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INSIDE

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Looking for ways to make life easier? Technology can lead the way

New products can save time and money, increase efficiency

When a health plan proposed a change in reimbursement for a particular drug, **Barbara Metzer**, administrator of Citrus Valley Urology in Glendora, CA, wanted to know how it would affect her practice's bottom line.

She simply ran a report on her practice management software, and in a few minutes, she knew that the practice had 100 patients on the drug but only seven belonged to that particular health plan.

"Without the aid of my computer, this would have been very time-consuming. There are so many ways the new technology can help you manage your practice," Metzer says. For instance, you can track how many patients you saw on each plan, what you are getting in the way of reimbursement, and what you should get reimbursed for. To track this by hand is virtually impossible, she adds.

"Ultimately the objective of information technology is to support the organization's objectives. This includes improving patient care, improving efficiency and effectiveness — and if you're lucky, reducing costs," says **John Spearly**, vice president of Phoenix Health Systems, a health care information technology consulting and outsourcing firm in Washington, DC.

But if your practice isn't on the cutting edge of technology, you aren't alone.

"Health care, in general, is considered behind the times in terms of technology," asserts **Julie Elmore Jones**, MBA, MHA, consultant with Gates, Moore & Company, a health care management consulting and accounting firm in Atlanta.

However, physician practices are under pressure to computerize their operations to meet the demands of managed care companies and payers alike, she adds. "If physicians aren't submitting claims electronically, the intermediaries want to know why."

Electronic submission of claims greatly improves your cash flow. Not

only can you get payments more quickly, if you need to re-file, you can do so in seven to 10 days as opposed to 30 to 60 days with paper claims, Jones says.

At Citrus Valley Urology, all of the billing is handled electronically. "More and more carriers are insisting on it," Metzer says.

"Turnaround time used to be months. Now that we're billing electronically, the turnaround time for payments is much improved. When you cut to the bottom line, it can be extremely beneficial," she adds.

Computerized patient records can save money and staff time by cutting down on transcription time and the time spent looking for charts, according to Jones. "The larger the practice, the bigger the expense involved in maintaining a paper system. Transcription is consistently one of the most expenses line items that physician practices have," she says.

> *"But once they've gone through that transition, the majority of clients say they would never go back to a paper system."*

Practices lose a lot of money chasing charts and often have to hire people just to pull charts and look for them when they are out.

Urology Associated of Southeastern North Carolina, based in Wilmington, developed an electronic medical records system five years ago, primarily to reduce the amount of time and energy required by the staff to chase down charts, says **Richard Rutherford**, CMPE, former administrator of the practice. Rutherford recently joined the American Urological Association in Baltimore as head of its practice management section.

The practice is now implementing a new, more comprehensive system, he says. **(For details on how the system works, see related story, p. 75.)**

Computerizing the patient records has saved staff time and helped the growing practice avoid hiring additional staff, particularly in the medical records department, Rutherford says.

The electronic medical records system, combined with the practice's voice mail system, has also helped cut down on overtime pay for the nursing staff by making it easier for the nurses to return telephone calls between patient encounters. Now, instead of having to look for the charts, the nurses can access the records by computer when they have a few minutes and have all the information they need when they call back patients, he adds. **(For more information, see story, p. 76.)**

More than 95% of Gates, Moore & Company's clients are transmitting at least some of their claims electronically, and a few have converted to systems that completely computerize their patient records and billing systems, Jones says.

"Just two or three years ago, I didn't have any clients with computerized patient records. Now I can list a handful of clients who do have them, who have implemented them successfully, and who are very happy with them," she says.

The transition to computerized patient records can be painful because the staff has to adjust to the new system. "But once they've gone through that transition, the majority of clients say they would never go back to a paper system," she says.

At this point, practices are not solely computerized, Jones points out. "A lot of legislation has to occur before they can become truly paperless."

Metzer's practice uses the computer to set all appointments. The software has time slots for each physician and asks for specific patient demographic information so the check-in will go more smoothly.

"Computers help our office improve customer service. During the first phone call, we gather data. That helps with the flow of scheduling. We see who comes in for shots and enter it there. We can see who needs what procedure and know how long it takes," Metzer says.

"Some physicians are faster than others and need shorter appointments. Some take more time," she says.

COMING IN FUTURE MONTHS

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- How to incorporate alternative medicine into a traditional practice

The daily procedures involving appointments are as follows:

- Staff run a list every day to find out who is coming in for an appointment.
- The computer runs a fee slip that is put in the chart.
- The physician checks off what he or she did.
- When the patient checks out, if he or she needs another appointment, it's entered into the computer.
- The chart then goes to the billing person, who looks at it and evaluates it. The system gives the practice the ability to bill electronically every day.

The computer also prompts the staff to make reminder calls or send out cards when it's time for a patient to come in for a checkup or diagnostic procedure. "I can't say enough good things about how efficient this makes us," Metzer says. ■

Front-end planning avoids back-end mistakes

Plan carefully when buying technology

It's not hard for a large physician practice to make a $1 million mistake when purchasing information technology, says **John Spearly**, vice president of Phoenix Health Systems, a firm specializing in health care information technology consulting and outsourcing in Washington, DC.

A simple practice management solution could range from $30,000 to $40,000 for a small office to more than $1 million for a large multigroup practice.

With that kind of expense, it's necessary to do careful planning.

"Choosing information technology can be very complex. Front-end planning is very important," Spearly says. Before considering a purchase of new information technology or upgrading what you are currently using, do some strategic planning, he advises.

"A mistake that is easily made in information technology is to sit down with the salesman, look at a product, decide it looks right for the practice, and make a purchase. There needs to be a more logical approach," Spearly says.

