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EDITORIAL

Are Health Plan Ratings Unfair to Physicians?

A number of physicians are unhappy about health plan efforts to rate physicians so they can place them in tiers according to how well they deliver care to plan members.

The problem is that health plans rate physicians according to algorithms they apply to claims data. Then, plans place those physicians who have the best quality and cost scores in the upper tiers. Those physicians who have lower scores are placed in lower tiers. Plans then publish lists of these doctors and some are steering patients to higher-scoring physicians.

For physicians, a particularly onerous aspect of this system involves the plans' use of proprietary software to rate physicians. Since the data are unavailable to physicians, physician associations in Connecticut, Washington State, New York, and elsewhere have complained that the process is unfair.

In Minnesota, health plans use a ranking system to decide which physicians will receive pay for performance (P4P) bonuses. In retaliation, the Minnesota Medical Association developed a system to rank the P4P programs insurers use.

In October, New York Attorney General Andrew Cuomo required Cigna, Inc., to submit to state officials the rating criteria it uses to place doctors into tiered networks. The ratings should be based on independent quality measures not claims data or costs, Cuomo said. Also, physicians should be able to appeal the rankings. Last month, Cuomo announced that UnitedHealth Group Inc., (which includes Oxford Health Plans), Group Health Inc., and HIP Health Plan of New York Inc., agreed to adopt a similar model for ranking physicians.

UnitedHealth said it would apply the model nationwide and planned to launch a doctor-ranking program known as UnitedHealth Premium in New York. WellPoint Inc., Cigna, and Aetna Inc., also agreed to make similar changes to their physician-ranking programs nationwide. Empire Blue Cross Blue Shield, a subsidiary of WellPoint, said it would adopt Cuomo's model for any future program it adopts in the state.

"We are witnessing the insurance market correcting itself," Cuomo said, "The three largest insurers in the country have now all said they will apply the principles of our model for doctor rankings nationwide. Leaders in the insurance industry are setting the standard for rating doctors by using a model that was created with the input of physicians and consumers."

The model requires companies to ensure their rankings for doctors use established national standards to measure quality, disclose to consumers how their programs are designed and how doctors are ranked, and are not based solely on cost.

We applaud Cuomo's efforts because his plan brings a level of transparency to a process that was previously inscrutable and unappealing.

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STRATEGY

Physicians Join the Blogosphere

By Michael Bihari, MD

Benjamin Kruskal, MD, PhD, misses the days when he had time to sit with his colleagues over a cup of coffee to discuss clinical and practice-related concerns. A pediatrician, Kruskal has joined several physician-only online communities and started his own blog to interact with physicians and others in health care. In March, Kruskal launched his blog (at http://drbensblog.com) to add his voice to the debate about how "to improve our health care system from the micro to the macro level."

A blog (short for "web log") is an online journal or personal diary that can be updated regularly with easy-to-use content management software. Typically, blogs include a front, or home page, with dated posts starting with the most recent, a list of topic categories, a dated archive, and links to other related online content. Most blogs allow visitors to post comments in response to the blogger, often leading to an ongoing dialogue about issues.

"Blogs will have a tremendous impact on the practice of medicine, offering a way for physicians and others to share opinions and discuss issues in a way that is immediate, efficient, and cost-effective," says Benjamin Kruskal, MD, PhD.

Clinical Lessons Learned

"Blogs will have a tremendous impact on the practice of medicine, offering a way for physicians and others to share opinions and discuss issues in a way that is immediate, efficient, and cost-effective," says Kruskal, the director of infection control and travel medicine at Harvard Vanguard Medical Associates, a 500 physician multisite, multispecialty practice in Boston. Since starting his blog, Kruskal has come across interesting information relevant to his practice, including a new type of family therapy for treating patients with anorexia nervosa.

Kruskal is not alone, as thousands of health care professionals, patients, and others are writing health-related blogs and influencing how people receive and use medical information. Bypassing the traditional journals and static web pages that communicate in only one direction, blogs provide an immediate way to get and respond to information.

And, to capture the attention of medical professionals and patients, health-related companies and organizations, and the medical media have not only created blogs but also participate in the commentary on physician's blogs. One prominent example, Health Blog from *The Wall Street Journal*, offers news and analysis on health and the business of health (at http://blogs.wsj.com/health/). The health policy journal *Health Affairs* has entered the blogosphere (at http://healthaffairs.org/blog), to engage readers in health policy debates. Such medical journals as *The Lancet* (at http://blogs.thelancet.com) and the *British Medical Journal* (at http://blogs.bmj.com) are experimenting with clinically focused blogs either featuring their own content and editorial commentary or offering frequently updated observations on the most important articles from respected medical journals.

Why Physicians Blog

For many reasons physicians blog to express opinions about their work and society, offer their knowledge, or share their creative side through poetry and writing. Empowered by the Web's anonymity, many physicians feel free to express themselves openly. Specifically, many physicians use their blogs to:

- Articulate concerns about issues that effect their practices, such as managed care, malpractice reform, and Medicare reimbursement. By sharing such concerns, physicians can expect to get comments from colleagues who share similar frustrations.
- Voice opinions on medical news and controversial issues. This function serves as a catalyst and outlet for debate, giving some an online soap-box.
- Communicate with patients about recent medical developments or new services a practice offers or issue reminders such as the onset of the flu season or information about self-management of common chronic illnesses.
- Market their services and enhance their visibility in a community among referring physicians and potential new patients. Many younger patients conversant with technology may be attracted to physicians who have an Internet presence.
- Share clinical information and skills with other physicians to improve treatment practices, enhance con-

(Continued on page 4)

Michael Bihari, MD, *is a writer and editor in Falmouth, Mass.*

(Continued from page 3)

nections with colleagues, and create new relationships. Personal blogs give physicians the opportunity to connect with other health care bloggers worldwide.

Although it is unlikely that blogs will replace face-to-face interactions between doctors and patients, they may enhance physician-patient communication. Along with keeping their patients up-to-date about medical advances and healthy lifestyle and illness prevention, physicians can use blogs to help patients understand the issues physicians face.

