

# UROLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

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## Physicians Work for Malpractice Reform Behind the Scenes

**D**uring this year's debate on medical malpractice reform, members of Congress and many state legislators have been featured prominently in the news. But while politicians have grabbed the headlines, many physicians have been working diligently behind the scenes to make liability insurance more accessible and more affordable.

"Clearly we are in crisis; we need to save our profession as we know it by being able to offer some tort reform legislation," says Phil Gingrey, MD, an obstetrician and gynecologist who has been serving in Congress since January as a Republican representative from Georgia. A former school board member and Georgia state senator from Marietta, Gingrey finds his new job as difficult as practicing medicine. "There are as many demands and a steep learning curve," he says. "I'm working harder than ever, but it's a great challenge, and I hope to be here a long time." He had practiced medicine for 28 years.

### A Big Challenge

Gingrey serves on the House's Health Policy Committee and on an ad hoc committee that drafted legislation to reform Medicare and to provide prescription drug coverage to senior citizens. Among the many issues

Congress is considering this year, tort reform may be the biggest challenge for its supporters, Gingrey says. Even though the House passed H.R. 5, which calls for a \$250,000 cap on noneconomic damages in medical malpractice cases, a similar bill (S. 11) in the Senate was voted down in July.

After the Senate voted to defeat S. 11, the American College of Obstetricians and Gynecologists, in Washington, D.C., vowed to keep medical liability reform high on the nation's political agenda. The bill called for limits on noneconomic damages and putting an end to meritless lawsuits, ACOG says.

"Federal medical liability reform remains ACOG's top legislative priority," says ACOG President John M. Gibbons, Jr., MD. "Though disappointed by the Senate's action, we must remain optimistic that reform will win passage in Congress this year. The current liability system is affecting women's ability to find a doctor and is a serious threat to their health care. This crisis is growing rapidly, and women's health care is at the breaking point."

ACOG urges physicians to support efforts to pass tort reform legislation and believes patients should join with physicians to have a meaningful effect on Congress and the legislative process in the states, says Charles

*(Continued on page 8)*

## Report: Caps Help States Retain Physicians

States that have enacted limits on noneconomic damages in medical malpractice lawsuits have about 12% more physicians per capita than states without such caps, according to a recent study by the federal Agency for Healthcare Research and Quality, in Rockville, Md.


The study is the first of its kind to associate caps on noneconomic damages with increased physician supply, AHRQ says. For the study, researchers reviewed the growth of physician supply since 1970, before any state had enacted caps, and found that physician supply has grown more in states with caps than in states without caps. Released in July, the study, "Impact of State Laws Limiting Malpractice Awards on Geographic Distribution of Physicians," is available online (at [www.ahrq.gov](http://www.ahrq.gov)).

Many physicians favor limits on noneconomic damages in medical malpractice suits, but Congress and some state legislatures have been reluctant to enact such caps. Some experts believe many factors have contributed to rising malpractice insurance rates; for example, the inadequate pricing of such insurance years ago which led to insurance industry losses and lower returns on insurance investments. Many lawyers and some consumer groups do not favor such caps.

For the AHRQ study, researchers analyzed state experiences over the past 30 years and adjusted for the effect of multiple factors believed to affect physician supply, such as per capita income and physician residency training programs, AHRQ says. By 2000, states that had enacted caps had a significantly larger number of doctors per 100,000 county residents (135) compared with states that had not enacted caps (120), the study shows. By contrast, in 1970 there was no statistically significant difference among states in their per capita supply of physicians, the researchers say.

"The robustness of these findings is quite remarkable," comments AHRQ Director Carolyn M. Clancy, MD. "Even when adjusting for numerous state characteristics, states with caps had a significantly higher number of doctors per person compared to states that didn't enact caps."

Speaking about the AHRQ report, Tommy G. Thompson, secretary of the federal Department of Health and Human Services, said, "Our broken medical litigation system is affecting patients' ability to find a doctor. This study confirms and quantifies the association between reasonable limits in medical lawsuits and the supply of physicians available to treat patients who need them. It is critical that we fix this broken litigation system now. In the current system, the fear of excessive awards stimulates wasteful defensive medicine and deters doctors and hospitals from identifying and addressing medical errors, thus increasing costs and decreasing quality."



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# Hybrid EMR Accommodates Paper

By Nancy Curosh, MD

**F**or the past year, our office has been using a new type of hybrid medical record system that is an excellent compromise between the convenience of using paper and the functionality of a full-blown conventional electronic medical record. For us, the system offers nearly all of the functionality of an EMR, but has not required us to type or to change the way we see patients. The system, called Zamclin, is offered by Kietra (at [www.kietra.com](http://www.kietra.com)), a company in Portland, Ore., founded, financed, and run by physicians.

We are a small, private, internal medicine and endocrinology practice that operates on tight margins. We have no extra staff or space to devote to computers, IT support, or systems that require a substantial amount of training. We are typical of many practices in that we are experiencing lower reimbursement levels in the face of rising expenses for malpractice insurance, personnel, and chart-related expenses.

## Resource Allocation

Deploying a conventional EMR was simply not an option for us. The expenses aside, there is no way that we could type, interact with patients and computers simultaneously, and still maintain the patient volume that we need to stay in business. The training time alone would be a serious problem. Zamclin is an alternative to more traditional EMRs.

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Kietra's approach is unusual in that it allows a physician to use paper, computers, dictation, or any other means to document visits.

Regardless of how a physician records information, Zamclin is implemented using the application service provider (ASP) model, meaning Kietra keeps all of the servers, backups, technicians, and other hardware needed to maintain the records and data at its secure Internet service facilities. The medical record data are uploaded from each doctor's office to Kietra's servers via a secure Internet link and are then available over the same secure Internet connection to any authorized user.