Urology Associates of Southeastern North Carolina took 18 months to decide what new technology was needed, analyze the options, make a decision, and place an order, says **Richard Rutherford**, CMPE, former administrator of the Wilmington, NC, practice. He recently joined the American Urological Association as head of its practice management section. "New products come on the market every day; it's an intimidating process," he says.

Spearly suggests that physician practices begin the decision-making process by learning more about their external environment, internal business objectives, and computer systems and applications, as well as the gaps between what they are using now and what they want or need.

Then practices should look at the options available and develop a plan to meet their objectives. It may be a multi-year, multifaceted process, Spearly adds. "Information technology should be viewed as a means to achieve business objectives and approached in that manner."

There are a lot of companies offering a variety of products that can get health care providers technologically up to speed, says **Julie Elmore Jones**, MBA, MHA, consultant with Gates, Moore & Company, a health care management consulting and accounting firm in Atlanta.

"There is an endless array of products that will do everything from providing on-line services to computerized patient records. Some are good technology, and some are not there yet," she adds.

When it comes to purchasing technology for your practice, you've got a lot to choose from.

One industry journal lists more than 200 vendors of practice management software and more than 275 computerized medical records vendors.

Here are some factors you should consider when selecting technology for your practice:

❒ **Functionality**.

Most physicians won't use the software if it isn't fast, easy, intuitive, and geared toward how a physician thinks, organizes, and works, Spearly adds.

Also consider these questions:

— Will the software meet the needs your practice has identified?

— Is the system easy to use?

— Is it an intuitive system with minimal training time involved?

"My experience has shown that it's hard to get physician practices to change their work flow to match the functionality of computer system," he says.

Before you buy, you should see the program in

use and talk to people who use it to make sure it fits your needs.

A common step is to have vendors respond for a request for proposal (RFP) that lists the necessary functions and features. But don't stop there. "A vendor will never answer 'no' to an RFP feature or function because it will have them excluded. You'll probably get 'yeses' and qualified 'yeses'" Spearly says.

❒ **Technical factors.**

Many vendors may try to undersize a system to keep the initial cost down, Spearly says. If you buy an undersized system, you'll end up having to invest in more storage space on the computer drive or more licenses to accommodate the number of users. Make sure your system can grow with your practice in case your practice grows or merges with another practice.

Check to see that your new hardware and software are compatible with existing systems such as corporate headquarters or your community hospital.

❒ **Costs.**

Take into account the initial cost and ongoing maintenance and support.

"The careful buyer realizes that, in many ways, software vendors are not in the software selling business but in the support and maintenance business. That's where they make their money," Spearly says. Find out if the license fees are perpetual or annual, and what the maintenance and support fees are.

❒ **Support and service.**

These are critical needs when you purchase information technology. You need to make sure that when you have a problem and call for support, the company is going to answer your call and get back to you with a solution. Check references very carefully to verify the company provides good support and service. ■

Turnkey or best of breed: Which works for you?

Here's a look at the types of products available

There are two approaches to choosing technology for a physician practice: turnkey and "best of breed," according to **Richard Rutherford**, CMPE, former administrator for Urology Associations of Southeastern North Carolina in Wilmington. He recently joined the American Urological Association in Baltimore as head of its practice management section.

If you choose a turnkey approach, you'll buy all your software from one vendor, or from a reseller who contracts with another company with a compatible software package — the two vendors get together and build the links.

When Rutherford purchased his practice's first medical records and billing system, he took the turnkey route. For the most recent purchase, he bought from more than one vendor because no one had everything he needed.

When you start your technology-purchasing project, you'll probably want to look first at software. Software for physician practices includes practice management software, clinical applications software, physician support software, and decision-support software. **(For a list of what each will do, see box, p. 69.)**

"In each of the four categories, most vendors will proclaim that their product will enhance quality, service, and cost-effectiveness. Most can and do save time, improve efficiency, and give more time for patient care if the practice is utilizing the appropriate software for its needs," says **John Spearly,** vice president of Phoenix Health Systems, a health care information technology consulting and outsourcing firm in Washington, DC.

If your practice chooses a Windows-based system for electronic medical records, it will be easier for all your software to interface, suggests **Julie Elmore Jones**, MBA, MHA, a consultant with Gates, Moore & Company, a management consulting and accounting firm in Atlanta.

Windows vs. UNIX

The majority of computer patient record systems will interface only with a windows system, she adds. "That's where everything is moving. A Windows-based system should be able to provide better management reporting capabilities. This is extremely important."

In the past, most billing and collection software was UNIX-based. Some vendors tell clients their system is Windows-based when it's actually a UNIX system with a Windows overface, she warns.

"These days, nobody should be looking at something that's not Windows-network capable. The ability to transport data from one platform to

another is what's going to make the difference," adds Rutherford.

Here are some more technology options:

Hardware options

In most cases, your hardware purchasing decisions will be based on the software applications and software vendors you select.

You need to determine how big a computer or server you need and how much disk and storage space you need, based on the size of the practice and number of patients served.

Your needs will range from one server with two or three computers for a small practice to a large network system for a large integrated health care delivery system.

User interface options

Your choice may be a traditional hard-wired terminal located in an office or examination room, a mobile device such as the personal digital assistant, or a laptop on a mobile cart. In choosing the type of user interface equipment, you should take into account what works best for the physicians in your practice.

Another consideration is what physicians will need for remote access when they're away from the office. This could be a traditional dial-up to an office computer system through the Internet, or cell phones with an integrated Web browser that allow you to dial up the system from wherever you are.

ASP provider arrangements

Application service providers (ASPs) allow their customers to run standard software applications through the Internet using a virtual private network. The advantage is that the practice doesn't need to purchase the hardware and software; users just log onto the network.