Interestingly, physicians use blogs to create online communities of patients with a specific health condition that may lead to the formation of an ongoing virtual group visit. For example, a busy internal medicine practice may have a significant number of patients with diabetes and by creating a patient-focused diabetes blog, physicians can post information about lifestyle modifications and issue reminders about eye and foot examinations. Patients can comment on the physicians' postings and offer suggestions. By encouraging patients to share problems and solutions, physicians are helping patients with similar needs to support each other.

Blogging Grand Rounds

Several blogging sites have created a type of grand rounds (also known as "carnivals") that present interesting posts from the health care blogosphere. One popular gathering place is Blogborygmi (at http://blogborygmi.blogspot.com), a blog written by Nicholas Genes, MD, PhD, an Emergency Medicine resident at Mount Sinai Hospital in New York.

Each week, a different medical blogger hosts a new edition of grand rounds and compiles posts on their own blog. Various bloggers involved in hosting grand rounds link to the host site and may let readers know about the host and if there is a specific theme. Genes also reviews the grand rounds schedule on Medscape (at www.medscape.com) and often interviews the various hosts.

Trusted.MD (at http://trusted.md), a blog published by Dmitriy Kruglyak, lists, annotates, and provides access to more than 100 medical blogs. The site also provides "open rounds," a service for bloggers to host, organize, and manage carnivals.

Blogging Procedures

Since search engines (such as Ask.com, Google, and Live Search) are constantly scouring the Web and creating permanent records of online content, everything a physician publishes in a blog may be

Start Your Own Blog

Blogs are easy to use and require little if any technical proficiency. Virtually any physician can start a blog in less than 30 minutes. If you can send e-mail messages, you can write, post, and publish a blog.

To start your own blog, consider using one of a number of free or inexpensive services available online that will help you set up a template, make entries, and review and moderate comments. These blogging services provide a unique Web address and an easy-to-use content management system that allows bloggers to add articles, text, photos, and links.

Some of the more widely used blogging hosts are:

- Blogger (www.blogger.com)
- Blog.com (www.blog.com)
- Live Journal (www.livejournal.com)
- Type Pad (www.typepad.com)
- Vox (www.vox.com)
- Word Press (www.wordpress.com).

Before going "live" or public with a blog, become familiar with the blogging templates hosting sites provide. Spend some time reading and posting on medical blogs to get a feel for the physician blogosphere. Think about the audience you want to reach, the relevance of your content, and the point-of-view you will communicate.

When you launch your blog publicly, ask colleagues, family members, and friends to visit the site and post comments. This support network is the first step in building an audience online.

And, from your first post, remember that what you say on the Internet stays on the Internet!

—MB

Be aware of what you're talking about, who your audience is, and the potential consequences of any information you post to your blog. If you comment on your job, colleagues, or hospital administrators, it may come back to haunt you!

recorded forever. Be aware of what you're talking about, who your audience is, and the potential consequences of any information that you post to your blog. If you comment about your job, colleagues, hospital administrators, or others, it could come back to haunt you.

As a physician, you have both ethical and legal obligations to provide accurate health-related information and to protect the identity and confidentiality of your patients. In an online community, physicians and staff members also must comply with the Health Insurance Portability and Accountability Act (HIPAA) just as they would in the office. For some physicians who believe their online comments could be seen as controversial, it may be prudent to blog anonymously, at least to start.

Any physician joining the blogosphere should be familiar with the Healthcare Blogger Code of Ethics (at http://medbloggercode.com). These standards for medical bloggers include an understandable representation of the author's professional prospective; clear distinction between information and advertising; confidentiality of patient information; commercial disclosure, especially ties to pharmaceutical and medical device companies; accuracy of the content and a requirement to cite sources of the information, as appropriate; and, during debate, acting courteously and avoiding personal attacks.

Blogs are changing how physicians interact with their colleagues, patients, and others. Being knowledgeable about the advantages, disadvantages, and the effect of blogs can help physicians navigate this rapidly evolving online communication platform successfully.

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

Here's a List of Popular Medical Blogs

By some estimates there are several thousand physician blogs, however, a number are widely read or referred to in the media. The following popular blogs should give potential physician bloggers a flavor for what their colleagues are writing as well as the range of topics.

Kevin, MD (www.kevinmd.com/blog): Provides commentary on current medical issues written by Kevin Pho, MD, a practicing internist in Nashua, N.H. Recent posts include commentary on Zagat's plan to rate physicians, malpractice reform, the FDA and children's cold medications, and defensive medicine.

Med Innovation Blog (http://medinnovationblog.blogspot.com): Written by Richard Reece, MD, editor of *Practice Options* and author of 10 books including *Innovation-Driven Health Care: 34 Key Concepts for Transformation*. Recent commentary includes physician shortages, physician autonomy, and medical tourism.

Medgadget (www.medgadget.com): Written by a group of physicians and biomed engineers to provide commentary on the latest medical technology. Recent posts include reviews of several new pieces of surgical equipment, organ donor matching, and the American Medical Association.

DB's Medical Rants (www.medrants.com): The blog of Robert Centor, MD, director of general internal medicine at the University of Alabama in Birmingham. Labeling his blog as an exploration of medicine and the health care system, Centor has recently commented on the appropriate use of antibiotics, health care inflation, and pay for performance.

Musings of a Distractible Mind (http://distractible.org): This blog, written by "Dr. Rob," a primary care physician in the Southeast, is a good example of an anonymous blog that includes comments on professional and personal issues. Recent posts include the emotional challenge of being a primary care provider, physical examination of the pharynx, and MRSA and antibiotic resistance.

The Health Care Blog (www.thehealthcareblog.com): Although not written by a physician, this blog has a significant following. Mathew Holt, a health care industry analyst and consultant writes about business issues effecting physicians including patients without health insurance, malpractice reform, Massachusetts health care reform, and managed care.

Surgeons Blog (http://surgeonsblog.blogspot.com): Sid Schwab, MD, a retired general surgeon, describes his blog as "wherein a surgeon tells some stories, shares some thoughts, and occasionally shoots off his mouth. Like a surgeon." Recent posts include commentary on academic hospitals, second opinions, and breast cancer.

