Health care is one of the major issues in the 2008 election. In the following, I attempt to offer a comparison of the health care positions of the Presidential candidates and the Missouri gubernatorial candidates. I encourage you to learn more about each of the candidates and study available information sources so you can make an informed decision at the polls.

Presidential Level

Health care spending surpassed $2 trillion in 2006. Its continued rapid climb is driven primarily by an aging population and technological advances and not by increased physician compensation. The number of uninsured peaked at 47 million in 2006 before dropping slightly in 2007 to 45.7 million or 15.3 percent of the population. The national cost of getting comprehensive health insurance for all of the uninsured is estimated by the Kaiser Family Foundation at about $125 billion per year. These numbers explain why health care is an important political issue. Candidates of the major political parties have put forward ambitious health care reform proposals to reduce the number of uninsured.

Barack Obama (D)

Obama would introduce a national health insurance plan for the uninsured, small businesses and the self-employed that would offer comprehensive coverage similar to the one offered to members of Congress. Premiums would be subsidized based on income. Small businesses would be incentivized with tax credits to provide health insurance coverage for their employees. Larger employers would be required to provide health insurance to their employees or pay a tax into the national health insurance plan. No pre-existing condition exceptions would be allowed by any insurance plan and insurance portability would be guaranteed. All private plans would have to be as generous with benefits as the national plan, and premiums would have to be “fair and stable” and not be based on the applicant’s health status. Insurers would be required to pay out a specified percentage of premiums for health care delivery. The government would negotiate with drug companies on drug prices. For lower income individuals, Obama would expand Medicaid and SCHIP eligibility. Children would be required to have health insurance coverage.

Physicians participating with any federal insurance program would be required to provide care based on established “disease management programs,” and publicly report on measures of health care costs and quality. Insurers would have to report on what percentage of premiums goes to providing health care. Obama would prevent insurers from overcharging physicians for malpractice premiums. There would be no tort reform. He would invest $50 billion over five years to promote adoption of electronic health information technology.

To pay for his proposals, very little detail is available. His current tax proposals call for repealing the Bush tax cuts and eliminating the ceiling on Social Security and self-employment taxes. This would raise the combined federal marginal tax rate on earned income for most self-employed physicians in 2009 from 37 percent to 53 percent.

John McCain (R)

McCain would give a $2,500 tax credit to individuals and $5,000 to families to subsidize their purchase of health insurance. He would guarantee insurance portability. He supports expanding health savings accounts. McCain would work with the states to develop a “guaranteed access plan” that would reflect the best experience of states to ensure that patients have access to health coverage. The states would be encouraged to pool their state plans for those who have been denied coverage to spread the insurance risk and lower overhead costs. Subsidies would be provided for those not able to afford the premiums. McCain would encourage states to develop and implement new approaches to controlling health care costs. McCain supports permitting purchase of health

The choice is yours. The candidates at both the federal and state levels offer starkly different approaches.
insurance across state lines and association health plans.
McCain would encourage prevention, early intervention, healthy habits, new public health infrastructure and expanded use of electronic health information technology. He would push for national legislation to limit frivolous lawsuits and caps on non-economic damages.

The main cost to the federal government of his health care proposal is the tax credit. He would fund the cost by eliminating the deductibility of employer-provided health insurance and by reducing costs through tort reform. His tax proposals would prevent Bush’s tax cuts from expiring, keeping the combined marginal tax rate on earned income for most self-employed physicians in 2009 at 37 percent.

Plan Comparison

Obama’s plan would cover more of the uninsured than McCain’s plan. Consequently it would also cost far more than McCain’s proposal. Neither plan would achieve universal health care coverage. McCain’s plan relies on individual responsibility, federal subsidies and state involvement. Obama’s plan would dramatically expand the role of the federal government in health care from the current 40+ percent of health care spending. Both plans would try to reduce costs by encouraging best practices, transparency, re-importation of drugs from outside the U.S. and non-payment for preventable medical errors. In addition, Obama would attempt to control insurance premiums and drug costs by government-set or negotiated prices. McCain would also control costs through tort reform. McCain’s support for association health plans would be very helpful for many small businesses. Physicians would be able to purchase health insurance through their professional associations, thus spreading the risk and reducing premiums. Both would use the tax code to pay for their proposals. McCain would eliminate the deductibility of employer-provided health insurance premiums. Obama would raise the combined top marginal earned income tax rate above 50 percent (the last time this was the case was during the administration of President Eisenhower almost 50 years ago) to raise money for his proposals.