"The Internet has enabled this method of application delivery to be much more efficient than in the past. More and more ASPs in the physician practice arena give physicians more options," Spearly says. An ASP arrangement is not necessarily a more cost-effective solution than purchasing your own software, but it is one that should be explored as an alternative, he adds.

Voice recognition technology

This technology allows the user to speak into the computer, which transcribes the sounds into words on the screen. Users must "train" the system to learn their speech patterns, a slow process that involves speaking into the computer and making corrections on the screen.

The technology gets mixed reviews from practices that have tried it, Jones says. "In the beginning, it's a slow process, but it's an area where we expect to see better technology come out in the next couple of years."

Physicians who don't want to take the time to train the system aren't happy with it, but others enjoy it and feel it makes a positive contribution to their practice, she adds. "You have to speak slowly, so I wouldn't say it saves them time. It may save them some money in terms of transcription expense."

On-line patient services

"The Internet is changing the way health care operates. We're seeing much more use and demand of the Internet and connectivity

What's available in software for practices?

Here are the most commonly used types of software for physician practices and what they will do:

- ✔ **Practice management software:** This is financial software and includes appointment scheduling, claims processing, billing, collection, and referral capabilities.
- ✔ **Clinical application software:** This provides clinical information along with patient demographics, their problem list, lists of medications, allergies, laboratory results and other tests, encounter notes, and alerts such as immunization or drug/food interactions, alerts of duplicate or overdue tests.
- ✔ **Physician support software:** This includes capabilities for appointment and scheduling, messages, documents for review and approval, and possibly electronic signatures.
- ✔ **Decision support software:** These programs may include medication lists and formularies, clinical protocols, reference guides, and patient education materials. ■

by patients," Spearly points out.

Some progressive practices offer on-line services to patients, Jones says. Those include appointment scheduling and on-line laboratory results.

"If you've got the right patient population, the patients love it. If you've got a heavy Medicare population, think twice about offering on-line services," she adds.

She warns that practices should be careful to comply with security regulations required by the Health Insurance Portability and Accountability Act if they are going to be sharing clinical information on the Internet.

"We're seeing a move toward on-line services. It will save costs in the long run, but more importantly, it caters to the patient in a managed care environment," Jones says.

For instance, when patients have surgery scheduled or have to be pre-authorized for a visit, they can check on-line to make sure everything is in order rather than going in for the visit, finding out the treatment hasn't been approved, and having to reschedule. ■

Learn how to choose the best technology

Care in the beginning helps avoid problems later

There's a bewildering array of technology products on the market that makes it hard to decide what will be best for you. *Physician's Managed Care Report* asked experts for advice on how physician practices should go about choosing technology.

Here are their tips:

• **Check out your vendors carefully.**

There are literally hundreds of vendors in every area of software applications. Choose your vendors carefully to avoid making costly mistakes. Find out how many installations they have done. You don't want to be a Beta site without knowing it.

Check to see if the vendor has experience with practices of your size and type. A large physician practice doesn't want to contract with a vendor that has experience only with individual and two-doctor practices, says **Julie Elmore Jones**, MBA, MHA, consultant at Gates, Moore & Company, a health care management consultant and accounting firm in Atlanta.

A vendor that specializes in the hospital environment may not have a solution that matches needs for physician practices, adds **John Spearly**, vice president of Phoenix Health Systems, a health care information technology consulting firm in Washington, DC.

• **Don't believe everything a sales rep promises or everything you see in a demonstration.**

A discussion and demonstration by the vendor are necessary steps, but don't stop there. Check it out for yourself by visiting other practices and talking with people who use the system, Spearly advises. "A salesman will promise anything. A demo on a laptop in your office is very different from real production," he adds.

• **Talk to other practices that are using the system.**

Visit other practices, and talk to the physicians and office staff currently using the system and verify what you heard from the vendor.

"Talking to other practices sold me on the system I chose even though I went to seminars and went through practice runs on the systems I was considering," says **Barbara Metzer**, administrator of Citrus Valley Urology in Glendora, CA.

Check out any problems the practice has had with the system, what kind of service they receive when they have problems, and whether the system is easy to use, she advises.

• **Don't consider a product that will require a lot of customization.**

"That's a slippery slope and a money pit. When the vendor comes up with next year's version, you'll have to pay to have it customized again," Spearly adds.

• **Check out all the options.**

In addition to looking at the big legacy systems, check out the new, smaller vendors, Jones advises. "There are some good competitive products out there that can compete with the big systems very well."

• **Avoid investing in either old technology or unproven technology.**

Choose a company with a track record and avoid what Spearly calls "bleeding-edge technology that salesmen like to promote."

• **Start with small steps.**

You and your staff may be overwhelmed if you computerize your entire operation all at once. "It's a huge mistake to do it all at one time. There

(Continued on page 75)

Physician's Capitation Trends™

• Capitation Data and Trend Analysis •

Capitation falls upon hard times for Medicare

Maybe capitation is 'not all that'

A hard rain is falling on Medicare's capitation program, Medicare+Choice (M+C), according to federal analysts, who say the program is failing to meet many of Congress' goals.[1]

"Since the passage of the Balanced Budget Act [BBA] of 1997, progress toward these goals has been halting," says the most recent analysis of Medicare's many programs, including the country's largest capitation system.

A similar storm is looming in private sector capitation circles, where recent trends show that the growth rate in HMO enrollment and the actual numbers of operating HMOs are both declining, says **Tammy Lauer**, lead analyst with InterStudy, a Minneapolis-based managed care research organization.

Further, a recent mega-study of global capitation shows that physician-hospital risk sharing — while helping hospitals and physician groups to better integrate their services — is not holding down costs, says **Gloria Bazzoli**, PhD, lead author of the study and a professor of health policy at Northwest University in Evanston, IL. **(See related story, p. 74.)** The study looked at 665 global capitation sites.