The Blog That Ate Manhattan (http://theblogthatatemanhattan.blogspot.com): Another example of an anonymous blog written by a physician who writes about medical practice, food, and New York City. Recent commentary includes defensive medicine, discussions about menopause, and several family recipes.

EBM: Often Admired, Seldom Practiced

By Tom Doerr, MD

Evidence-based medicine is often admired but seldom practiced. It is rarely practiced because few physicians have the time to appraise the medical literature critically. This reality is unfortunate considering the astounding improvements they could make in quality if they did have the time.

Three published estimates suggest that physicians are directing 80% of the spending in our $2 trillion health care market. Yet if one considers the lack of information that physicians bring to these spending decisions, frankly, it is primitive and pathetic. Imagine physicians as purchasing agents with $2 million annual budgetary authority. Studies show that as physicians we don't know how much the drugs and diagnostic tests cost that we order, and that we lack comparative information about their effectiveness and adverse effects.

Furthermore, our compensation is largely disconnected from the quality and cost-effectiveness of our performance. Is it any wonder that the United States has the most expensive health care system in the world, while perennially ranking near the bottom of industrialized countries in such metrics as healthy life expectancy?

Transforming Care

Evidence-based medicine (EBM) is often promoted as the solution to much of what ails our health care system. It promises to displace authority-based medicine, wherein practicing clinicians simply follow the recommendations of experts in the health care community. These so-called experts usually are affiliated with distinguished academic medical centers with successful college football programs.

Tom Doerr, MD, *is chief medical officer of Purkinje (at www.purkinje.com), a clinical decision support and medical software and services company in St. Louis.*

If the true practice of EBM takes too long and is not compatible with having a financially viable medical practice, and if most physicians lack expertise in critical analysis of sophisticated medical studies, then what can dedicated physicians do to improve the quality and cost-effectiveness of their care? The answer is advanced tools and economic incentives to optimize health care outcomes for patients.

The actual practice of EBM requires clinicians to formulate carefully structured questions about clinical problems in specific patients and then to perform searches of the medical literature to find valid randomized controlled clinical trials that contained patients representative of the particular patient being treated. This process usually takes the better part of an hour per question.

If the true practice of EBM takes too long and is not compatible with having a financially viable medical practice, and if most physicians lack expertise in critical analysis of sophisticated medical studies, then what can dedicated physicians do to improve the quality and cost-effectiveness of their care?

The EBM Adoption Question

The answer is advanced tools and economic incentives to optimize health care outcomes for patients. The state-of-the-art in evidence-based medical practice involves the integration of context-specific rules-based clinical decision support messages into electronic health records, according to an article last year in *Evidence-Based Medicine* (2006;11;162-164) by R. Brian Haynes.

On the technology side, advanced EBM tools need to follow and present medical evidence intuitively in the traditional four-step organization. This process involves aggregation of relevant medical studies, synthesis of such data as reviews, synopses of key studies and systematic reviews, and summaries of the relevant synopses.

Clinical decision support systems use rules behind the scenes to link relevant messages about patient care to patients who meet the characteristics of the rule. Simply presenting guidelines with no validation, or offering links to online textbooks is unlikely to improve health care outcomes.

For example, in 2004 Michael Fischer and Jerry Avorn published a study that showed that if all Americans aged 65 and older who had high blood pressure were treated with the drugs that the best evidence proved to be most appropriate, we would save $1.2 billion in annual drug costs. There would also be enormous additional savings due to fewer heart attacks, strokes, and heart failure.

Many primary care doctors may be

Group Improves Care with EBM

Clinical decision support integrated with evidence-driven data can help improve patient safety significantly. Consider what happened at Esse Health, an independent group of more than 75 physicians who practice in 28 different locations throughout the St. Louis metropolitan area.

Earlier this decade, 61% of prescriptions in the United States for non-steroidal anti-inflammatory drugs (NSAIDS) were for the newer COX-2 inhibitors. At that time, Esse Health had been sending messages to its physicians and patients via Purkinje's e-prescribing software about the risks and limitations of these drugs since two randomized controlled trials came out in 2000. The e-prescribing software is from Purkinje (at www.purkinje.com), a clinical decision support and medical software and services company in St. Louis. Esse Health tracked the prescribing patterns of doctors using the EBM clinical decision support software and found that 25% of all prescriptions for NSAIDs were for COX-2 inhibitors.

When two of these medications were withdrawn from the market within a year, many e-prescribing companies took pride in being able to notify physicians quickly and enable them to inform their patients to stop taking these medications.

While this development certainly shows the value of such systems, Esse Health went further by gathering the medical evidence and incorporating it into physician workflow at the point of medical decision making. In this way, Esse was ahead of the FDA in limiting the exposure of their patients to these drugs in part because it knew that incorporating clinical decision support at the point of care could improve patient safety measurably.

—TD

unaware of the most powerful financial incentive for EMR adoption, which also indirectly rewards evidence-based fiscally responsible care: CMS' Medicare Advantage HMO plans. About 20% of Medicare recipients receive their care in these plans. They are funded through a prospectively risk-adjusted compensation formula, wherein the revenue that physicians receive for each patient in one year are determined by the severity of illness that they documented through their diagnosis coding for each patient during the previous year.

The Value of Correct Coding

In brief, doctors using an EMR with sophisticated Medicare Hierarchical Condition Coding support may code more thoroughly and accurately, generating as much as 30% more revenue than doctors who lack EMRs and do not pay attention to their diagnosis coding practices. Insurers that administer the Medicare Advantage plan often have a risk-sharing contractual agreement with physicians for a substantial percentage of this incremental revenue. Ironically, this powerful P4P program costs CMS nothing, since it is a zero sum game: the risk adjustment model is rebalanced every 12 months. Doctors who code poorly and are paid poorly fund the incremental revenue for doctors who code well.