Plan Comparison

Jay Nixon’s plan would help uninsured low income children and very low income adults. Hulsof’s plan would help uninsured Missourians at all income ranges. Hulsof’s plan would insure more of Missouri’s uninsured than Nixon’s plan. Tort reform is not mentioned by either candidate. In the past Jay Nixon was opposed to tort reform and Kenny Hulsof has been a proponent for limiting frivolous lawsuits and capping non-economic damages.

Conclusion

The choice is yours. The candidates at both the federal and state levels offer starkly different approaches. The Democratic candidates propose expanding the government’s role in health care, while the Republicans prefer less government mandates and more individual responsibility. By being informed, you can make an intelligent choice on November 4th.

References

www.barackobama.com
www.johnmccain.com
www.jaynixon.com
www.kenny08.com
www.kff.org
Harry’s Homilies ©

Harry L.S. Knopf, MD

ON CARING

When you think only of yourself every day, then every day you will have less and less to think about.

Each day, we are diminished physically in one way or another. (A recent study showed that the number of fibers in the optic nerves of healthy 80-year-olds is only half of those of 10-year-olds.) There is no way to reverse the aging process, but there is a way to enhance your existence: Give! Become less selfish and more "elfish." Reach in and put out. You may have lots to offer to other people: love, comfort, knowledge, and understanding. Don’t horde it! When you give, you get back. You are replenished. You are living even as your body is dying. Give! Until it feels good!

Harry’s Homilies ©

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Dr. Knopf is editor of Harry’s Homilies. ©
He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

SCAM-Q*

* How insurance companies, hospitals, government, etc.
Slice Costs And Maintain Quality

Money Back Guarantee

Isn’t it great to buy something knowing you will get your money back if you are not satisfied? However, we all know there is usually a catch. You have to pay return postage, and in some cases this can be exorbitant.

Well, our federal government has set up some money back deals, but as you would expect, there is more than meets the eye! The feds have also set up some deals that not only do not give money back, but will cost you to go with the program. Some of these I have mentioned before but are worth mentioning again.

The money back deal is Pay For Performance (P4P). Medicare has offered to reward some groups in a study for meeting certain practice guidelines. This is called P4P. However, when compared with control groups, there is no difference in practice outcome whether there is a money incentive or not. In fact, some of the control groups did better than the P4P groups. In addition, the P4P groups had expenses that exceeded the P4P rewards just to satisfy documentation of the compliance. What this shows me is that most physicians practice good quality medicine and do not need financial incentives to do what is best for patients.

Electronic Prescribing – This sounds like a good idea on paper, but will cost some physicians more than they will get back from the feds. In addition, this will be a great way for outsiders to keep track of medication that may have been prescribed. Oh, well! So much for HIPAA!

The rest of my list contains deals from the feds with no money back, just extra expense to comply. (The Clinical Laboratory Improvement Amendments - see SCAM-Q July/Aug 2008 “Potpourri”)

Triple protection prescription pads – this is really a stupid idea, especially if one needs to prescribe electronically. I guess this is a good way to make physicians get used to spending extra money and getting nothing in return.

I know this column may have been somewhat redundant, but I am trying to get all of you ready for triple work for one-third pay.

NOTE: If not satisfied with this column, send a copy to me with a self-addressed, stamped envelope with one dollar cash or money order to cover restocking fee.

Richard J. Gimpelson, MD

Dr. Gimpelson, a past president of SLMMS, is a gynecologist in private practice.
One of the things we’ve done successfully during the last couple of years is to add some new benefits for SLMMS members. There are three major programs that have been added to the already impressive list of benefits offered to our members.

