"That's usually seen as something you don't do, but it opens up a partnership," says Miller, who is director of organizational development at Virginia Mason Medical Center in Seattle.

The informed patient

In fact, sharing clinical pathways and guidelines improves patient satisfaction and gives patients realistic expectations, says Edgman-Levitan, who co-chaired the IHI collaborative. When patients don't know what to expect from a hospital visit and discharge, "there is a cascade of problems that arise," she says. "They don't know they're going to need to set up a series of follow-up appointments, or they don't have the equipment they need for home care."

Patients also need to be completely informed of who is responsible for their care. If a diabetic has questions about the insulin schedule, should she ask her patient educator, physician, or pharmacist? "Some teams developed a glossary of sorts of the different professionals you will see in the course of this illness, what they're responsible for, and who is the final authority," says Edgman-Levitan.

In fact, she knows from her own experience as a breast cancer patient how confusing the team of specialists can be. "From my perspective as a patient, my experience of how my managed care organization manages and coordinates my care is mostly through the approval process for seeing specialists," she says. "It doesn't facilitate my seeing the specialists. It just makes it possible for me to see the specialists."

Truly coordinated care eases patients through their health care experience and even reaches into their home environment, when necessary. At Cedars-Sinai Medical Center in Los Angeles, efforts to create a smooth hospital discharge begin within 24 hours of admission.

A case manager or social worker from the department of case management visits patients,

Sample Questions on Coordination of Care

The following questions are excerpted from the adult office visit questionnaire developed by The Picker Institute in Boston. They are designed to provide feedback on the patient's experience with care:

- ❒ Did the provider explain what to do if problems or symptoms continued, got worse, or came back?
- ❒ Did someone tell you how you would find out the results of your tests?
- ❒ Did someone tell you when you would find out the results of your tests?
- ❒ If you needed another visit with this provider, did the staff do everything they could to make the necessary arrangements?
- ❒ Did you know who to call if you needed help or had more questions after you left your appointment?

hands them an information sheet, and provides them with names and phone numbers of the case manager and social worker who cover that area. "In that brief intervention, you're also able to determine whether this person has discharge-related needs," says **David Esquith**, LCSW, MPA, manager of medical social work.

To improve communication with attending physicians, the department of case management also faxes a sheet to their office briefly outlining the discharge plan. Physicians need only respond if they have questions or concerns.

Just before discharge, a case manager or social worker again visits the patient and discusses any discharge needs, such as transportation, nutrition, psychosocial support, home care, or therapy. In many cases, the staff person simply says, "It did not appear there were any specific needs you would have when you were discharged. From your perspective, has anything changed?"

In cases of elective surgery, such as scheduled cardiac surgery, Cedars-Sinai is working with medical groups to begin discharge planning before the patient even enters the hospital. With extra time to plan, the social workers and case managers can better meet patients' post-discharge needs.

The changes in discharge planning led to a surge in patient satisfaction, Esquith says.

Medical groups and hospitals can monitor patients' experiences with coordination of care just as they do satisfaction with access or communication, says Edgman-Levitan.

The Picker Institute ambulatory care survey contains questions about coordination of care, including questions about receiving test results and smooth referrals. **(See sample questions at left.)** "It's as important to send them the normal results as it is to send them abnormal results [of tests]," she says. "That becomes part of your quality control. If [patients] don't hear from you, they will follow up."

For chronically ill patients, coordination is especially important as different physicians prescribe medications for different conditions. But even the healthy patient should have coordinated preventive care that includes reminders about screening tests or immunizations.

"Continuity is something patients have a right to expect," says Ralston.

[Editor's note: A new collaborative on Improving Service in Health Care will begin in November. For more information, contact the Institute for Healthcare Improvement, 135 Francis St., Boston, MA 02215. Telephone: (617) 754-4800. Fax: (617) 754-4848. Web site: www.ihi.org.

For more information on Picker surveys and services, contact The Picker Institute, 1295 Boylston St., Suite 100, Boston, MA 02215. Telephone: (617) 667-2388. Fax: (617) 667-8488. Web site: www.picker.org.] ■

Program links primary and psychosocial care

Medical group breaks barriers to behavioral care

When physicians refer patients to a psychologist or other behavioral health specialist, more often than not they never follow through. But by connecting behavioral health with primary care, HealthCare Partners in Torrance, CA, improved successful referrals by up to 80%.

"It's a new system of delivering health care so you're dealing with the biopsychosocial aspects," says **James D. Slay Jr.**, RelD, director of behavioral health and collaborative care. The collaborative was named an Acclaim Award honoree by the American Medical Group Association in Alexandria, VA.

Behavioral health specialists, including psychiatrists, psychologists, and chemical dependency specialists, moved into primary care offices where they have staggered hours.