From Medicare's corner of the world, the BBA was the tool by which Congress set out to lower costs, increase benefits, and overall make managed care the silver bullet of health care reform. Instead, Medicare Payment Advisory Committee's (MedPAC) March 2000 documents show some financial success but some troublesome, highly nonglamorous results as well, including:

• Availability of plan options has not increased.

• Most beneficiaries in rural areas still cannot enroll in M+C plans.

• Benefit packages have become less generous while premium costs have increased.

One goal was achieved, however, MedPAC officials report: reducing Medicare's expenditures. In government parlance, Medicare has been able to "reduce the rate of increase in spending" in program payments per beneficiaries for both fee-for-service and M+C programs. Thus, officials are facing some financial success but at the cost of some unpopular political fallout.

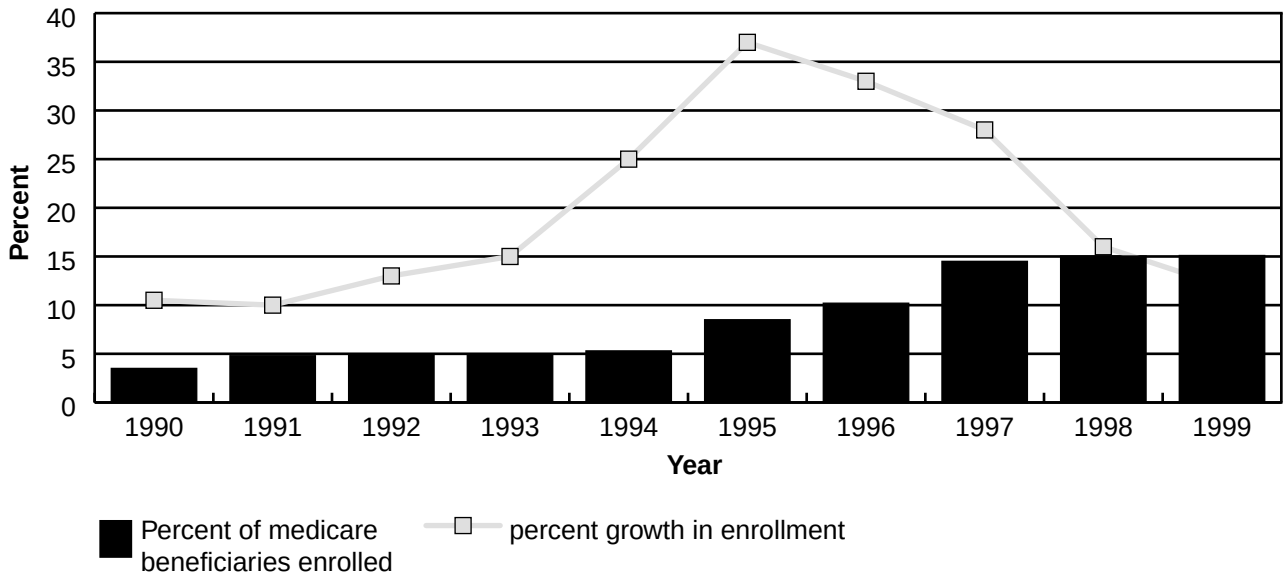
Here are the key trends MedPAC analysts say now characterize Medicare's capitation efforts:

• Success at cutting back Medicare's expenditures. No question the business community made it loud and clear that it wanted control over private sector health care spending. And with concerns of Social Security's demise looming amid the private sector's complaints about its problems, little wonder Congress placed so much focus on lowering costs. Managed care — for both public and private sector — showed the most promise. Medicare was successful at decreasing per capita spending as well as slowing the growth rate overall, MedPAC reports.

Here is how much specific sectors of health care are slowing their growth rates, based on MedPAC's analysis:

Service Area Annual Growth Rate

	1992-1997	1997-1999
Inpatient hospital	5.8%	-0.5%
Home health	21.9%	-26.9%
Skilled nursing facility	30.9%	0.4%
Physician fee schedule	4.8%	3.7%
Outpatient hospital	6.7%	-5.1%
Medicare+Choice	7.9%	6.5%
Total Medicare (per beneficiary)	8.0%	-0.7%



Source for all charts in this story: Medicare Payment Advisory Commission. "Medicare+Choice: Trends since the Balanced Budget Act." *Report to Congress: Medicare Payment Policy.* Washington, DC; March 2000.

To achieve these reductions, Health Care Financing Administration used several tactics, including the following:

• A reduction in the national update of 0.8% in 1998 and 0.5% cut in 1999.

• An assessment (paid by insurers) for education charges to inform beneficiaries about the M+C program.

• Gradual removal of payments for graduate medical education, which had at first been part of capitation's base payment amounts.

• A new capitation floor provision for M+C payment rates increased payments in some localities and lowered it for others; but, overall, the new payment blend (now in transition) generally redistributes payments from higher to lower levels.

• Cuts in payments to physicians and hospitals in the traditional fee-for-service plans.

• Less success at keeping insurers committed to Medicare capitation — i.e., "the big bail out" by business. Despite the government's efforts to woo insurers to adopt capitation and to keep it, the statistics aren't looking good. **(See charts, above and p. 73, bottom.)** In January 1999, 45 insurance plans dropped out, and as of January 2000, 41 more terminated their relationship with Medicare.

At the same time, contractors are reducing their scope of service areas by withdrawing from at least one county they previously served, MedPAC officials report. As a result, in 1999, 405,000 beneficiaries could not remain in the risk plan they had enrolled in as of July 1998; at the beginning of 2000, some 327,000 M+C enrollees faced the same situation.