**The EMR allowed this small practice to keep its IT costs low and to forgo the worry of maintaining or backing up EMRs and servers in its office.**

This approach has advantages and disadvantages, but for us it has meant that we can keep our own IT costs low and we do not have to worry about maintaining or backing up EMRs and servers in our office. We have easy access to medical records from the hospital or from home. All we needed was a computer, a small bulk-feed scanner, a laser printer, and a broadband Internet connection. In total, these costs amounted to about \$3,000 for the entire office. Kietra doesn't sell hardware but did refer us to a local company that put the system together, installed it, and provides on-site service. The most expensive component of the system was a one-time purchase of third-party scanning software required for

paper-based data entry. This cost us \$6,000, although lower-cost suppliers today can drop the price to \$4,500. Zamclin is sold on an annual subscription basis of about \$125 per month.

## Data-Entry Issues

Since no one in our practice wanted to deal with a computer while seeing patients, our implementation of Zamclin was based on paper-based data entry. The implementation took a couple of weeks to set up but the system was quite simple to use thereafter.

First, Kietra took all of our standard billing, lab-order, prescription, and other forms and reformatted them into machine-readable docu-

ments that could be printed on demand on the laser printer. Then Kietra established an account for our clinic and gave each physician and staff person a user name and password. Permission to access various parts of the clinic system and medical record was set according to each person's need to know under federal privacy laws.

Zamclin also can be connected directly to practice management, scheduling, and billing systems. Doing so would make it possible to pass patient information between the systems automatically, and obviating the need to enter billing data by hand, while ensuring that the systems have the same information. Unfortunately, we could not take

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advantage of this function because our practice management system was due to be replaced and we had not yet chosen a new one.

Once everything was set up, training took about 15 minutes for each physician, and a couple of hours for the receptionist and office staff who would run the system. After on-site training was completed, Kietra provides any additional training and technical support directly over the Internet in real time.

### **Making Changes**

Setting up the system in the office was the most difficult part of the transition. For the physicians, practice procedures from that point on were either exactly the same or easier than they had been before. Here's how the system works.

Every day begins by printing out the billing and encounter sheets for the clinic for that day. Each sheet is customized for each patient and the physician who will see that patient. These sheets are all analogous to the sheets we used previously for recording diagnoses, CPT codes, and vital signs, and for ordering labs and writing notes. We also continued to use our preprinted history and physical notes with anatomical diagrams. Prescription forms also are printed for a given patient.

The patient is taken to an exam room and vital signs are recorded in designated spaces on one of the pages. The paperwork is then placed in the bin outside the exam room just as we had done previously. In our office, we still like to pull the paper version of the chart for clinic visits, but this is purely a matter of preference. Anyone choosing to view the

record on a laptop, tablet, or other computer screen could do so easily.

Just as we have always done, the doctor sees the patient, takes the history, does the physical, and writes the note. As before, the physician fills out the billing sheets and lab orders by checking boxes. If new prescriptions are written, they are done on the page provided. Prescribing refills is particularly fast. All a physician has to do is make an alteration, fill in the quantities, and sign the page. At the end of the visit, the chart is handed to the medical assistant or receptionist, and the doctor moves on to the next patient.

After labs are drawn, the prescription and lab forms are copied and given to the patient to take to the pharmacy and lab, respectively.

### **Searchable Records**

Between patients, the receptionist takes the encounter sheets and puts them in the scanner. As the pages run through, all of the quantitative data about diagnoses, vital signs, procedures, medications, and labs are read and converted automatically to digital values. The progress notes, correspondence, and lab values that come back on paper are scanned and converted to images that can be displayed later. Kietra decided not to convert these free-form pages to text, since it would be too costly and error-prone. In our experience, we have never had a problem recalling or reading a Zamiclin note, so it seems to be a reasonable trade-off.

After one final step in which the computerized values are verified, the information is sent electronically to Kietra, where it is turned into a complete electronic medical record within

seconds. This is where the real magic takes place, since this electronic version is fully accessible and searchable. We can view patients' electronic records, generate reports, review lab work and vital signs over time, upload transcribed dictations, and send messages to patients with very little typing required. A complete electronic record creation and management interface are available for those who would like to click and type.

In the summer, we tested a computer tablet version of Zamiclin that seems to be the perfect combination of pen and computing. Notes can be written completely freehand on the tablet screen using the same practice-specific templates and diagrams that we currently use on paper. Absolutely no typing is required, although keyboard entry continues to be available for anyone who wants it.

### **Saving Time and Money**

Of course, Zamiclin doesn't attempt to do everything. For example, it won't try to tell a physician how to upcode a given procedure. But it does have some nice touches that we haven't seen on other systems, and the drawbacks have been easily tolerated given the simplicity and low cost of the system, and the fact that our practice was not disrupted by installation and training. While our office is sufficiently small that we did not have any dedicated medical records personnel to eliminate, we're clearly saving time and money in the turnaround time needed to write prescription refills, copy records, and look up lab results and patient notes. Its secure built-in patient Web pages and electronic messaging system have saved a significant

**“We can view patients’ electronic records, generate reports, review lab work and vital signs over time, upload transcribed dictations, and send messages to patients with little or no typing required.”**

## By simply clicking on a diagnosis, medication, or procedure, the patient can get pages of excellent educational information.

number of telephone calls.

One nice feature of the program is the completely separate educational Web sites that are automatically and uniquely customized for each patient in our practice. Each of these Web sites is kept secure with its own password and user name. Patient Web sites list all of the diagnoses, medications, tests, and procedures that the patient has had or that we would like the patient to learn about. By simply clicking on a diagnosis, medication, or procedure, the patient can get pages of excellent educational information. This information is in English, but much of it is also available in Spanish. If the patient does not have Internet access, we can print and give these pages to the patient during a visit. Patient feedback has been quite positive about this aspect of the program.

Another nice feature is a database of thousands of consent forms for tests, procedures, and medications. These forms can be printed out at the office for signing, but the appropriate forms also appear on each patient's customized patient Web site. Since office time is scarce, we'll often ask the patient to go home and read about his or her illness, tests, and treatments and call or come back with specific questions.

A third nice feature is that we can use our practice database to search for the names of patients with specific diseases and medications and automatically send secure messages to all patients fitting a specific profile. Having gone through thousands of

charts by hand when the manufacturer of cerivastatin withdrew this lipid-lowering medication from the market two years ago, we'll be using this feature the next time a drug is recalled.

### Fixing Problems

As with any new process, there were problems initially that have been resolved. Some Internet-related installation problems, for example, have been fixed. Still, there are some features that we'd like to see added or improved.