For example, on a Monday morning, a child psychologist may be available, and a specialist in depression may be on site in the afternoon. The specialists have formed links with family practitioners, internists, pediatricians, and OB/GYNs.

The primary care physician can introduce patients to the specialist he or she is recommending for referral, and the patient can schedule an appointment at the same office site. The physicians and specialists also can discuss cases, as necessary. Even receptionists have been trained in the collaborative care model, Slay notes.

In the case of emergency situations, such as a patient who appears suicidal or homicidal, a handoff occurs on the spot.

"The behavioral health department spends more time in primary care than it spends in the department working traditionally," he explains. "It is true coordination in real time — verbal exchange, record exchange, information exchange."

Lunchtime focus

The relationships are enhanced by a monthly collaborative care forum — a lunchtime meeting, which focuses on a biopsychosocial theme such as depression or somatization (a physical ailment that has a psychological origin). Physicians and behavioral health specialists also can bring cases for discussion.

The collaboration breaks down barriers, such as stigma felt by patients who have never sought help for psychosocial issues, and it ensures that patients receive appropriate care, says Slay. "We're reducing the anxiety and resistance of the patient. We demystify the process."

The result, he says, is higher patient and provider satisfaction and better outcomes. Primary care physicians are more likely to refer patients for evaluation by behavioral health. Two-thirds of the patients seen in the collaborative care had never before had behavioral health or mental health treatment.

The program also decreases inappropriate utilization of primary care, Slay says. "By treating people appropriately, according to their real need in real time, you always have a better result." ■

Coalition leads push to restore gainsharing

Group to urge Congress to change law

Law firm McDermott, Will & Emery has formed a coalition that seeks to restore the ability of physicians and hospitals to enter into cost-reduction arrangements without risking fines from the Office of the Inspector General (OIG) of the Department of Health and Human Services.

The coalition, largely made up of hospital system representatives, is seeking an amendment to the Civil Monetary Penalties Statute that would legalize properly structured gainsharing arrangements, says **Marilu M. King**, JD, an attorney who is heading up the effort from the law firm's Washington, DC, office.

Gainsharing is an arrangement in which a hospital gives physicians a percentage share of any reduction in the hospital's cost for patient care that can be attributed to the physicians' efforts.

In a July advisory that surprised many in the health law community, the OIG pulled the plug on gainsharing arrangements between hospitals and physicians. It advised hospitals and physicians to terminate their gainsharing arrangements and seek legislative relief by clarifying the law to permit properly structured gainsharing arrangements.

The Coalition to Restore Physician-Hospital Cost Reduction Arrangements was formed in August to try to convince Congress to amend the Civil Monetary Penalties Statute as cited by the OIG in its special advisory bulletin, King says. At the same time, the coalition is supporting the efforts of U.S. Rep. Bill Thomas (R-CA), chairman of the House Ways and Means Subcommittee on Health, to correct problems in the Stark II statute.

Thomas' bill, called "the Physician Self-Referral Amendments of 1999," would amend the Stark law so physicians who have a share of ownership or who have compensation arrangements with entities such as clinical labs or cardiac catheterization units could refer Medicare or Medicaid patients, King says. "Because our coalition is focused on gainsharing, we are more interested in the compensation arrangements rather than ownership. There is some concern by lawmakers that the Stark statute would prohibit some kinds of gainsharing arrangements."

The coalition includes hospitals, health systems, academic medical centers, group practices,

accounting firms, and health care consulting firms.

In addition to discussions with Congress and the OIG on revising the law, the coalition is seeking support from national hospital and physician advocacy associations. King urges physician practices to:

- bring the matter to the attention of any hospitals with which they have compensation arrangements and ask them to support the coalition's efforts;
- make sure the professional societies to which they belong are aware of the effort;
- contact their congressional representatives and urge their support of the measures.

[Editor's note: For more on the coalition, contact Casey Kundert at McDermott, Will & Emery's Chicago office at (312) 899-7203 or visit the law firm's Web site at www.mwe.com.] ■

NEWS BRIEF

New resource for managed care contracting

Administrators and physicians who need help honing their contract negotiation skills may want the new book by editorial advisory board member Reed Tinsley, CPA. The American Medical Association published the book, *Managed Care Contracting: Successful Negotiation Strategies,* in October. It provides practical information and tools to help practices get the most favorable legal and financial terms possible. Specific issues addressed include how to:

- analyze and assess contract issues ahead of time so you can enter a contract negotiation with confidence;
- find leverage over managed care payers;
- negotiate discounted fee for service contracts;
- create a profitable capitation arrangement.

The book is available for $45 to AMA nonmembers and $34 for members. It can be purchased by calling (800) 621-8335 or visiting the AMA's Web site at www.ama-assn.org/catalog. Reference order No. OP317999AVX. Further discounts are available for multiple orders. ■

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