Overall, the shifting and / or terminating of risk contracting reflects declining ability of Medicare to reach beneficiaries via risk-based plans, MedPAC officials report. When the BBA was enacted, insurers were still signing up; in 1998, 74% of Medicare beneficiaries had access to a Medicare risk option. Access dropped to 71% in 1999, to 69% in 2000. In actual numbers, that means about 1 million fewer elders had access to M+C plans in 2000 than in 1999, and 2 million fewer than had access in 1998. **(See chart, p. 73, top.)**

• Minimal success at developing additional capitation products via more flexible, innovative insurance products and providers. While Congress set up the legal infrastructure for varied M+C plans, "almost no progress has been made toward the availability of these new types of M+C plans," MedPAC officials report. The BBA created these options for Medicare risk structures:

— Provider-sponsored organizations (PSOs). The BBA established a waiver process for encouraging the development of PSO plans, but PSO potential candidates (physician groups) said the process was still too bogged down in regulatory burdens. Also, several PSOs in Medicare pilot projects withdrew.

— Preferred provider organizations (PPOs).

Medicare+Choice Contract Terminations and Service Area Reductions

	January 1999	January 2000
Terminations	45	41
Service area reductions	54	58
Enrollees who could not stay in their plans	407,000	327,000
Enrollees in counties where all plans withdrew	50,000	79,000

No existing PPOs have opted to accept M+C plans, arguing that they can't meet the quality standards established by HCFA.

— Private fee-for-service plans. Congress offered an option for fee-for-service to add on a managed care option, but so far none have taken that option.

— Plans attached to medical savings accounts (MSAs). The budget law also offered an option for MSAs to include a capitation plan, but so far no MSA applications for capitation have been made.

— Increased premiums and decreased benefits. MedPAC probably didn't need to tell Congress this, given the public outcry over this trend. On average, according to MedPAC analysis, beneficiaries enrolled in a Medicare capitation contract in 1999 who could get the same benefits and carrier the next year faced a premium increase of $11 per month from their own pocketbooks. This premium increase represents a 68% hike and benefits would not be improved. In other cases, the availability of zero-premium plans and zero-premium plans with drug coverage has declined. Beneficiaries willing to switch to a new insurer saw their premiums increase on average from $6 in 1999 to $9 in 2000.

In looking at the future of Medicare capitation, MedPAC officials warn that to a large extent, Congress' dual objectives of lower costs and richer benefits are in conflict. Nevertheless, some regulatory tweaking in the future will help with increasing payments to providers, officials say. These tweaks include a reduction in the education assessment, an increase in 2002 in payments, and a provision to allow providers to charge more to certain service areas.

Also, lawmakers are hoping that their recent repeal of major regulatory requirements for PPOs to step into capitation will expand commercial interest in Medicare capitation.

In summary, MedPAC said, it "believes that the Congress' attempt to increase plan participation and availability through several [recent regulatory] provisions has the potential to succeed in providing Medicare beneficiaries with more coverage choices."

Yet, much depends, too, on commercial market forces. In some markets, capitation is going strong, but in others, hospitals and physicians have defended themselves rather strongly against having to assume capitation, MedPAC says. "The pattern of managed care plan withdrawals suggests that in some markets, providers have regained leverage and do not find it in their interest to contract with managed care plans," they write.

Also, in some markets, Medicare payments account for a major piece of a hospital or physician group's revenue, while in others it does not.

Availability of Plans With Selected Benefits, 1999-2000

	Total eligible beneficiaries (millions)	Any plan		Zero-premium plan		Plan with Rx coverage		Zero-premium plan with Rx	
		1999	2000	1999	2000	1999	2000	1999	2000
National	39	71%	69%	61%	53%	65%	64%	54%	45%
County rate per month									
$401.61 (floor)	4	14	15	5	3	12	12	3	2
$401.62-$449.99	12	50	47	29	18	39	40	18	14
$450-$550	14	86	81	78	67	81	76	70	52
More than $550	10	97	97	97	94	96	96	95	91
Rural areas	9	23	21	14	9	19	16	8	6
Urban areas	30	86	83	75	66	80	79	68	57

"For many providers, Medicare is the 800-pound gorilla in the market, significantly outweighing commercial payers. For others, however, Medicare payments may be a much smaller factor."

Reference

1. Medicare Payment Advisory Commission. "Medicare +Choice: Trends since the Balanced Budget Act." *Report to Congress: Medicare Payment Policy*. Washington, DC; March 2000. ■

Global capitation fails to save costs, study says

Financial and political expectations of capitation — and other aspects of managed care — are falling short, based on recent research of capitation's performance.

One big blow to capitation's armor comes from a recently released study that suggests that global capitation — a capitation contract in which patient responsibility and payments are shared between a hospital and a physician group — is not cutting back hospital expenditures.

A recent analysis of 655 hospitals with integrated physician groups, jointly funded by two foundations and two universities, says provider capitation has motivated tighter integration between physicians and hospitals, but it has not lowered costs.[1]

"Our empirical analysis suggests that provider capitation is promoting certain types of physician-hospital integration, including development of financial risk-sharing arrangements, administrative and management service integration, joint ventures to create new services and development of computer linkages," says **Gloria J. Bazzoli**, PhD, professor of health policy at Northwestern University in Evanston, IL, and lead author.

Interestingly, Bazzoli's survey refutes the theory that HMO penetration increases the likelihood of more physician-hospital global contracting. Instead, many localities are engaged in integration efforts, whether or not capitation is widespread in their market, the researchers found.

In either case, cost advantages are not surfacing. "Empirical analysis of hospital costs suggested that capitation is not significantly affecting hospital costs, with other factors held constant, and that integration has not led to hospital cost reductions," the researchers wrote. In fact, these arrangements — based on 1995 hospital data — have increased hospital costs.