The first one would be an easy way to change or edit the billing sheets and medication lists directly from the office. Currently, Kietra formats these sheets and lists, meaning that if we want to make even simple changes (such as adding or deleting a drug name from a list), we have to ask Kietra's customer service to do so. A forms editor that would allow our office staff to alter a list of medications, diagnoses, and procedures online would be quite helpful.

A second useful tool would be the ability to memorize frequently run reports. The current system allows us to search for various case characteristics (such as all patients with diabetes who have had hemoglobin A<sub>1c</sub> tests), but it would be convenient to save all of the search parameters as a named custom report type (such as "Vaccinations Due This Month").

Finally, full electronic integration with all of the different clinical laboratories would be great. Such integration will take time even for a small

clinic such as ours because we use several different labs. Kietra is building interfaces with several key labs, but has not yet made these available for use in office practices. Meanwhile, we simply scan in the printed lab reports or enter certain results into the Zamiclin system by hand as needed.

Even given these minor drawbacks, Zamiclin is a solid addition to our practice. It may not be the first choice for large clinics, but it clearly fills an important need for a simple, inexpensive system that gets the job done with a minimum of physician time and trouble. Unlike many of our colleagues who bought more complicated EMRs, our clinical routine and productivity never declined after we took this approach with a hybrid EMR. In fact, we spend far less time on repetitive tasks, such as handling refills and answering questions that are well explained by on-line patient education materials. These sorts of efficiencies will almost certainly expand as the software is improved over time. Also, we hope that Kietra's specially designed tablet interface will take us all the way to a paperless office with little or no disruption of our current work flow or pen preferences.

For physicians in small practices who want to maximize their time spent seeing patients while minimizing their need to type and click, the Zamiclin approach is worth considering.

—More information on physician practice strategies is available on our Web site (see page 16).

**“Unlike many of our colleagues who bought more complicated EMRs, our clinical routine and productivity never declined after we took this approach with a hybrid EMR.”**

# Systems Aid Rural Health Delivery

Innovations in technology and financing are helping physicians in rural communities to improve the quality of health care they provide, according to a recent report by the California HealthCare Foundation. By working with federal, state, and local governments, private companies are providing some of the necessary funding for new technology, the report says.

Patients and physicians in rural settings face several problems, according to *Rural Health Care Delivery: Connecting Communities Through Technology*. The report was written by the Boston-based First Consulting Group for the foundation, a research organization in Oakland (at [www.chcf.org](http://www.chcf.org)). For patients, the need to travel away from their community for specialty care can result in lost work time, high costs, and the complications of coordinating care in different locales. The likelihood that health information will be missing or incomplete is therefore greater and may cause delays or fragmented care.

Rural physicians and other providers need time to travel to patients in hospitals and nursing homes and so have fewer face-to-face patient visits; they also spend more time on the telephone with patients and other providers than their counterparts in other settings. The net result is limitations on productivity, communication, and education, the report says.

In recent years, tertiary care centers and other delivery organizations have developed a range of technologies to improve communication

among physicians, access to information, and care services to rural areas. Recognizing the benefits possible from using remote technology, Medicare and other payers are easing some restrictions on reimbursement for technology-based services that specialists offer, the report says.

In particular, five technologies are helping physicians improve the delivery of care:

1. The Internet and e-mail
2. Web portals
3. Scanners and digital-imaging technology
4. Video teleconferencing, or telemedicine
5. Remote patient-monitoring systems

## E-Mail Applications

Since e-mail requires only a computer workstation, Internet access, and low-speed connectivity, it helps foster a communication network for health-related questions from patients to physicians or among physicians. It also facilitates appointment scheduling, prescription renewal requests, and referral authorizations. More than half (55%) of all physicians use e-mail to communicate with other physicians for professional purposes, the report says.

Robert Webber, MD, a primary care physician in the rural community of Watsonville, Calif., found the most significant benefits of e-mail involve communicating with specialists and transmitting lab results and X-ray data, the report says. Since there are no rheumatologists in Watsonville, Webber has developed a consulting relationship using e-mail

with a rheumatology group in Santa Cruz, Calif., for example, according to the report.

## Web Portal Applications

Applications based on Web portals allow rural physicians and patients to share patient-specific data, medical information, and remote educational data. Medical-related Web portals offer a broad range of applications and are typically sponsored by hospitals, academic medical centers, libraries, and professional training centers, according to the report.

Patients can learn about specific medical conditions and see detailed information about a specific organization's resources for a given medical condition using Web portal applications. Physicians can locate and print medical information to answer clinical questions using online libraries, free Web sites, such as Medline (at [www.medlineplus.gov](http://www.medlineplus.gov)) or Intellihealth (at [www.intelihealth.com](http://www.intelihealth.com)), and a number of commercial vendors. "The key to successful use of these medical services is to integrate health reference links with the provider's other applications, such as prescription writing tools, electronic medical records, or e-mail communication vehicles," says the report.

For rural providers, a solution to the time involved to mail records back and forth is a centralized Web-based health record containing information provided by hospitals and patients that physicians can access and that meets federal and state privacy standards. An example is Eastern Maine Healthcare, a physi-

**In recent years, health care delivery organizations have developed a range of technologies to improve communication among physicians.**

cian and hospital network in Bangor that created MyOnlineHealth, a Web portal that allows participating patients to engage in secure communication with physicians and other providers. Patients can communicate with physicians, request an appointment, view laboratory test results, and obtain a prescription refill online. They also can complete health risk assessment surveys online and receive feedback from physicians, who can send them health information about their specific needs, says the report.

### **Digital Imaging**

Providing access to remote specialist services is one of the most successful uses of technology to support rural health delivery, the report says. Since about 90% of specialty physicians practice in urban areas, some specialists (particularly radiologists, pathologists, and cardiologists) are in short supply in rural areas, the AMA says.

In urban areas, many academic medical centers and independent radiology practices have the capacity to read more images than their own practices demand. Technology plays an important role in connecting the demand to the supply, says the report. Using digital diagnostic equipment or digitized scanned images, diagnostic specialists can read images from multiple sites and send back interpretations electronically in a matter of hours.