Employers are becoming increasingly interested in P4P programs; however, most businesses need to see a strong case to become engaged in these programs on a large scale. One promising incentive for evidence-based care is the Bridges to Excellence (B2E) program. This program is offered in collaboration with the National Business Coalition on Health, the National Committee for Quality Assurance, and the Leapfrog Group, all in Washington, D.C.

B2E encourages physicians and physician practices to deliver safer, more effective and efficient care by giving them financial and other incentives to do so. Thousands of physicians participate in B2E's Physician Office Link, Diabetes Care Link, Cardiac Care Link, and Spine Care Link programs. As a result of B2E's extensive reporting requirements, purchasers and their employees have the information they need to make better health care decisions while also obtaining cost effective care.

The American Board of Internal Medicine, with support from B2E, is developing a new program called the Comprehensive Care Practice Improvement Module. This program will allow as many as 180,000 internists who seek to maintain ABIM board certification to send their performance data collected through that process to B2E and eventually to other payers. Under this new partnership with ABIM, participating internists will qualify for maintenance of board certification, continuing medical education credits, and bonus payments under B2E's new Internal Medicine Care Link program, according to B2E.

Beyond Anecdotal Benefits

An EBM approach has clear benefits related to quality, reduction of medical errors, and cost savings. In peer-reviewed studies published in the *Annals of Family Medicine* and the *Journal of Managed Care Pharmacy*, an e-prescribing clinical decision support solution showed a significant effect on the cost and quality of patient care. The studies demonstrated a 12% savings in the costs of new prescriptions and refills, compared with costs from contemporaneous control groups. The participating payer, Affinity Health Systems, enjoyed ongoing savings of

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$1,270 per doctor per month, relative to the contemporaneous control group, in pharmacy costs. In fact, there was remarkable consistency among the largest groups.

Another third-party study performed in Maine by Anthem found a savings of $3.55 per prescription, which amounted to $470 per physician per month. Because Anthem was the payer for approximately 30% of patients in Maine, the total savings for all payers could be estimated to be more than $1,500 per physician per month in one quarter alone.

Considering that small and medium-sized practices deliver 70% of health care in the United States, EBM clinical decision support solutions should be tailored to this audience to speed adoption. But doing so means eliminating the cost barrier; ensuring that workflow is not disrupted by infusing EBM into the workflow; making evaluation transparent, Web-based, and convenient; and achieving rapid and non-disruptive implementation.

Clinical decision support with EBM can help physicians shift their focus from reacting to patients with acute illness toward using data to actively manage patients with chronic disease and patients with specific conditions. More aggressive reimbursement reform that rewards fiscally responsible, high quality, evidence-based care will save money for payers, representing a win-win proposition for physicians, payers, and patients.

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

Can Pay for Performance Help Foster EBM?

One way to foster improvements in care is through pay for performance (P4P) programs. But 2005 P4P measures outlined in the Healthcare Effectiveness Data and Information Set (HEDIS) rewarded the lowering of blood pressure without distinguishing whether this reduction happens as a result of using a calcium channel blocker that may worsen the patient's five-year mortality, an expensive new drug with no five-year outcomes data, or with a thiazide diuretic that clearly improves five-year mortality.

Not only is simply supporting P4P guidelines inadequate, but many vendors of electronic record systems don't support guidelines in the work flow in the first place. It is rare for electronic health record (EHR) companies to integrate evidence-based context-specific decision support information into the work flow of busy clinicians. EHR vendors will be reluctant to invest in building the decision support needed to improve the quality and cost of care unless the market demands it because higher reimbursement rewards it.

Thus the incentive carrot is as important as the technology. In England, the contract between general practitioners and the National Health Service puts 18% of physicians' annual income at risk, depending on their performance against 146 quality measures. In contrast, physicians in the United States are lucky if 2% or 3% of their income depends on their performance against quality measures.

In America, P4P is a plastic carrot: it looks appetizing, but when you bite into it, there is little satisfaction. Yet, doctors will continue to pretend to perform in the clinical outcomes arena as long as the health care system pays them for outcomes.

Some observers might object to the thesis that physicians need incentives and ask: Why should we have to pay physicians more to perform well? Isn't this their job? The reality is that physicians need financial incentives to be able to cover the costs of software, hardware, and implementing electronic health record systems. Primary care physicians practice under surprisingly severe economic pressures. Many are struggling for financial survival.

Between 1995 and 2003, family physicians increased their billable productivity by 35%, only to receive an 18% inflation-adjusted reduction in average income in this same period. Meanwhile, the number of American-trained physicians choosing careers in family medicine declined by 50%. And Medicare projects physician payment cuts of about 35% by 2015, while physician costs are expected to rise by 20%.

What's more, payers are reluctant to offer generous performance bonuses because physicians tend to treat all patients in their practices the same regardless of which payer is paying the bill. If one payer with a 20% market share finances an effective incentive program for evidence-based care, then most of the benefits will actually accrue to the sponsoring payer's competitors.

The Integrated Healthcare Association (IHA), in Oakland, Calif., has a P4P program that is a notable exception insofar as multiple payers cooperated to overcome this problem. Nonetheless, this multi-payer coalition has grossly underfunded the bonuses. The bonuses typically amount to only 1% to 2% of a physician's income. Experts estimate that such bonuses should be in the 5% to 10% of income range to be effective, according to an article, "To Get Doctors to Do Better, Health Plans Try Cash Bonuses," in *The Wall Street Journal.*

Some of the Hawaii Medical Service Association's performance-based bonuses reach into this range, but HMSA has an 80% market share, and Hawaii enjoys an aberrantly strong sense of community that is lacking in the mainland. HMSA is the exception that proves the rule.

—TD

Speech Recognition Speeds Data Entry

By Douglas Golding, MD

Speech recognition technology at Lifetime Health Medical Group complemented data entry via the keyboard and led to increased report accuracy and substantial cost savings. The technology let physicians describe patient encounters in their own words through free-form dictation.

For many physicians, electronic medical record (EMR) systems offer the potential to improve the quality of health care they deliver and reduce costs as well. However, many factors inhibit widespread adoption of EMRs, and one of the most significant roadblocks for physicians is the high installation and operating costs of these systems. EMR systems also can be inflexible and have other limitations that often prevent physicians from using them. Many physicians find that EMR systems are more effective with the help of enabling technologies.