These include the Mason Road Wealth Advisors investment program, offering exclusive investment opportunities at low cost; special membership opportunities to the AAIM Management Association which offers a superlative array of services for small businesses (i.e., physician practices); and most recently a special membership rate for any of our members who want to also become members of MedjetAssist, the premier provider of emergency medical evacuation services whenever you’re away from home. As our newest member benefit, MedjetAssist is a strong new addition to our benefits portfolio.

The special benefit to SLMMS members are reduced membership rates – $195 for an individual, $295 for a family (covering up to seven members, including spouse, domestic partner and/or five dependents up to age 19, or 23 if full-time students). There are also discounts available on multi-year memberships.

Don’t confuse this program with something you think you may already have through the AMA or even the best of your credit cards. No travel insurance, standard medical insurance, assistance plan or platinum card membership offers a protection program as comprehensive and with as few restrictions as MedjetAssist. In addition, the vast majority of traditional health providers do not provide coverage for air medical evacuation and transportation services. If there is some coverage of this type, it will likely contain restrictions and significant out-of-pocket costs.

What is MedjetAssist? It is a worldwide medical evacuation and consultation service that is available to travelers 24 hours a day, seven days a week. It transports members who are hospitalized more than 150 miles from their primary residence, either in the U.S. or abroad, to the hospital of their choice. They utilize a fleet of medically equipped jets configured as mobile intensive care units, staffed with physicians, nurses and respiratory therapists. Notably, MedjetAssist members are protected for an entire year regardless of how many trips they take.

There are also consultation services included. MedjetAssist staff is on hand, in consultation with the University of Pittsburgh Medical Center, to communicate with attending physicians caring for members anywhere in the world – through translators, if necessary.

There are a few restrictions. Normal memberships only cover members up to 75 years of age. However, there is a special program – the Diamond membership – that covers members age 75-85. SLMMS members receive a special rate for this program also. There is a “transport criteria” that must be met – inpatient status at both ends. You are only allowed two transports per year, except in the case of a common accident involving multiple family members, in which case each and every member of the enrolled family will receive one transport.

But why is Medjet unique? First, you don’t have to be abroad to utilize their services. Anywhere more than 150 miles from home and you’re covered. The vast majority of their transports are domestic – something most services of this type don’t cover. Second, they will transport you to the hospital of your choice. In addition, there is no monetary limit to its benefits. The membership fee covers all transport costs. They have their own fleet of permanently configured aircraft. If you are physically able to fly commercial, continued on page 8
members always fly first class, accompanied by medical personnel; if commercial air travel is not medically tenable, members are evacuated by fully medically equipped private jet.

If it sounds like I’m impressed with this program, it’s because I am. I’ve been a member and although (thankfully) I’ve never had to use their services, it’s always been nice to know when I’m traveling that I have their card in my pocket. One of my hobbies is scuba diving, and I’ve had the opportunity to travel and dive in some remote and exotic locations, including Vietnam, Malaysia, and off the Myanmar coast in the Andaman Sea. I once spent a week doing some specialized training on a small island called Koh Tao in the Gulf of Thailand, where the nearest major hospital was at least a long ferry ride and two plane trips away. Even then I would still have been on the other side of the world. It was good to know I had MedjetAssist as a partner in case I needed help. But it’s also good to know their coverage applies in New York, San Diego or anywhere in the U.S., whenever you’re more than 150 miles from home. Whether you’re on an adventure vacation, or a golf trip to Vegas, MedjetAssist offers a valuable service.

If you don’t want to worry about injury or illness when traveling, call 1-800-527-7478, or go online to www.slmms.org, and click on the MedjetAssist link on our home page. I think you’ll be impressed as well.

MedjetAssist makes a Great Holiday Gift!

“What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?”