And, in circles beyond those of statisticians and economists, the success of managed care in general and capitation in particular also is highly debated. Clearly, the political flames against managed care are still are raging.

"The managed care industry is at a crossroads," according to **Alice Noble**, PhD, and **Troyen A. Brennan**, PhD, professors of public health at Harvard University in Cambridge, MA. "Belief in the ability of market forces alone to create an environment fostering quality health care at lower cost is eroding,"[2] they write in a recent article in the *Journal of Health Politics, Policy and Law.*

Many states have passed legislation as part of a national "managed care backlash," Noble and Brennan pointed out. Yet major political changes often traverse a series of predictable stages. Managed care regulation, they proposed, is somewhere between a third and a fourth stage. They describe the third stage as: State-based "legislative patterns." These laws started appearing on the books in the late 1990s and are continuing. Nearly all the states are adopting similar managed care laws but they still lack any integrative or overall direction.

The fourth stage they call "regulatory middle ground." This is a period only now beginning, the authors say. These regulations will be more "nuanced" and comprehensive in nature. The goal is to help make managed care's objectives more achievable without discouraging the influence of market forces. An example of this stage is growing regulation of risk-bearing provider groups, which look at organizations as a whole rather than specific practices within a managed care organization.

For managed care to have acceptance both politically and financially, some middle ground will have to be reached, Noble and Brennan suggest, between unfettered market dynamics and stricter regulatory oversight. That's the difficult compromise that both private sector and Medicare capitation opinion-leaders are searching for now.

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(Continued from page 70)

are so many changes that people are forced to make that they suffer from information overload," says **Richard Rutherford**, CMPE, former administrator for Urology Associations of Southeastern North Carolina in Wilmington.

Start with something less complicated

Rutherford, who now heads the practice management section for the American Urological Association, suggests starting with a voice mail system if you don't already have one. Then go to a computerized billing and insurance filing system, and expand into electronic medical records.

• **Don't expect to buy a system and just forget it.**

Set up a capital budget and invest money every year to keep up with technology.

• **Make sure your new system can meet all the requirements of the Health Insurance Portability and Accountability Act (HIPAA).**

Get detailed information about how the vendor will meet the regulations and get it in writing. "At this point, it's fairly accepted that the proposed regulations will become final. We recommend that clients take the proposed regulations and work with them when they set up or add to their systems," Jones says.

• **Make sure the vendor will offer updates to keep your software HIPAA-compliant.**

Even if you are not in the market for new software, talk to your vendors to make sure they are HIPAA-compliant and will continue to update your system to keep it in compliance, she adds. ■

Computers run the show for this savvy practice

Scheduling, check-in, records, billing linked

Physicians at Urology Associates of Southeastern North Carolina in Wilmington are using wireless laptop computers to review patient charts and create encounter notes right in the examination room.

They perform the tasks necessary to treat the patient, decide on what prescriptions to order, and enter the information into the computer.

Based on the data entered, the software recommends a CPT code for each procedure. The information is automatically transmitted to the front desk where a charge ticket with the calculated charges and any prescriptions are printed out.

Any paperwork is waiting for the patient at checkout without anybody having to write anything by hand.

It's all a part of the practice's new information technology system. **(For information on the practice's e-mail and voice mail system, see article, p. 76.)**

The practice is implementing its second generation of electronic medical records and billing after five years experience with another system, says **Richard Rutherford**, CMPE, former administrator, now with the American Urological Association in Baltimore.

The practice's electronic medical records are linked to the billing system. When a patient is registered and the demographic information is entered, the system automatically creates the chart.

The scheduling package is linked so when the receptionist checks in the patient, the patient's name automatically shows up on the nurses' work screen to alert them that there is a patient at the front desk.

With the new system, doctors have the option of dictating their notes verbally or using an office visit template that allows them to point and click at boxes of procedures they may be performing.

"It takes a while for the busy physician to retrain himself to follow that path. They are accustomed to gathering data mentally, stepping out of the room, and dictating it onto magnetic tape," Rutherford says.

Speak directly into the laptop

The laptops will soon come with built-in recording devices that allow the transcriptionist to access them through a network, he adds. "We eventually hope to reduce the amount of transcriptions."

With the previous system, the physician dictated the chart and the transcriptionist typed it and attached it to the electronic chart. "One frustration with electronic medical records is how difficult it is to go totally paperless. Even though all the information can be accessed by the computer, we still print out the chart notes and file them in the chart. The advantage is that we don't have to go looking for the chart unless there is

something really important," Rutherford says.

Ultimately, the computer system will automatically generate a referral letter back to the patient's family physician at the conclusion of the visit.

"In the old days, if a physician wanted to write a letter to the patient's family doctor, he re-dictated the whole chart note. With this system, he can dictate the chart note and tell the transcriptionist to send out our normal referral letter. It cuts and pastes the chart note into letter format," he says.

The transcriptionist can e-mail the letter back to the physician for review and an electronic signature. Then, the letter can be submitted by fax, e-mail, or regular mail if other technology isn't available.

When the practice started its first electronic medical records project five years ago, the principals agreed that the electronic records would start with the first patient encounter after the system was implemented.

The physicians summarized the patient history in the first dictation summary so there was a reference point. From that point forward, all the notes were encoded electronically and accessible through the system.

With the new system, the practice will continue to pull charts for three months during the transition process.

"In the medical profession, there still is a lot of concern about the legal aspects of electronic records but every state is passing laws almost daily indicating the acceptances and the insurance companies are getting in line because of the speed of access and the information transmitted back," Rutherford says.

All staff, including physicians, were assigned a slot for a four-hour training session on the new system. "The staff has to be willing to practice to learn the new system. It's a skill. It's awkward the first time you do it, but the more time you spend, the quicker you can do it and the steadier you are," he says.