For the physicians at the Lifetime Health Medical Group, an example of enabling technology is speech recognition software to assist with transcription. We installed speech recognition technology shortly before implementing EMR systems in our offices in Buffalo and Rochester, N.Y., and experienced a smooth integration of the two technologies. The Rochester offices began EMR implementation in late 2006, while Buffalo began implementation early this year. In both places, speech recognition technology was implemented prior to EMR, and then integrated into the system. In both cases, the results were pleasantly surprising.

Save Time and Money

Recognizing that transcribing dictated notes can be costly and time consuming, our physicians embraced speech recognition technology to describe patient encounters in their own words through free-form dictation. The use of speech recognition at Lifetime Health complemented data entry via the keyboard, and led to increased report accuracy and substantial cost savings.

Prior to implementing speech recognition technology and our EMR, the providers engaged in a variety of documentation methods, ranging from hand writing notes to dictating into cassette tapes which were then sent to transcriptionists. Annual transcription costs at six Buffalo health centers ranged from $750,000 to $800,000, or about $15,000 per provider per year. In addition, getting notes and tapes transcribed could take as long as three weeks, delaying the flow of information needed to deliver care effectively.

Facing the financial challenges that many physician practices encounter, we needed to reduce transcription costs and purchased one copy of Dragon NaturallySpeaking Medical from Nuance Communications, Inc., in Burlington, Mass., to assess its ability to meet our group's needs. The functions and recognition accuracy of the system impressed our early users, who decided that all providers in Buffalo should use it.

Implementation Steps

Speech recognition technology was rapidly implemented among 69 providers, many of whom became accustomed to the technology quickly. As added motivation for those who were less eager to adopt the "once-and-done" mode, we instituted a modest penalty for using traditional transcription after a certain deadline. In a short time, all providers were using speech recognition to dictate a large portion of their daily patient documentation.

System architect Marc Reinhardt said the system's functions were impressive, and users become familiar with them quickly. "You're always sure that the spelling of some inanely spelled medication will be correct," Reinhardt said. The speech recognition technology comes with 14 medical vocabularies covering 60 subspecialties and templates and macros specific to medicine. Using simple voice commands, the team has created additional templates, dictionaries, macros, and shortcuts for formatting and inserting text.

The software can be integrated with any Windows-based EMR system or Microsoft Office application without adding additional middleware or interfaces. It also can be used on any personal computer, and includes tools for network deployment, such as support for Citrix thin-clients. To input data, providers use their computers' integrated microphones, external USB headsets, or wireless Bluetooth-enabled microphones.

At Lifetime Health, the doctors and

(Continued on page 10)

***Douglas Golding, MD,** is the Buffalo region medical director and associate chief of health care informatics for Lifetime Health Medical Group, a nonprofit organization that provides primary health care to more than 100,000 patients in Buffalo and Rochester, N.Y.*

(Continued from page 9)

other providers use the software on tablet PCs. Documents were initially created using Microsoft Word and stored on network servers. We now dictate directly into the EMR. Roaming user profiles allow health care practitioners to access their voice files, templates, finished reports, and related files at any location on the network or via an Internet connection. The program automatically synchronizes and updates any adaptations created locally with files stored on network servers.

Speech recognition software has allowed physicians at Lifetime Health to finish notes more quickly than they did in the past. This improvement often allows them to spend more time with patients, which can enhance customer satisfaction and improve patient outcomes.

Increased Satisfaction

Providers are extremely satisfied with the benefits we've attained as a result of pairing speech recognition with our EMR system. "I use it every single day in a lot of different ways," said Donald Brown, DPT, manager of physical therapy. "It's such an efficient system, I couldn't imagine going back to dictating and waiting. It's good for quality and good for communication between colleagues." Many providers are getting recognition accuracy rates of 98%, which helps them complete their notes quickly.

By finishing notes more quickly than he did in the past, Brown can spend more time with patients, which can enhance customer satisfaction and improve patient outcomes. "By spending more one-on-one time with them, we can get patients better faster," Brown said. Speech recognition also helps to overcome one of the disadvantages of having EMR systems in exam rooms. Many physicians complain that entering data on a PC forces them to focus on the computer while meeting with patients. But by being able to work anywhere, physicians can dictate notes while more effectively engaging patients, Brown added.

One other significant benefit is the savings associated with eliminating transcription across the Buffalo health centers. In the first year of using speech recognition, Lifetime Health saved $415,000 in transcription costs. In the second year, the group expects to save $680,000. The impressive and rapid transcription savings translated into a return on investment within only 1.5 months. Most technology investments take two to three years to break even.

More Accurate Coding

Speech recognition also has facilitated more accurate coding within our group. When a physician is recording his or her notes, it is easy to check that all aspects of care are documented appropriately, and if necessary, code levels can be revised to improve coding accuracy. "However you document a visit, the documentation of that visit is the key, and supporting the code that you submit with that is essential," commented Arthur Orlick, MD, Lifetime Health's chief operating officer and chief medical officer.

Even in the early stages of EMR implementation, the value speech recognition adds to electronic records is clear. A physician who worked at another practice found it difficult to enter notes when using a typical "point and click" interface. But speech technology was much easier because it allowed physicians to enter a note by speaking to supplement point-and-click data entry instead of typing.

While some information is still captured via the point-and-click method, such as choosing from a list of medications or allergies, the substance of an encounter requires a physician to explain the visit using the spoken word. Clinical findings, patient descriptions, past medical and social history, and correspondence all require that a physician enter data using unrestricted free text. The ability to incorporate narrative dictation into a note is critical to documenting why a provider has chosen a certain diagnosis.

For all of these reasons, the physicians at Lifetime Health have found the EMR system is more effective when driven by speech. Searches, queries, and filling out forms are done faster with voice commands than when using a keyboard. Charting, prescribing, aftercare instructions, order entry, database searches, and clinical documentation are all highly conducive to control by speech.