GLASBERGEN
A physician faces this scenario: An elderly patient, already being treated by other doctors for various chronic conditions, presents complex symptoms that also could involve the interaction of these conditions as well as the patient’s age. What’s more, the patient seems confused and has difficulty hearing.

As the population ages, this scenario will become more common. Experts say the health care system will be challenged to meet the unique needs of a growing number of elderly patients. Caring for older adults brings not only greater complexity in diagnosis and case management, but also requires more time and patience in communicating with the patient.

SLMMS physicians join national leaders in calling for more geriatric specialists as well as greater training in geriatrics for all physicians. The Institute of Medicine in April released a major report urging action on the coming crisis in geriatric care, entitled Retooling for an Aging America: Building the Health Care Workforce.

The Problem
What concerns the health-care community is that the number of people over age 65 will double by 2035. Their portion of the population will increase to 20 percent from its current 12 percent. Some 78 million baby boomers will begin to turn 65 in 2011. The number of people over age 85 will quadruple.

While the current supply of 7,100 geriatricians is not enough to meet demand today, by 2030 the need will be for 36,000 specialists, but only 8,000 will be practicing, said the IOM. In addition, there are only 1,600 geriatric psychiatrists nationwide today.

“Already, in some parts of the country a lot of older adults and families can’t find a geriatric specialist, or the ones available don’t take new patients,” said SLMMS member George Grossberg, MD, Samuel W. Fordyce professor and director of the division of geriatric psychiatry at Saint Louis University School of Medicine.

“Geriatric medicine is time-consuming work. It isn’t reimbursed highly by insurers,” he said. “Physicians would rather go into other specialties where they have a good lifestyle and make more money.”

In its report, the IOM said, “The nation faces an impending health-care crisis as the number of older patients with more complex health needs increasingly outpaces the number of health-care providers with the knowledge and skills to adequately care for them. … Fundamental changes in the health-care system must take place and greater financial resources must be committed to ensure they can receive the high-quality care they need.

“Right now, the nation is not prepared to meet the social and health-care needs of this population.”

Health-Care Needs of Older Adults
The IOM study cites data on how older adults use more health-care services. Some 80 percent have chronic diseases, and many exhibit various geriatric syndromes.

The 12 percent of the population over age 65 uses:
• 26 percent of physician office visits
• 35 percent of hospital stays
• 34 percent of prescriptions
• 38 percent of EMS responses.
Dr. Grossberg said a head-to-toe approach is needed in treating an older patient. “You need to understand how what happens is different in an 85-year-old than a younger person. Every area has special needs in older people. The patient may have four or five problems, and you need to be more concerned about side effects,” he said.

Bio-psychosocial issues also are important, he added. “They may be dealing with widowhood, loss or disability. You may need to counsel families on social services available to help them,” he said.

Adding to the challenge are physical impairments to communication. The American Geriatric Society is working with various specialty societies on a project to improve geriatric training among medical specialties. The Geriatrics for Specialists Project was launched in 1994 and involves:

- Improving the amount and quality of geriatric education that medical and surgical residents receive
- Developing faculty leaders who promote geriatric training and research within their disciplines
- Enabling professional certifying bodies and societies to build the capacity of their members to provide better care of older adults

Ten medical and surgical specialties are participating, including anesthesiology, emergency medicine, general surgery, gynecology, ophthalmology, orthopedic surgery, otolaryngology, physical medicine and rehabilitation, thoracic surgery and urology.

In pointing out the need for this project, the AGS cites not only the growing aging population, but also an increasing number of older people who are candidates for surgery and other non-primary care interventions. These include such procedures as cardiac catheterization, knee replacements and liver transplants.

For more information, visit www.americangeriatrics.org/specialists.
Aging Population Challenges the Health-Care System

(continued from page 19)

**Prevalence of Disability/Limitations**

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<td>Trouble hearing</td>
<td>16.8</td>
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<td>Vision limitations</td>
<td>9.5</td>
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<td>Absence of all natural teeth</td>
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Source: Institute of Medicine

“Some patients may have difficulty with hearing or vision, and may not understand things the first time you explain them. You have to be very patient, you can’t rush,” Dr. Grossberg said.