The practice has a Web site that is hosted by a service bureau for urologists, which provides a generic Web page and adds information from the practice.

"It has provided us with a tremendous amount of educational materials for the patients," he says.

Rutherford views the current Web page as a first step to give the practice a perception of how the patients access the page. The practice may create its own Web page in the future, he adds. ■

Using electronic avenues: A case study in efficiency

Nurses return calls between patient encounters

Before they had a voice mail system, e-mail, and electronic medical records, the nurses at Urology Associates of Southeastern North Carolina put in a lot of overtime returning calls from patients.

"They would have to stay after hours, sometimes until late in the night, to return phone calls or come in early in the morning," says **Richard Rutherford**, CMPE, former administrator of the Wilmington, NC, practice.

Now when staff have time between patient encounters, they can pull up the records on the computer when they contact patients, Rutherford says.

Here is how the voice mail system works:

When a patient calls, a receptionist who has been trained on how to route the calls answers the telephone. "More than half of our patients are Medicare patients, and they get lost in the technology. We haven't gone full force into the automated process yet," Rutherford says.

Whoever answers the phone gathers enough information to determine where the phone call should be routed. He or she explains to the patient that the nurse isn't available and gives the patient the option of leaving a detailed message in the voice mailbox. If patients are reluctant to leave voice mail messages, they have the option of leaving a message with the receptionist.

"The patient acceptance has increased significantly over the past several years. There was a lot of resistance at first, but technology is a part of our lives and even a large portion of our Medicare population uses the Internet," he says.

Each employee of the practice and each physician have a personal voice mailbox. There is a voice mailbox for the triage nurse and for the emergency room doctors to use to call and leave information about a urology consult.

During the height of interest in Viagra, the practice created a special mailbox that included a dictated message on the drug.

The practice has an internal e-mail system that allows everyone in the office to communicate. For instance, if a nurse is processing information and needs to tell the doctor that Carol Jones has a problem with her medicine, the nurse can leave

an e-mail message without having to track the doctor down. The doctor can send a reply authorizing the change in medication.

"It improves our efficiency. We have three locations, and our doctors practice at two hospitals. The doctors are never in one place for very long. We have to communicate with every electronic avenue we can find," Rutherford says. ■

Internet will expand patient, physician options

Project aims to keep all involved informed

Patients and their physicians in southeastern Ontario, Canada, will soon be able to check an Internet site to find out how long they will have to wait to see a specialist, have elective surgery, or receive outpatient services.

Kingston (Ontario) General Hospital, in partnership with Hotel Dieu Hospital and the Queen's University Health Policy Research Unit, is developing a public Web site to help physicians and patients find out about and access referral services that require the least amount of waiting, says **John Marshall**, MD, Kingston's general chief of staff.

Kingston General is an academic health science center with regional responsibility for tertiary care services in southeastern Ontario.

The Web site will include information from 200 physician offices affiliated with Kingston General, listing the procedures they perform, the number of patients on the waiting list, the average monthly throughput, and the earliest time for an appointment.

Voluntary waiting times will be included. For example, some patients may wait for several months because they want to go to Florida for the winter before having the procedure performed.

"This will allow the referring physician and the patient to understand what the alternatives are," says Marshall. "For instance, the patient will know that he could see Dr. X in three months but could see Dr. Y the next week. They would be able to make an informed decision."

The Canadian medical system often has situations where patients are waiting for one physician practice and are not aware they could get services if they went to another practice.

"It is completely unfair for referring physicians to have to go shopping to find the shortest waiting time for their patients. They should be able to get it with today's technology," he says.

So far the project is more conceptual than operational but the Web site should be up and running by fall, Marshall says

"It is more problematic than we originally thought, not because the technology is difficult and not because we have the wrong ideas but because we have to deal with 200 separate physician offices. That is the big challenge," he states.

The first step is lining up the data to construct the backbone of the Web site. "The biggest challenge is ensuring that we can and do get reliable data," Marshall says.

For instance, all 200 physician office sites use the same scheduling system for their clinics but most don't put the patients on the scheduling system until one week before the patient is due for the appointment.

"We have to change that habit. We are educating my colleagues and their secretaries to do what they need to do," he says.

The hospital is working with Atlanta-based Per-Se Technology to create a template and a waiting list module for the patient care system that will automatically create the information necessary for the Web site.

"If I'm going to get my colleagues to do this, it is realistic to expect that we mustn't impose extra work. The issue is to automate it. If we are going to have a meaningful Web site, it should be updated automatically. We are putting in place the infrastructure at present," he says

The project is not entirely altruistic, Marshall says. "Part of my purpose is to have the leverage to impress upon the ministry people who fund our hospital that we need more staff and more hospital resources."

For the past six years, the hospital has been on a global budget for physician services. The hospital gets a lump sum based on what the physicians were billing when the plan started.

"Those who are responsible for the limitation of resources need to be aware of what we are doing and not doing. The waiting list shows what we are not doing. If we are coding as much as we are paid to do and we still can't serve the population, we probably need to get more funds," he says.

The project is funded by a $95,000 grant from The Change Foundation, a charitable organization incorporated by the Ontario Hospital Association. The hospital is matching the grant funds. ■

Shave your waiting time with an office redesign

Planning can help you optimize the use of space

Are you looking for a way to increase staff efficiency, maximize the time physicians are in the office, and keep your patients happy at the same time? Redesigning your office space may be the answer.

You may need to add space or just redesign the space you have. But if you plan carefully, your efforts can make your office run more smoothly.

But, don't just run out and lease more space. Plan carefully to make sure your investment will pay off.