Looking Ahead

Currently, Lifetime Health is introducing the EMR to all 110 providers in our 10 health centers. "Our vision is to be paperless," said Bob Krenitsky, Lifetime's chief information officer. "Without a tool like speech recognition, we could never achieve that vision. It is a pinnacle piece to making our electronic medical records a success."

The group envisions that virtually all providers at the Buffalo health centers will be using EMR and speech recognition in tandem soon. But given how much speech technology has helped to improve our use of EMRs, the physicians hope to find other uses for speech recognition technology in ways that will meet our needs and serve our patients as well. For more than three decades, we have pioneered innovative ways to deliver care, and we plan to continue to integrate technology that can improve the patient experience.

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

Sell Your Practice With a Buyout Fund

By David B. Mandell, JD, MBA, and Jason M. O'Dell, CWM

A buyout of a medical practice requires a commitment many years before the buyout, meaning physicians need to plan for and fund the buyout over time. As with any financial planning tool, particularly one involving retirement, it is best to implement a plan as soon as possible.

Physicians often fear they will not be able to sell their practices for any significant value. For some reason, these physicians generally do not believe their practices are worth much, especially if they do not have younger partners to buy them out.

Even in large medical practices with a significant number of younger physicians, most doctors have similar worries. These physicians believe they will get a couple of months of payments from accounts receivable (AR) after they retire, which is most likely true, but this amount is a pittance compared with the value they brought to the practice over the years. Certainly a few months of AR payments do not compensate a physician for more than 20 years of building a practice and its reputation in a community.

Steps to Take

So what can physicians do about it? Unfortunately, the most common advice physicians seem to get from their advisers is some version of "grin and bear it." Many financial and practice advisors say there is no white knight coming along to buy practices for seven-figure sums, especially if the selling physicians will be retiring in the same year or in the near future. In fact, few physicians have built a solid plan for a lucrative buyout based on their existing advisers' help.

But there are ways to sell a practice for millions of dollars and they require planning and preparation. It is not necessarily true that an outside party such as a management company or insiders such as younger doctors will cut you a seven-figure check as you are about to retire. If the physician's buyout plan is to see patients with no forethought about how to sell the practice upon retirement, it is highly likely that the physician will get virtually nothing for the practice. On the other hand, if a physician begins when he or she starts a practice to fund a buyout vehicle for the practice, the physician can almost be assured of getting a multi-million dollar check upon retirement.

There are a couple of alternative techniques to use but the key point is simple: A buyout of a medical practice requires a commitment many years before the buyout, meaning physicians need to plan for and fund the buyout over time. As with any financial planning tool, particularly one involving retirement, it is best to implement a plan as soon as possible.

A Traditional Plan

Most physicians have heard about traditional retirement plans, which include qualified plans such as pensions, profit-sharing plans, 401(k)s, 403(b)s, SEP-IRAs, and Keoghs. Non-traditional plans are less well known and sometimes are called non-qualified deferred compensation plans or split-dollar plans.

Most *Fortune* 1000 companies make non-qualified deferred compensation plans available to their executives. While many of these plans in public companies involve company stock or stock options (which, of course, do not work in a private medical practice), many use structures that a physician could use in a practice.

These plans are not qualified and so can be offered only to a few employees, such as the physicians or

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partner physicians. Among the many ways this type of plan can create a large buyout fund for retiring physicians is by requiring each physician to put a certain dollar amount or a percentage of income into the plan each year. The plan's funds then grow over time so that as each older physician retires, he or she has a right to a certain percentage of the plan's assets. This amount would be in addition to each physician's qualified plan (such as a pension plan) as well.

The practice could build vesting requirements into the plan, so if physicians leave the practice they lose the benefits in the plan, allowing remaining doctors to benefit from the departing physician's share. Conversely, the practice could establish the plan so that a departing physician could take his or her share of the benefits and the remaining physicians would not get a share of the departing physician's benefits.

For most practices, the alternatives are numerous. But the point is that simply by implementing such a plan, a medical practice could create a multimillion dollar buyout fund in as little as five years. And, the longer physicians continue to add cash to the fund, it will continue to grow.

The Captive Option

One other option exists for physician groups that have captive insurance companies (CICs) or want to start one. Typically, medical groups establish CICs because the physicians get certain risk management, tax, and asset protection benefits from them. Certain small CICs can enjoy beneficial tax treatment, allowing the physician owners an opportunity to build tax-favored wealth, as opposed to giving profits to insurance companies.

In addition to these benefits, the CIC can be an ideal source of buyout funds for retiring physicians. In many cases, a CIC will have significant reserves left to invest and build each year it is in existence. Over 10 to 20 years, the CIC could accumulate very large amounts. If a buyout formula is built into the CIC's stock agreements, then it can be another source of buyout funds for retiring doctors.

These are just a few of the techniques physicians can employ to "sell" their practices lucratively when they retire. As above, planning and diligent funding are the keys to success. Since there are not many buyers willing to pay physicians millions of dollars for a practice, physicians who want a buyout must plan for it.

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

Consider the Tax Implications of Retirement

Physicians who have standard retirement plans, such as an IRA, should be aware of the tax implications of such plans. In recent years, there has been much discussion in Washington about the possibility of revising the laws to reduce taxes on these plans. Unfortunately, all signs point to the clear fact that significant taxation of assets at death will continue to be an estate planning issue for the foreseeable future. Indeed, for most physicians, the area where such taxes will hurt the most remains pensions and IRAs, where over 70% taxation can still be the norm.

Several reform bills have emerged in both chambers of Congress over the last two years; none has garnered the necessary votes for passage. The proposals closest to passing essentially would have raised the estate tax exemption (the amount below which no federal taxes would be due) to $5 million per person, or $10 million per couple and lowered the tax rate to around 20%.

Since this proposal has not moved forward significantly, physicians should plan on an exemption of no more than $1 million per person and a combined federal and state estate and inheritance tax rate of 55%. Under current law, these figures would apply for individuals dying after 2011.