J. Collins Corder, MD, SLMMS member and councilor and geriatric specialist, said, “For a busy doctor, listening to patients often can be neglected. You need to be patient and allow more time, especially when problems are more complex.”

**Recommendations for Addressing the Crisis**

The IOM report calls for a comprehensive approach to the crisis that involves:

- Enhancing the geriatric competence of the entire workforce
- Increasing recruitment and retention of geriatric specialists and caregivers
- Developing new models that improve the way care is delivered

The report said, “The nation needs to move quickly and efficiently to make certain that the health-care workforce increases in size and has the proper education and training to handle the needs of a new generation of older Americans.”

For physicians, the IOM recommends that geriatrics be included as part of the requirements for licensure, certification and maintenance of certification. Also, hospitals should encourage the training of residents in all settings where older adults receive care, including nursing homes, assisted-living facilities and patients’ homes, the report says. The report also recommends improved training for all health-care workers.

Dr. Grossberg said, “All physicians caring for aging patients should become proficient in geriatric care.” In residencies, geri-

**RAND ACOVE Project Seeks to Improve Quality of Care to Elderly**

A team of experts from RAND Health, a unit of the RAND Corporation, has developed a system for measuring the quality of care delivered to the elderly.

Called Assessing Care of Vulnerable Elders (ACOVE), the system provides quality indicators on 22 conditions comprising the diseases, syndromes, physiological impairments and clinical situations that account for the majority of health care received by older adults. Overall, the system has 236 quality indicators covering four types of health care: prevention, diagnosis, treatment, and follow-up.

A study used ACOVE to assess the quality of care given to a group of community-dwelling older adults who were members of a managed care plan. The key findings from their assessment are:

- Vulnerable elders receive about half of the recommended care, and the quality of care varies widely from one condition and type of care to another.

- Preventive care suffers the most, while indicated diagnostic and treatment procedures are provided most frequently.

- Care for geriatric conditions, such as incontinence and falls, is poorer than care for general medical conditions such as hypertension that affect adults of all ages.

- Physicians often fail to prescribe recommended medications for older adults.

Patients who received better care are more likely to be alive three years later than those who received poorer care, RAND says. Interventions based on the ACOVE indicators improved the care physicians provided to vulnerable elders for several selected conditions.

In 2007, the ACOVE indicators were updated to include more health conditions and to give greater consideration to the appropriateness of care for patients with advanced dementia or an otherwise poor prognosis.

For more information, visit www.rand.org/health/projects/acove.
Attrics should be included in a rotation with other disciplines, he added.

To attract and retain more geriatric specialists, the IOM suggests financial incentives in the form of higher salaries, grants and other support. Currently, according to the IOM, the median compensation of a geriatric specialist is $163,000 per year while a rheumatologist receives on average $207,000 and an oncologist is paid $358,000. As a result, the fill rate of geriatric residencies is only 54 percent compared to 96 percent for rheumatology and 95 percent for hematology/oncology.

Also cited by the AMA is the importance of resolving current Medicare rules that call for steep cuts in reimbursement. If these cuts are allowed to go into effect, this will force physicians to limit the number of Medicare patients they see, thus seriously harming seniors’ access to care, the AMA says. To learn more about AMA legislative activity on the Medicare issue and the Save Medicare Act, visit the AMA’s site, www.patientsaction-network.org.

The third broad area of IOM recommendations concerns developing new models of care delivery. These include new payment mechanisms that enable such innovations as interdisciplinary care teams.

Dr. Corder is a strong advocate of interdisciplinary care. “A team approach with ancillary staff and services is necessary. This involves the physician and the patient, as well as nurse, hospital, PT/OT, social workers, pharmacy and the patient’s family.”

For more information on geriatrics, Dr. Corder and Dr. Grossberg suggest physicians look to professional societies, medical schools and online programs. The American Geriatric Society has a training program for specialists (see sidebar) and the RAND Corporation has developed a system for measuring the quality of care given to older patients (see sidebar).