For example, the radiology department of the Cleveland Clinic can connect the clinic to a physician group or hospital that has only a CT scanner, X-ray, or MRI. The clinic provides all other equipment and infrastructure. The Cleveland Clinic can supply off-hours radiology coverage and subspecialty expertise that

rural hospitals can't attract, the report says.

### **Video Teleconferencing**

Video teleconferencing, or telemedicine, allows patients, their primary care physicians, and specialists to communicate in real time using interactive video equipment. At the point of origin, clinical assistants help the patients and control the equipment. Telemedicine consults are most common for dermatology, mental health, cardiology, emergency triage, and orthopedics, the report says. The key to making telemedicine work well is high-speed data transmission, according to the report.

The telemedicine program at the Department of Veterans Affairs Medical Center in Iron Mountain, Mich., allows physicians and other providers in clinics in Milwaukee or Chicago to assess patients at the Iron Mountain facility in real time. Robotically controlled microscopes allow pathologists to render diagnoses with the same accuracy they would have as if they were onsite, the report says.

### **Remote Patient Monitoring**

One problem many hospitals face in rural areas is a potential lack of intensive care services. Many of these hospital services are at risk of being closed because qualified specialists, physicians, and technicians are not available for 24-hour patient care monitoring and services. Technology can connect monitoring equipment from a rural hospital to remote specialists who provide continuous monitoring. Telecommunications options, such as dedicated telephone lines and pagers, can alert nurses

about problems within seconds of the sounding of a monitor alarm. When a physician is involved in remote monitoring, providers can use video teleconferencing to support communication between an intensivist and caregivers at another site, says the report.

At Allen Memorial Hospital in Moab, Utah, for example, a lack of skilled technicians to support patient monitoring resulted in a majority of cardiac patients being transferred to other facilities. This caused hardship for the patients, who had to travel at least 100 miles to the closest tertiary hospital, as well as for the 38-bed hospital, which was losing patient revenue. Allen Memorial collaborated with physicians at St. Mark Hospital in Salt Lake City by installing monitoring equipment in the ICU that transmits data to a telemetry center at St. Mark Hospital, where technicians watch the data streams, validate alerts, and contact ICU nurses at Allen Memorial immediately via pager or phone as needed.

### **Funding and Reimbursement**

E-mail services and Web portals are inexpensive, but the other technologies mentioned in the report can be very expensive. The report explains, however, that funding to start and maintain these programs is available from a number of sources, and it lists potential sources.

"The starting place for building a partnership is to identify organizations with common interests and goals for solving a particular health delivery problem," the report says.

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice strategies is available on our Web site (see page 16).

**Technology plays an important role in connecting the demand to the supply, says the report.**

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Hammond, MD, a professor of ob-gyn at Duke University Medical Center, and immediate past president of ACOG. "We've developed brochures to give to patients, and we have an 800-telephone number patients can call to register their support for legislative reform," Hammond explains. "Our e-mail center tries to facilitate both physician and patient contact."

Hammond urges ACOG members to call or write to their state legislators and federal representatives. "It's not terribly disruptive, but it badly needs to be done," he says. "Individual doctors can write letters to the editor as a way to reach a fairly large number of women in their community." The association has sample letters physicians can use for this purpose.

Also, ACOG is seeking to develop coalitions with other medical groups, women's organizations, and individual patients. "Each of us as ob-gyn physicians has a fairly large number of patients—all of them women—who should be involved in maintaining their access to health care," Hammond says. "We're doing whatever we can to facilitate the impact physicians can have."

### Specialty Focus

With obstetricians increasingly affected by liability issues, ACOG identified 20 states in or close to crisis. "When you can't afford the premium, you can't practice medicine," says Hammond. "In 13 crisis states, 75% of our members are making changes in their practice: stopping obstetrics, retiring prematurely, or relocating. Patients need to hear

these facts and understand the impact. Reading about individual physicians and their stories in the newspapers can have an effect." In a national advertising campaign, ACOG asks women, "Who will deliver your baby?"

Through ACOG's key contacts program, physicians can become spokespersons at the local level or be called on by Congress as experts on ob-gyn issues.

### Family Matters

Like ACOG, the American Association of Family Physicians, in Kansas City, Mo., supports tort reform and is appealing directly to physicians and patients. AAFP developed what it calls the waiting room advocacy program in which it provides posters and brochures for physicians to give to patients, explains Jim Martin, MD, AAFP president and director of Christus Santa Rosa Family Practice Residency Program in San Antonio.

AAFP invites its 94,500 members to address key reform issues while seeing patients and offers important points to address with patients. It also has drafted sample e-mail and fax letters for patients to send to policymakers. "Several U.S. senators told us they received a significant number of letters about Medicare reforms, which affected their response," Martin says. "Completely apart from patient care, we want family doctors to spend a few minutes answering questions and providing information, educating the patient to become an effective political force."

The liability insurance crisis is the AMA's top priority as well. It has a

similar program called house calls, which is designed to build public awareness about malpractice insurance and to tell physicians what they can do about it. AMA officials visit hospital cafeterias to talk with doctors and answer their questions.

"We know it's important to involve medical students, residents, and grassroots doctors," says an AMA spokesperson. "They just want to have a place to practice tomorrow." To support tort reform efforts at the federal and state levels, AMA officers visit Washington and the legislatures in the 19 states where the AMA says a crisis exists.

"Rather than get angry, I chose to get involved," says John Nelson, MD, MPH, a Salt Lake City ob-gyn and AMA trustee. Earlier this year, Nelson spent a week in Pennsylvania, working with the medical society there to spread the word about the need for tort reform. "We went to Scranton, Wilkes-Barre, Philadelphia, and Pittsburgh to see people who'd listen to us: hospital medical staffs, administrators of small local hospitals, and people at radio and TV stations and on editorial boards," he says.

Nelson was pleased with the results, saying, "Many physician allies asked their legislators to be on our side. More patients understand what this is about. To call attention to our plight, we got doctors to close practices, go to rallies, and march in their white coats, taking actions they wouldn't have taken otherwise."