Even if the federal government reduces estate tax levies, it is likely that individuals would still face a stiff tax penalty because it is likely that states would seek to make up the difference. When the federal government repealed the previously onerous estate tax levies in 2001, it also cut the amount of estate tax dollars collected that previously had gone from the IRS to the states. This aspect of the law was not widely reported at the time. Under the pre-2001 law, individual states shared heavily in the estate tax revenue that the IRS collected. Thus, states had little need to impose their own estate taxes. But under the repeal legislation, states stood to lose billions of dollars of estate tax revenue.

In response, many states have implemented their own state estate tax or inheritance tax levies. A state estate tax is similar to the federal estate tax in that it is levied on a decedent's estate before it is distributed to heirs. An inheritance tax is levied on the heirs once they receive their inheritance. To date, 24 states plus the District of Columbia have instituted either a state estate tax or state inheritance tax.

As a result, physicians and other individuals who face such tax levies may want to discuss these issues with a qualified financial planner.

—DM and JO

Broker Sees Positive Trends for CDHPs

__Jeffrey Hogan__ is the New England/New York/New Jersey regional manager in Farmington, Conn., for Rogers Benefit Group Insurance Brokerage, Inc. Rogers Benefit Group works with insurance agents and brokers to arrange group insurance coverage for employers and provides consultative strategies and administrative sales and marketing support for insurers. It specializes in fully insured employee benefits for small and midsize firms. In this interview, Hogan talks with Editor-in-Chief Richard L. Reece, MD, about the effect of consumer-directed health plans on physician groups.

Q: *What do you tell physician groups about high deductible health plans and health savings accounts (HSAs)?*

A: The groundswell toward consumerism in health care started about six years ago when the IRS revised its interpretation of the tax code to enable health reimbursement accounts. Since then, I've been telling doctors that the United States is a consumer-oriented country. If a person buys a new car or a new refrigerator, they take the time necessary to investigate the quality and cost of the product before they buy it. Whether it's on the Internet, or in *Consumer Reports*, or by asking friends and family, they do their due diligence.

When it comes to health care, however, most people have little sense of cost or quality. The real revolution in the health insurance marketplace is now over six years old, and the pace is picking up. I'd say 95% of the companies that we quote are now installing some aspect of consumer directed health care plans in their strategies to contain health costs. By moving toward consumer directed care, these companies are now requiring employees to be educated about cost and quality.

That means doctors will be seeing patients who feel empowered to evaluate cost and quality and who have done their homework. In this new marketplace, physicians who are on the top of their game, who can show tangible evidence of value and quality, and who treat patients in a consumer-friendly way, will be the most successful.

Q: *Are insurers explaining the issues that physicians will face as more patients use these consumer-oriented health plans?*

A: Unfortunately, only a few national insurers have conveyed the message to employers, consumers, and physicians. In fact, insurers are not fully explaining to physicians the issues involved with consumerism and what steps the insurers are taking to make doctors toe the line on quality, value, and to reduce costs. But in their back offices, insurers are integrating their systems with data mining technology to pick up unwarranted practice deviations or contraindicated practices.

Insurers, for example, have studied dozens of different disease processes. By collecting these data from claims, insurers can now inform consumers about physicians who deviate from best practice patterns or who practice in ways that are contraindicated. Many insurers that have built these technologies into their platforms are also developing systems that allow them to inform consumers via an online encrypted personal health record about practice deviations or contraindications.

In this way, insurers are making the entire process of delivering and paying for all aspects of health care delivery more transparent to consumers. The role of the traditional health insurance company is changing dramatically. By informing consumers and providers of deviations or variations and by paying doctors for performance, they are developing a better insurance product.

One example of a more transparent system is the development of pay for performance (P4P) programs, which will continue to grow in the coming years. Right now, P4P programs are in their infancy and they are not so much based on patient outcomes but on physician processes. They have the potential, however, to foster the move toward transparency and to allow grading of physicians according to their patient outcomes.

Q: *What should doctors do to prepare for seeing patients with high-deductible plans and HSAs?*

A: Many good physicians have been among the adopters of HSAs for themselves and their employees. The better and more sophisticated doctor groups have

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"In this new marketplace, physicians who are on the top of their game, who can show tangible evidence of value and quality, and who treat patients in a consumer-friendly way, will be the most successful."

—Jeffrey Hogan, Rogers Benefit Group Insurance Brokerage Inc.

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modernized their offices, upgraded customer service, and are actively preparing themselves. They and their staff know that their patients will ask questions about disease processes, best practices, and contraindications they should be concerned about. I'm finding that the better doctor groups are preparing their practices for a patient-centered, consumer-oriented future. They will be ready when empowered patients visit their offices.

Q: *How do insurers react to complaints from physicians that the two-tier system in which insurers use data mining to identify preferred providers and exclude others are unfair? The doctors say they shouldn't be judged on data alone and that tiered systems are about cost, not quality.*

A: Insurers have found that behavior is difficult to modify. We have found that employees and patients take a long time to become informed about important issues such as where to get data or how to evaluate drugs, hospitals, or even outpatient surgical centers. Sometimes the data systems we're using are imperfect, but we're developing better technologies and better informatics about the cost, quality, and outcomes of care.

At the same time, there are very good doctors, mediocre doctors, and bad doctors. Some constituencies will always protest new procedures that are unlike those that we had years ago. The reality is that technology is bringing transparency to health care and outcomes improve with transparency.

If you or someone you know is having a heart-lung transplant, you would want to find a hospital that is doing lots of heart-lung transplants. But if you discover online that the infection rate at that hospital is high, you should not go there. Infection rates and outcomes data allow patients to make informed decisions. The more informed a patient is about the decisions he or she is making, particularly about care for catastrophic illness and costly procedures, the less opportunity there is for a misunderstanding about what was supposed to occur.

We're seeing a generalized movement toward the integration of new technology to prevent bad outcomes. Employers are embracing these data because they know that 8% to 10% of their employees, dependents, or retirees are responsible for 60% to 80% of their claims. If you can control catastrophic claims by informing the patient about which providers deliver the best outcomes, you are helping the patient get better care than he or she would get otherwise and you're saving money, too.