They also encourage physicians to get involved in legislative efforts to improve Medicare reimbursement, and support increased training for both medical students and practicing physicians.

The growth of the elderly population is nearing.

Dr. Grossberg said, “When I lecture to medical students, I tell them that no matter what specialty you are in, more and more of your patients will be elderly and you should be aware of their special needs. They will become an increasing part of your practice.”

Web Links

**Institute of Medicine Study**
*Retooling for an Aging America: Building the Health Care Workforce*

[www.iom.edu](http://www.iom.edu) (see “topics” and click on “aging”)
or [http://www.iom.edu/CMS/3809/40113.aspx](http://www.iom.edu/CMS/3809/40113.aspx)

**American Geriatric Society**
*Geriatrics for Specialists Project*

[www.americangeriatrics.org/specialists](http://www.americangeriatrics.org/specialists)

**RAND ACOVE Project**
*(Quality measures in geriatric care)*

[www.rand.org/health/projects/acove](http://www.rand.org/health/projects/acove)

**AMA Patients’ Action Network**
*(Legislative action to secure fair Medicare)*
Calendar

October 14
SLMMS Council, 7 p.m.

October 18-19
MSMA Council Meeting, Lake of the Ozarks

November 1
Advanced Revascularization Chapter 3, “Percutaneous Cardiac & Peripheral Vascular Therapeutics 2008,” The Ritz-Carlton. CME credits. Presented by Washington University School of Medicine. For more information, (314) 362-6891 or cme@wustl.edu or http://cme.wustl.edu.

November 7-8
6th Annual Midwest Updates in Sleep Medicine, 5:30 p.m. Nov. 7 and 7:00 a.m. Nov. 8, Doubletreee Hotel St. Louis Westport. Presented by Midwest Updates in Sleep Medicine and Clayton Sleep Institute. Information, Debra McGrath, (314) 645-5855 or mcgrathd@claytonsleepinstitute.com; Web site, www.sleepupdates.org.

November 8
SLMMS Practice Management Conference, 8:30 a.m. to 12:30 p.m., St. Luke’s Hospital Emerson Auditorium. CME credits. For more information, Liz Webb, (314) 989-1014 or lizw@slmms.org.

November 11
SLMMS Council, 7 p.m.

November 8-11
AMA Interim Meeting, Orlando

November 21-22
36th Annual Kilo Diabetes Symposium, “Current Topics in Diabetes, Endocrinology and Vascular Disease,” Hyatt Regency Riverfront. CME credits. Presented by Kilo Diabetes & Vascular Research Foundation. For more information, Beverly Cantoni, (314) 434-6500 or beverly@kilorf.com.

November 21
Dr. Roy Petrie 12th Annual Symposium, St. Mary’s Health Center Kohler Auditorium, St. Louis, Missouri. Presented by Saint Louis University. CME credits. For more information, cme@slu.edu.

December 9
SLMMS Council, 7 p.m.

December 10
Annual SLMMS Hippocrates Lecture, 6:30 p.m., Ces & Judy’s Catering, 10405 Clayton Rd. Speaker: Michael Maves, MD, MBA, executive vice president and CEO, American Medical Association. For more information, Liz Webb, (314) 989-1014 or lizw@slmms.org.

List your events: Please send listings of continuing education programs, organizational meetings and other events related to the practice of medicine, to St. Louis Metropolitan Medicine by e-mail editor@slmms.org, by fax to (314) 989-0560, or by mail to Editor, St. Louis Metropolitan Medicine, 680 Craig Rd., Suite 308, St. Louis, MO 63141.

Perfect Together

Primaris can help only a limited number of Missouri’s primary care practices.
Call 314.504.0600 or visit www.primaris.org for details.
While most technology discussions in health care today center on either EMR or data security, every practice still needs to process its accounts receivable accurately, efficiently and in a timely manner. The means of doing this is a Practice Management System (PMS). PMS, for purposes of this article, includes scheduling, registration, billing, claims filing, payment posting, collections, ERA (electronic remittance advice), and reporting modules.