In Wilkes-Barre, a local drive-time radio show scheduled the physicians for a 10-minute presentation. "We stayed on for 90 minutes, and we

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**"Clearly we are in crisis. We need to save our profession as we know it by being able to offer some tort reform legislation."**

**—U.S. Rep. Phil Gingrey, MD (R-Ga.)**

## Insurer Sponsors Physician's Efforts

**R**onald Stevens, MD, is so concerned about the malpractice insurance crisis that he spends much of his free time helping to prevent malpractice. A staff anesthesiologist at United Medical Center in Cheyenne, Wyo., Stevens works with The Doctors Co., a physician-owned mutual insurance company, in Napa, Calif., that is seeking to reduce malpractice claims.

When the insurer sees a pattern of unusual complications or situations, its risk reduction panels make recommendations to help prevent such problems from occurring in the future; Stevens has been invited to serve on these panels. "We want to take better care of patients so we don't have malpractice claims," Stevens says of his work with The Doctors Co. "They're preemptive strikes, and I like to think we're doing it for altruistic reasons."

Despite calling himself a hopeless idealist, Stevens concedes: "No matter how much you reduce risk, I don't think it will solve the problem. The standard keeps getting raised. In anesthesia, mortality has gone down to less than one in 50,000 among healthy patients. Even with fewer cases and improved mortality, jury awards have skyrocketed. Tort reform is the most important part of the puzzle. Without it, we won't get insurance relief. The biggest impediment to weeding out the few doctors who actually commit malpractice may be the lawyers who defend such physicians."

Physician advocacy is part of the mission of The Doctors Co. (at [www.thedoctors.com](http://www.thedoctors.com)). For nearly a decade, the company's political action committee has raised funds to support candidates and incumbents who favor effective tort reform. It operates in California, Colorado, Florida, Montana, Nevada, Washington state, and Washington, D.C.

For local elections, The Doctors Co. holds fundraising events for candidates supporting its position and has raised \$20,000 for some candidates. "Some doctors are enamored of the political process, and want to shake hands," says Leona Egeland Siadek, a former California legislator who is now the director of government relations for The Doctors Co. She is convinced that letters and phone calls matter. "Others are too busy but ask us to keep them informed so they can write letters," she says. "Knowing that the folks who vote for you are watching what you do, and can contribute to your campaign, builds a much greater propensity for that elected official to be on top of that issue."

"We'd like physicians to know about important elections and legislation so that when their state legislature is in session, they can make their position known to the correct person at the correct time," Siadek says. Physicians should visit their representatives when possible to express their views, how they are affected by the legislation, and what problems they see the legislation solving, she adds.

—CM

(Continued from page 8)

got many calls," Nelson explains. "We debunked the other side's disinformation. The federal government estimates that by capping liability awards, it would save \$20 billion a year, more than enough to pay for prescription drugs for seniors. This has caused me to be just short of militant." For Nelson, the liability insurance crisis is particularly important because his own premiums have doubled since 2001.

### Banding Together

Despite the hard work and increased costs, Nelson remains positive and has been encouraged by the efforts of the AMA and many officials in Washington and elsewhere. "The president, the surgeon-general, the secretary of Health and Human Services, and the majority of the public want liability reform," he says. "We're working with the Senate majority leader and other leaders. I'm hoping we can get something done, and I can't do it sitting in my office. As an AMA trustee, I was gone 75 or 80 days last year. I feel very strongly about what I do."

"If we band together, we can be impressive," Nelson adds. "AMA is leading the fight here, and we can't do it alone. We want to coalesce everyone. We need the voice, dollars, and political action contributions of physicians. They should join their specialty society, state, and county associations. They need to call legislators and talk to patients about getting involved. This issue is more important than anything we've faced in a long time."

Congressman Gingrey advises, "Get behind people that support our issues. Quit voting for members of Congress or state legislatures who will just gut the health care legislation we need."

—Reported and written by Carol Milano, in Brooklyn, N.Y. More information on physician practice strategies is available on our Web site (see page 16).

# Practice Finds Increasing Efficiency Requires Making Numerous Changes

**B**y implementing a series of changes over several years, a Colorado practice has measurably improved efficiency, lowered overhead, and increased revenue. What's more, increased efficiency has allowed the physicians to see more patients than ever before.

Primary Care Partners is a 25-physician, three-site primary care group in rural western Colorado. Gregg Omura, MD, is a family physician in the group's five-physician Western Colorado Physicians Group in Grand Junction. The practice has a long tradition of innovation and continuous improvement; Omura is the group's self-appointed developer of new processes.

## No Easy Answers

"There isn't one simple answer to practice improvement of the kind we need today," says Omura, who is a strong proponent of applying proven quality improvement techniques to health care. "You have to address problems on many fronts."

Omura has led his practice to adopt innovations, such as electronic medical records, open-access scheduling, and care teams. The combination of changes has improved both efficiency and effectiveness: Compared with data collected two years ago, appointments have risen by 20%, and the number of no-shows has dropped by 17%; charges have increased by 22%, gross revenue by 21%, and income by 20%. Staff and

patient satisfaction has never been higher.

Like the vast majority of practices, Omura's group once relied on paper charts. But the shortcomings of this system were often evident: Information was not readily available when and where it was needed; the records were time-consuming to maintain; and they occupied a significant amount of physical space.

"We had thought about constructing an addition on the building for more chart storage," recalls Omura. "We realized we could spend a lot of money on bricks and mortar and solve the problem for a while, or we could spend a lot of money on converting our records to a computer system and solve the problem forever. We opted for the computer system."

## Electronic Records

The cost of implementing an EMR is often the first hurdle practices face in converting to a computer system. But consider the costs of maintaining paper records, say the experts. According to *Cost Survey: 2002 Report Based on 2001 Data*, by the Medical Group Management Association in Englewood, Colo., the median cost for staff who manage medical records in multispecialty practices is \$7,495 per year per full-time equivalent (FTE) physician. Another \$5,891 per physician goes to transcribers. Using an EMR means a typical savings of more than \$13,000 per physician each year. Those

savings alone can cover the average cost of an EMR, which MGMA estimates at \$10,000 per physician.