Q: *What is the state of the market for HSAs and high-deductible health plans?*

A: This year, employers are showing great interest in HSAs. Our inventory of prospects for January has tripled from a year ago. The awareness of these insurance products has reached into boardrooms and the offices of the chief executive, and financial officers of all companies, including the smaller, middle-market companies and large national account companies. In the 1980s, health plans sold their products as a commodity. Typically the buying decision was made in the human resources department and wasn't necessarily tied to the company's business plan. But in the intervening years, cost rose and these new plans, such as health reimbursement and health savings accounts, were introduced. As a result of these new plans, chief executives have sensed an opportunity to control health inflation and benefits costs. They have a strategic interest to control costs and educate employees about cost and quality in the process.

Companies consider it significant to offer employees financial incentives to choose these plans and get educated about cost and quality issues. Employers also offer incentives for employees to take health risk assessments and engage in healthier lifestyles.

For most corporations, introducing and implementing consumer-driven plans is a multi-year strategy. The phenomenon is not unlike what happened when 401(k) plans were introduced. The average employee was reluctant to defer earnings on a pretax basis into a tax-free account, even though the benefits were obvious. Employees wanted more than just guaranteed accounts, they wanted options as well. In other words, they became very informed about the tax benefits of 401(k) plans.

We're seeing a similar phenomenon with consumer-directed plans. Now that employees have had a year or more of experience with these accounts, we find employees are very interested in learning about these plans during open enrollment meetings. They're interested in getting more data on which medications cost them $8 instead $50, for example. Also employers are seeing that such consumer empowerment can help them reduce their annual cost increases to single digits. Their employees are excited about carrying money forward from year to year. This year everybody wants to talk about

"Many good physicians have been among the adopters of HSAs for themselves and their employees. They and their staff know that their patients will ask questions about disease processes, best practices, and contraindications they should be concerned about," Hogan comments.

the details, benefits, and carryovers.

Q: *Have your clients had some success in decreasing health care inflation?*

A: Costs are declining, and the more sophisticated insurers are offering employers a trend cap lower than the traditional HMOs. Insurers are offering financial incentives to employers that persuade employees to adopt consumer-directed plans and whose employees are modifying their behaviors.

Many insurers, though, have come late to the market. For whatever reason, they didn't believe consumerism would work and didn't introduce high-deductible plans or HSAs until after others did. To make the strategy realistic and transparent they offered these caps on annual increases in their consumer-directed products to companies that adopt these new products.

We are also seeing that there is less turnover among members of these plans. Companies such as Aetna, UnitedHealthcare, and Cigna have found that employees stay in their consumer-directed products longer than they had stayed with the traditional HMO products. In part because employees are staying with high-deductible plans, insurers are seeing greater profitability from these plans.

We find that employers that have embraced this strategy are successfully engaging employees and actually carrying money forward in HSA accounts from year to year. When employers put money into the employees' accounts and the amount reached say $1,000, the employees got the idea.

Q: *Are the preventive-care services that are covered under these high-deductible plans attractive to employees?*

A: Yes, the preventive-care services are very attractive, but honestly, in the first year of these plans employees have been so well trained about making a co-payment that the "free" aspects of the preventive-care services are less attractive than perhaps they should be.

"Companies consider it significant to offer employees financial incentives to choose these plans and get educated about cost and quality issues. Employers also offer incentives for employees to take health risk assessments and engage in healthier lifestyles," Hogan says.

Preventive care is important, of course, and helps keep a person healthy who otherwise might ration his or her own care. In other words, because these services are fully covered, the employees and family members are more likely to use these services than if they had to pay for them. The preventive offerings are covering Pap tests, mammograms, baseline psychological exams, and in many cases, bone density tests. All of these tests have the potential to pick up a more serious illness before it becomes a complication.

I'd like to say that the free preventive-care services are a huge selling point about health savings accounts, but that's not yet true. The huge selling aspect or incentive for employees into the HSA are the financial incentives via contribution strategies and actual dollar contributions into the HSAs. That's what sells.

Q: *Some articles have reported that adoption rates of HSAs and high deductible plans are disappointing. Has that been your experience?*

A: No. Not at all. Enrollment depends somewhat on the section of the country involved. In the Northeast, including New York and New Jersey, growth has been slow for consumer-directed care. Also growth has been slow in many of the wealthier urban areas because people enjoy the entitlement programs they have had and want to retain them. But that's changing rapidly.

In sections of Connecticut, Massachusetts, Maine, and other areas, consumer-driven care is gaining a stronghold. Employers have become informed about how high-deductible plans and HSAs can work effectively for them. Knowing how stubborn people are in their behavior patterns, I've been surprised how quickly people have moved into these plans. I don't trust published reports because I find them to be uninformed in their comprehension of how these products work.

These plans require employees and family members to take responsibility for learning about the cost and quality of health care, which means evaluating issues they have not thought about in the past. People tend to be lazy. It's much easier for them to use co-pays. Interestingly when they're offered financial incentives to take more responsibility, they're willing to do so. It just takes a couple of years for them to get into it.

I don't know the proper way to evaluate what "disappointing" means. I haven't seen any intelligent projections and I'm impressed with the uptake of HSAs so far.

Q: *Since there are 200 million Americans in HMOs and PPOs, and about 8 million in high-deductible plans with HSAs, is it safe to say that high-deductible plans and HSAs have a tiny portion of the market?*

A: Yes, but it's been increasing exponentially over the last three years, and the majority of request for proposals from employers I'm looking at are requesting HSAs or health reimbursement accounts (HRAs) as a central part of their strategy.

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

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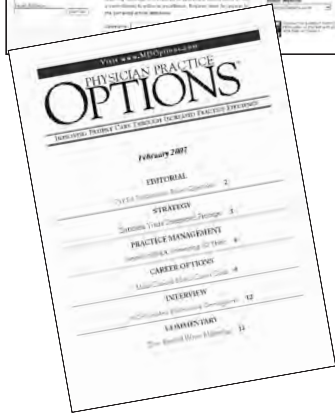

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