There are hundreds, maybe thousands, of PMS systems in the market. Some are specialty-driven. Some are relatively inexpensive – $1,500. Some are one-site only. Some are functional for multiple sites, multiple TINs. How do you decide which PMS is right for you?

Here are some tips to make your decision more informed, and simpler!

- Decide what you need. Do you require the PMS to be integrated into your EMR? If so, that limits your selection, and you should make a joint selection of the two software packages. If we assume you already have an EMR you like but there is no PMS available, we then move on to other questions.
- Does the software need to be able to process multiple TINs?
- Must the software handle multiple doctors and nurse practitioners?
- Must the software be specialty-specific? For instance, anesthesiology billing uses a unique set of modifiers and claims are often calculated by time/units. Not all PMS systems are going to handle these idiosyncrasies adequately.
- Can the scheduling system allow scheduling of procedure rooms?
- Can you double-book appointments?
- Do fields automatically populate all related screens when data is entered into the fields on one screen?
- Do you need electronic claims filing and electronic remittance advices (answer yes to this one!)?
- How sophisticated do you want your reports?
- Decide what you want. Yes, this can be different than what you need. You may want certain bells and whistles when you hear about them, but do you need them? Will you need them in the future? The key question here is, “Will you use the items that you want but don’t necessarily need?” Include all users – your staff

- in determining what you really need in this software.
- Determine how much you can afford to invest. This is a simple way to narrow the field of contenders. Don’t waste your valuable time on PMS systems that are beyond your means. As you decide what you can afford, don’t forget these expenses:
  - Up-front cost of software. This is the actual cost of the PMS software, including all the modules necessary to get the job done. It will be harder to convince yourself to re-invest in another needed module later.
  - Up-front cost of hardware. You may need to upgrade your hardware in order to adopt the new software. This could include servers, printers/scanners, and input devices such as tablets or desktop computers. Many software vendors don’t sell the actual hardware, but they will provide the specifications (specs) for you to obtain quotes from your preferred vendor.
  - Up-front cost of training. Generally, the PMS vendors do not include training in the software cost. If it is, the training should be separated from the software cost so you can be sure of what you’re buying. There also may be tax advantages for the software purchase component.

It will be tempting to downplay the amount of training that is required. It takes a lot of training to get your staff up to speed on new software and if they aren’t efficient, it will cost you more in the long run. One strong suggestion is to double-train. By this, I mean that you have the trainers on-site during the “go-live” period. In six months, have the trainers come back or provide a second round of training via Internet. This serves as a refresher for the staff and allows an opportunity to pick up the “quick tips” to be more efficient.

Items to consider:
- Location of training. While on-site training is the most effective, you will also pay for the trainers’ travel expenses. Most vendors also offer Internet (Web-based) training.
- Monthly support and maintenance. How much is the monthly support of the PMS? What does it cover?
- Monthly network and hard support. Often, the network and hardware is not supported by the software vendor. Your hardware/technology support provider should be able provide a quote for this support.

Steps in soliciting proposals:
- Prepare a Request For Proposal (RFP). The RFP can be a simple document that states who you are (practice size, specialty,
number of providers, etc.) what you need, what your requirements are, your timeline, and other information you deem pertinent to the selection process. After you’ve stated who you are, the rest of the RFP is about the vendor and their product. Ask them who/what owns them. Outline each of your components. Ask them for references and pricing.

Your RFP should be in numerical format. Ask the respondents to reply to the RFP in that same numerical format for ease in comparing apples to apples. Remember to ask them to send their brochures, demo disks, etc. with the RFP response. Allow at least two weeks for responses and require everyone to meet the same deadline to be fair to all. Send the RFP to only those PMS systems that seem to fit your criteria. Usually, you will send the RFP to 10 or fewer vendors.