Omura and his partners carefully researched a number of EMR systems, settling on Practice Partner Patient Records by Physician Micro Systems, Inc., in Seattle. Among the features they liked was its format, which is similar to a paper chart.

"It's important to get the right system and to use it to its maximum potential," says Omura. "A good EMR should make the physician more productive. There are popular programs out there that actually decrease the doctor's productivity. Doctors don't want to be data-entry people, so they need to get a system that makes their work easier, not harder."

The practice spent several months planning for the new system, outfitting each office, exam room, nurse's station, and the back office. The system was relatively easy to learn, requiring the staff to take only several weeks of training.

The second hurdle many practices face regarding electronic records is the daunting prospect of converting patients' paper records to electronic versions. Omura's practice knew this process could not be done quickly, so the physicians established a plan to do it gradually. Once the system was running, physicians began using it to dictate summaries at the end of every day from the charts of the patients who were being seen frequently or

**Compared with data collected two years ago, appointments have risen by 20%, and the number of no-shows has dropped by 17%.**

who were in for a regular physical examination. The transcriptions then could be added into the EMR and all the relevant sections of the chart, including medication list and allergies, would be automatically updated.

Using this approach, it took the staff about a year to convert all patient records from paper to electronic charts. Now, physicians can add most progress notes during patient visits, and the system can accommodate dictation as well.

The conversion to the EMR saved the practice money in several ways, says Omura, paying for itself in about two years. Besides saving him between \$500 and \$700 a month on transcription costs, the EMR allowed the practice to cut front-office staff from 7.5 FTEs to three, thereby reducing overhead by 6% and saving the practice about \$75,000 per year.

In addition, getting rid of the paper files saved the practice from building an addition, and allowed the physicians to convert the former file rooms into exam rooms, making it possible to see more patients more efficiently.

### **Improving Access**

The most effective EMR doesn't mean much if patients aren't being seen in an efficient and timely manner. With a no-show rate of almost two patients a day, Omura's practice was losing revenue and the physicians were losing their patience. This was another problem that needed fixing.

Through the Institute for Healthcare Improvement (IHI) in Boston, Omura had learned about open-access scheduling, sometimes

called advanced access. Developed by Mark Murray, MD, and Catherine Tantau, RN, practice consultants in Sacramento, Calif., open access is designed to smooth out each day's schedule, give patients better and more timely access, and reduce the rate of no-shows. Attracted to the idea of increasing efficiency and meeting patients' needs in a more timely manner, Omura decided to try open access with his patients.

Open access uses advanced queuing theory to reengineer the standard appointment scheduling system, leaving the majority of the slots on a given day open for patients who call that day. "Demand is relatively consistent, and the day fills like a glass, from the morning up, not piecemeal," says Omura. It's a rare day that doesn't fill, he says, but when that happens, he's glad to have the empty slots at the end of the day when he is tired, not at the beginning or scattered throughout. And for patients, the benefit is obvious. "Every patient can get in within an hour or so of when he or she calls," he adds.

Like the process used in implementing an EMR, developing open access cannot be done overnight. It involves some short-term pain for long-term gain, namely working down the current backlog of patients. This is generally done by temporarily adding extra slots and working longer hours, or adding more staff.

Among the benefits of open-access scheduling are that both telephone access and staff availability improve because the need to triage patients over the phone, or "tease out information" as Omura puts it, is elimi-

nated, as well as the sometimes lengthy negotiations involved in making appointments. Patients' use of urgent or emergency care settings also decreases.

Omura's foray into open access proved so successful that two of the five physicians in the office use open-access scheduling today. Two others use a partial open-access system, and one has elected to use a standard approach to scheduling. Omura often sees his partners' overflow patients, since his schedule is more open than theirs.

### **Team Care**

The philosophy behind open access is to do today's work today. This approach applies both to appointment scheduling (meaning seeing patients the day they call) and to the content of the visit. "Before open access, if a patient came in with an abnormal skin lesion, I would examine and diagnose it during one visit, and schedule the patient to return for an excision," says Omura. "Now I do it all at the first appointment."

This approach was more satisfying for patients, Omura found, and reduced the need for additional appointments. But it also was more time-consuming for him. "When I started doing more for patients in a single visit, I realized I couldn't do that the way my practice was structured," he says. "I didn't have enough nursing staff to prep the patients."

After analyzing how he was spending his time and what tasks his staff was doing, Omura learned an important lesson. "I realized I was doing too much of everything, and I didn't

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**"A good EMR should make the physician more productive. Doctors don't want to be a data-entry people, so they need to get a system that makes their work easier, not harder."**

**—Gregg Omura, MD, Western Colorado Physicians Group**

(Continued from page 11)

have to be directly involved with every aspect of patient care," he explains. So, he began to delegate more responsibility to his registered nurse and his medical office assistant. Also, he hired a third assistant (a layperson) who was trained to take vital signs, initiate prescription refills, and triage patient phone calls. In this way, he created a care team.

The team approach to care allows Omura to spend more of his time doing the things that specifically require his expertise, such as clinical decisionmaking and building relationships with patients. The EMR, open access, and delegating of tasks support him in increasing his efficiency, enabling him to add about eight more patient slots to his weekly schedule.

"Eight more slots filling at about \$110 per visit more than pays for the additional staff," he says. The use of team care highlights the fact that the most expensive part of a practice's overhead is the physician's salary. As a result, team care creates a better balance between cost and revenue, says Omura.

### Consistency of Care

To support consistency of care across the team, Omura relies on about 150 medical history-taking templates available through his EMR. The templates prompt the physicians and other providers to get and record all appropriate information from patients. He and his staff have customized the templates to fit their needs.

The templates help make team care effective, says Omura, because they ensure consistency of information among providers. Focused on specific diagnoses, each template offers questions and prompts observations related to each diagnosis, which

can range from abdominal pain to depression. Clinical staff enter patient responses directly into patient records, using a computer in the exam room.

"The templates are crucial to efficiency because they allow a tremendous amount of delegation," Omura explains. By the time physicians see their patients, he says, most of the important information is already in the progress note, and they can spend their time "doing things that require an MD after their name."