The first step in redesigning office space is deciding what goals you want to achieve, advises **Mike Boguszewski**, manager for Hamilton HMC, a Minneapolis consulting firm.

Are you trying to utilize each examining room to the fullest or to maximize the physicians' time when they are in the office? "It's hard to do both. One is the principal around which you flex the other."

The third factor is maximizing the patient convenience with a minimal waiting time, he adds. "Physician office design . . . can't be done in isolation. It has to be done with the scheduling and throughput system you have," he says.

The best plan is to try to achieve a balance between patient convenience and the desired physician productivity and room utilization, he adds. "The goal is to be efficient in your room count. The assumption is that the practice won't want to pay for space that isn't utilized. But you don't want to have fewer rooms than you need because that wastes doctor time or wastes patient waiting time," Boguszewski says.

If you are in a highly competitive market, lengthy patient waiting time could send your patients to other physicians. "Many physicians put a lot of stock in the rapport they have with patients but extreme delays can affect the relationship," he points out.

At the very least, your patients may hesitate to recommend your practice to friends because of the long waits, he adds.

You don't need to do anything as formal as a time-motion study to determine how many rooms you practice needs. If the physicians and office staff sit down together, they can usually figure it out, Boguszewski says.

Look at the number of physicians who are working and the amount of time in any given practice day they have for an actual visit. Include what is attached to each visit. For instance, each visit may require 15 minutes of hands-on time, five minutes of chart review, and five minutes of charting.

Compile the blocks of time depending on the specialty or the practice and figure out what you have available.

Look at what the patient volume is and what kinds of patient load you want to have. It may be driven by physician availability and practice patterns. For instance, one physician might see eight patients in a day but another physician could see 16.

Don't count on your rooms being utilized 100% of the time, Boguszewski warns.

"To believe that a room will be 100% productive is folly. Things will happen. A patient will fall. Undiagnosed things will crop up. The doctor

will get an emergency call. The rooms may sit empty or a patient may need to wait in a room." he adds.

Typically in a private practice setting, you should plan for a room to be utilized no more than 80% of the time. So if you have 12 patients who take one hour each, you don't need just 12 hours worth of room time. You really need 15 hours worth because of the 80% utilization expectation. If a practice is largely pediatric or obstetric, Boguszewski suggests closer to 70% to 75% utilization because you can expect more walk-in appointments and more unexpected presentations. ■

Key steps for determining a practice's space needs

Here are some tips for improving your office efficiency:

1. **Determine the types of rooms you need.**

These may be history and physical rooms, procedure rooms, and examining rooms — and they'll vary by the type of practices.

"In an adult office, you can do anything in an examination room. Pediatricians often prefer that needlesticks be done in a laboratory or a different setting so the scary procedures will be done somewhere else beside the exam room," says **Mike Boguszewski**, manager for Hamilton HMC, a Minneapolis consulting firm.

2. **Categorize your visits by type.**

Narrow down the number of types by how long each patient spends in each type of room. Even if you have 20 types of visits, you can reduce it into larger categories. For instance, an obstetrics practice may have three types of check-up visits: regular, high risk, and low risk. But, if each one takes 10 minutes in the room, plus five minutes for a blood draw, they can all be categorized the same way.

3. **Add up the number of rooms you need for each activity.**

For instance, you may discover that every four examination rooms need to be supported by one procedure room and one history and physician room. It will vary by practice, Boguszewski points out.

4. **Determine the amount of time that needs to be spent in a room for each visit on average.**

Include the physician's time plus any time for cleanup and preparation, or other procedures. For instance in an eye clinic, factor in eye dilation time. In an OB/GYN practice, you might include time for the patient to disrobe and get dressed.

5. **Determine how the rooms will be configured.**

There's as much variability in the way to configure the rooms in a physician practice is there is in the type of specialty and personality of physicians, he says.

6. **Determine who has "ownership" of each room.**

On one extreme, each physician would have

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exclusive use of the set of rooms he or she needs. On the other extreme, every physician in the practice would share every room.

Most practices will come up with something in between. "High-level sharing puts restrictions on physician flexibility The easiest way is for each physician or each sub-team of physicians to have their own rooms," Boguszewski says.

But, if each physician has his or her own set of rooms, the rooms will have more down time, which will increase the cost per room, he adds."It will cost more but what they get in return is ease in scheduling and a greater ability to maintain their own schedules. It is a trade-off."

Another issue is physician preference for instruments, supplies, and equipment. For instance, if some physicians like a particular type of exam chair and others don't, it may be difficult to get them to share rooms.

7. Cluster the rooms around the physician preferences.

After you figure out how many rooms you need, you need to fit your space into the practice styles of your physicians.

This is where a good facility designer and architect come in.

For instance, the physician may want his or her office in the center of the rooms, or may prefer to have the office on the back hall, away from the patient areas.

Ask the physicians where they want to go for the five minutes of dictation that follows each patient visit. The doctors could prefer to go back to their office or do the dictation at a nearby computer station. Or they may prefer to spend an hour or so at the end of the day in their office to take care of all the dictation at one time.

Boguszewski also recommends practices include cushions of time in room schedules throughout the day. For instance, if Dr. Jones sees 12 patients in 15 room-hours, the patients shouldn't be scheduled every 20 minutes throughout the day. Instead schedule them every 20 minutes until 11:20 and then leave a 20-minute cushion of time before the next patient is due in the room. Do the same with your afternoon schedule.

Then if a patient is late, the physician gets an emergency call, or a visit takes longer than expected, your rooms won't be backed up late in the day. "These are recovery points that provide a cushion to keep mid-day appointments and late afternoon appointments on schedule. This way, something that happened early in the morning is not still affecting people at 5 p.m. It's a way to keep the physicians and the patients happy," Boguszewski says. ■

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