• Create a grading or weighting scale for evaluation (see accompanying table). List each of the items that must be included in the PMS. Weight them in terms of importance. For instance, if you are an FP high-volume practice, ease in generating a high volume of claims might be the most important item for you. If your payer mix is primarily Medicare, then a claims-scrubber based on Medicare rules might be the most important feature. Assign a weight to each item. List each in a simple table in the left-hand column and list each respondent’s name in the next columns and complete the resulting spaces in the table.

• Review and grade the RFPs. Read the responses to the RFPs, including enclosures. Ensure that all questions were answered. Complete the evaluation table by assessing how well each vendor’s responses meet your criteria.

• Narrow the field to three. This is an important decision, but your time is valuable. Narrow the number of PMS systems that you will demo to no more than three. For these three, you will ask first for an Internet demo. Usually, the vendor will provide a guided tour via their Web site.

• If the Web-based guided tour meets your satisfaction, ask to see the PMS live. Every vendor should have a practice you can visit. During the visit, talk to the staff and physicians. At least one representative of each area in your practice should participate in the site visits. Observe the software in practice at the front desk, in the back office, in the claims follow-up areas, etc. Ask the practice what work-arounds they’ve adopted since they started using this software and what advice they would offer someone considering this purchase. Ask them if they would buy the software again if they knew what they know now.

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Sample PMS RFP Evaluation Table

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weight</th>
<th>Vendor #1</th>
<th>Vendor #2</th>
<th>Vendor #3</th>
<th>Vendor #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Claims Filing</td>
<td>4.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure Room Scheduling</td>
<td>1.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduling Template Flexibility</td>
<td>2.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ERA</td>
<td>3.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collections Module</td>
<td>3.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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ad-vo-cate

1. one that pleads the cause of another
2. one that defends or maintains a cause or proposal

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Tips on Purchasing a Practice Management System
(continued from page 25)

• Call the vendors’ references. Consumers often assume that if a reference is supplied, it must be good. In general, yes, the reference will be positive, especially if you ask questions like “do you like the software?” However, ask more open-ended and compelling questions, such as “when you generate claims, what is the process to actually get the claim to the clearinghouse?” or “what does it mean when the vendor says that collection agency turnovers are electronically sent to the agency?”

• Negotiate price and contract terms. Most every business deal has some element of negotiation. Don’t be timid to ask. A good business decision is based not only on the financial components but also on the language and terms within the contract. Utilize legal advice if you’re uncomfortable with the terms.

• As a courtesy, don’t forget to contact the unsuccessful vendors and thank them for their interest.

The purchase of a PMS is a huge decision for your practice. It will be the engine that drives the success of your practice. It needs to be functional and simple to use. The enormity of the decision is not only tied to the financial investment but also the time commitment. You will have considerable time invested in the selection process, but you will also face a loss of productivity during the first few months following implementation. Don’t let this discourage you. Plan for it. Schedule a few less patients each day. Allow for temporary staff to help with non-PMS tasks in the beginning so that your practice stays on schedule. If you feel overwhelmed by the process, utilize outside sources for help such as your accountants and practice consultants.

The investment of time and money will be well worth it when your office is running efficiently and cash is flowing steadily!

Jerrie K. Weith, FHFMA, is director of Health Care Services with Anders Minkler & Diehl LLP. If you would like to contact Jerrie about this article, she can be reached at (314) 655-5558 or jweith@amdcpa.com

Hospital Launches Geriatric Assessment Program

SM St. Joseph Hospital of Kirkwood has launched a geriatric assessment program designed to provide families with an objective analysis of an older patient’s condition.

The assessment, covering physical, mental, emotional and social factors, is accompanied by specific recommendations for any in-home or other services that can help the patient maintain an independent lifestyle. The program is supported by Continuum Health Care.

Assessments last approximately two hours and include a complete medical history, physical examination and testing led by board-certified gerontologist Timothy Pratt, MD, along with other members of the St. Joseph medical staff. Following the physical exam, licensed professionals from Continuum will perform an in-home assessment that includes mental, emotional, social and environmental evaluations.

For more information, call (314) 966-1580.