### Moving Forward

Each success strengthens Omura's devotion to continuous improvement. "I feel renewed and invigorated as we do things better and better," he says. So now he is leading the practice through an ambitious eight-point program to redesign other aspects of patient care, modeled on IHI's Idealized Design of Clinical Office Practice program. IDCOP brings together professionals from across the country to work together to redesign a practice for greater effectiveness and satisfaction, often at the most fundamental level.

Called the Renaissance program, the redesign at Primary Care Partners has eight specific goals, the first four of which involve chronic disease management. Specifically, they aim to improve care and management for patients with diabetes, hypertension, heart disease, and depression. The practice intends to develop a comprehensive care plan for 90% of patients with these conditions.

Acknowledging the sense of independence and autonomy that most physicians guard, Omura doesn't expect every one in his practice to approach care in the same way. "We want to focus on outcomes, not on

process," he says.

The EMR system is an important component of improving outcomes, in part because it can produce population-based data. "Even the best doctors are surprised by what they learn when they start getting data," Omura says. "We all focus on who we are seeing. We know our patients with heart disease are taking aspirin because they are coming in regularly. But what about the noncompliant ones who aren't coming in? My perception is skewed because I'm not seeing the whole population. That's why population management is so important."

Over the next several years, Omura plans to make even more changes. He wants patients to have electronic access to their medical records, a medication list, and lab results; he also wants them to be able to request appointments through a secure Web site. What's more, he wants to offer specialists access to patients' records (with patient permission and within privacy guidelines) to allow for a more comprehensive understanding of patients' needs and more seamless care across the continuum of providers.

Omura has no doubt that the changes his practice has implemented have been good for both the practice and the patients. They have also been good for him, professionally and personally. "Practicing is more enjoyable because you are working as a team," he says. In addition, thanks to more efficiency, Omura's income rose compared to that of previous years, even though he took four weeks vacation, more than ever before.

—Reported and written by Ann B. Gordon, in Wayland, Mass. More information on physician practice strategies is available on our Web site (see page 16).

**The EMR, open access, and delegating of tasks have helped Omura to add about eight more patient slots to his weekly schedule.**

# After 15 Years, Physician Still Finds Variety of Temporary Work Fulfilling

**R. Cyril Bieger, MD, JD**, is a 69-year-old pathologist in Seattle. Over the past 15 years, he has completed more than 50 assignments as a locum tenens physician. A graduate of Xavier University in Cincinnati, Bieger received his medical degree from St. Louis University Medical School in St. Louis, he interned at the University of Utah in Salt Lake City, and he received his pathology training at the University of Wisconsin in Madison, the University of Cincinnati, and the Mayo Clinic in Rochester, Minn. His subspecialty training is in medical microbiology and forensic pathology. Bieger also earned a law degree from the University of Puget Sound (now Seattle University) in 1986. Editor in chief Richard L. Reece, MD, discussed with Bieger the life of a locum tenens physician.

**Q:** Would you explain for our readers who are interested in pursuing locum tenens work how and when you entered this field?

**A:** After working at the coroner's office in San Diego for nine months, I moved to Seattle in 1988 hoping to find full-time employment there. While I was looking for a position, I did locum tenens work, and I have been doing it ever since.

**Q:** What is the process that physicians need to follow in order to be eligible for locum tenens work and how do they obtain the licenses they

need to practice in different states?

**A:** There are a couple of ways that physicians can get into this field. One way is through various locum tenens agencies, such as CompHealth in Salt Lake City. These agencies are always seeking qualified people to fill positions, and they will help physicians to obtain state licenses, as well as do all the necessary administrative work. Filling out the medical license applications can take quite a bit of time and effort, and states are requiring physicians to provide detailed background information.

Another way that physicians can get into the locum tenens field is to develop a network of contacts, meeting as many people as possible at medical gatherings, and keeping their eyes and ears open about possible opportunities. It is helpful if they have a medical license in the state in which they want to practice before they begin networking, so that they can move quickly when an opportunity arises. I had a list of the states in which I wanted to work and obtained state licensing in those states.

**Q:** In how many states have you practiced as a locum tenens physician? What is your process for accepting assignments?

**A:** I have held licenses in 16 states, but now I am down to

six: Idaho, Michigan, Ohio, Oregon, Washington, and Wisconsin.

I work on a first-come, first-served basis. With new clients that are seeking temporary pathology services, I send two copies of a formal agreement, with my signature, stating that I agree to provide coverage for pathology services as described in the agreement. If the client approves the terms, the client will sign both copies and send one back to me. With a signed contract, I will provide the pathology services needed.

Some clients repeat over the years, which makes the process of accepting those assignments simple. Subsequent assignments with the same client are typically arranged by telephone, after which I send a letter confirming that I will provide coverage as discussed.

**Q:** How long is a typical assignment in a given location?

**A:** The length of a locum tenens assignment can vary from one day to six months or even longer.

**Q:** Does the client usually pay for your expenses and malpractice coverage?

**A:** Typically, clients pay for travel and housing expenses, but locum tenens physicians pay for their own meals and entertainment. Clients cover malpractice insurance costs, and it is important

(Continued on page 14)

**R. Cyril Bieger, MD, JD, a pathologist who works as a locum tenens physician, has worked in a variety of settings, from those with one pathologist to those with as many as 20 pathologists, in academic institutions, and in hospitals.**

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for physicians to be sure of the malpractice insurance coverage before starting their assignment.

**Q:** How do you obtain your locum tenens work?

**A:** Most of my work is through repeat assignments. Usually, there is a pathologist contact who requests my services. I have obtained new assignments by word of mouth and by reputation.

**Q:** Do you find a lot of variety in your practice life?

**A:** Yes. I have worked in pathology practices with one pathologist and as many as 20 pathologists, in academic institutions, community hospitals, and other types of practice environments—a wide spectrum of settings.

**Q:** Does a locum tenens physician often cover for a one-person practice?

**A:** I have covered one-person practices, but that is usually not the case. In general, I work in a two- or three-person practice. Many of my assignments have been in practices with two pathologists in which one pathologist wants to take time off and the other pathologist would be overwhelmed by the amount of work without some outside help.

**Q:** Do you often run across other locum tenens physicians on your assignments?

**A:** Yes. Often, hospital-based physicians, such as anesthesiologists and radiologists, are locum tenens physicians.

**Q:** What are the benefits of having a career as a locum tenens physician?

**A:** Some of the benefits of locum tenens work for physicians—as a career or as a temporary situation—include better control of their time, of the regions in which they work, and for whom they work. It also affords the ability to travel to new places and meet new people. I see parts of the country that I probably would not have visited otherwise.

Another benefit of locum tenens work that I have found is having the opportunity to observe a variety of practices, seeing different laboratory setups and methods of practice, as well as learning from the experience of the pathologists I have worked with. I have worked with people whose talents and interests vary, which makes my work life interesting.

Locum tenens work also provides additional contacts for future opportunities. Finally, it also involves fewer responsibilities than a permanent position, with no administrative work and probably no call.

**Q:** What are some of the challenges of locum tenens work?

**A:** One challenge can be the travel involved. With a full schedule, travel takes a toll on the body and makes it difficult to manage even basic things at home, such as answering mail and paying bills. I make sure I am never away from home for more than three weeks at a time. When on a long assignment, I will come home every three weeks to check the mail and the house and take care of any problems.

Another challenge I must keep in mind is that I am not a member of

the client's staff but, quite simply, a temporary worker. I do not participate in decisions affecting the work environment. For physicians who like to participate in strategy and planning, this is a major downside of locum tenens work. Basically, the job of the locum tenens physician is to do what the client needs and to do the best job possible.

What's more, locum tenens work might be a challenge for married physicians and those who have other obligations at home. I am divorced. Being single frees me to accept assignments quickly and to accept assignments that require me to be away from home for long stretches of time.

Finally, when locum tenens physicians are not working, they are not getting paid. They also do not receive any of the typical employee benefits, such as health insurance, disability, and paid vacation and meeting time.

**Q:** When you go to a new location, do you feel isolated from the life of the community or do you blend in?

**A:** I have never thought of it in terms of being isolated. I look on my assignments as an opportunity to learn about a new practice and a new community. With that attitude, I start exploring and probably see more of the community than the local people do.

**Q:** Is another downside of locum tenens work the unpredictability and uncertainty of when you are going to get an assignment? Are there some dry stretches?

**A:** There are some dry stretches, but just when I think nothing

**“Physicians looking for a permanent position would benefit from locum tenens work in order to try living in a certain geographic area or working in a particular type of practice.”**

**—R. Cyril Bieger, MD, JD**

## Organization Helps Set Locum Tenens Standards

The use of *locum tenens* physicians is growing at a rate of about 20% annually, according to published reports. This growth is fueled in part by consumer demand for greater access to specialty care, which has made it difficult for organizations to recruit full-time physicians.

The Latin term *locum tenens*, which means “to hold the place of” or “to substitute for,” is used to describe physicians who accept temporary assignments across various health care settings.

As the practice of taking on temporary physicians has grown, it has created a need for standards in the industry, according to the National Association of Locum Tenens Organizations. NALTO is a professional association in Altamonte Springs, Fla., that was created to provide health care organizations with high standards of service and to represent the industry as a whole. NALTO was created to address the unique aspects of *locum tenens* placement and to increase the level of service provided in this specific segment of the physician recruiting industry. Its members are held to a code of ethics developed specifically for the *locum tenens* industry, the association says.

When choosing a staffing company, a physician considering temporary work should seek one that is a member of NALTO, the association advises. Some clients pay for malpractice insurance. If not, then the physician should seek a staffing company that provides malpractice insurance for the physicians they place. What’s more, the physician should try to determine if the company has the financial resources to pay their physicians regularly. The physician should find out if the company offers the services necessary to ensure that all details have been taken care of when the physician arrives to work (such as licensing, credentialing, and hospital privileges) and makes all travel and housing arrangements, the association says.

In addition to these guidelines, the staffing company should place a high priority on providing quality service, NALTO says. By providing quality service to its physician clients, the company should have enough professional staff to provide each physician with personal attention; comprehensive services (such as those administered by payroll, travel, and housing departments within the company); qualified physicians who meet strict credentialing standards; and most important, enough assignments to allow its physicians to choose among client companies, the association says.

According to one study, only about 4% of physicians in nonacademic settings accepted *locum tenens* assignments in 1987, but by 2000, that proportion had grown to 15%.

—DJN

(Continued from page 14)

is going to happen, the phone rings and I am busy again. For ten years, I have not been home in Seattle during the summer. I’ve always been

busy then, and usually it’s because I am covering for people with children who are out of school on their summer vacation.

**Q:** To whom would you recommend this sort of life?

**A:** *Locum tenens* work is suitable for physicians who have just finished their residency. They may be seeking interim work to help them decide where to settle. Physicians looking for a permanent position would benefit from *locum tenens* work in order to try living in a certain geographic area or working in a particular type of practice. These physicians may find it helpful to do *locum tenens* for a group they are considering joining in order to get an idea about the group before making a commitment.

Also, there are some physicians near retirement who may not really want to retire. They might want to consider doing *locum tenens* work on a part-time basis to keep their hand in medical practice.

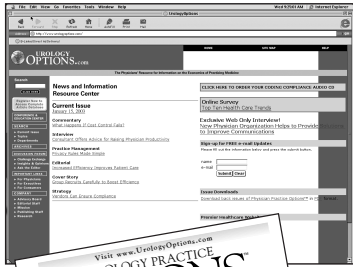
**Q:** Do you have any final thoughts about the obligations of a *locum tenens* physician?

**A:** *Locum tenens* physicians on assignment have an obligation to provide the best service and to do the best job they can, to never embarrass their client, and to remember that they are not in charge. Rather, they are guests, there at their client’s wishes. If they are asked to do certain work and they are trained and capable of doing it, they are expected to do that work.

Furthermore, *locum tenens* physicians must get along with people, including the staff. If they do not get along with the staff and, as a result, create friction, they will not be asked to come back. No client wants a troublemaker. Basically, *locum tenens* physicians are given the assignment because the client already has trouble, meaning not enough staff. The *locum tenens* physician is there to help the situation.

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

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