# How Are Physicians Returning to Private Practice?

The healthcare industry has gone through a lot of change very quickly in the past five years, with still more to come. Independent practices and smaller physician groups have a lot of reason to “seek higher ground” in mergers, partnerships, and buyouts by larger groups and hospitals that have the resources to better deal with lower reimbursement and increasing regulation. Still, just as we are seeing the crest of the wave of physicians selling their practices to hospitals, we are also beginning to see a lot of the reverse trend – physicians leaving hospital employment and starting their own practices.

We have a number of new solo physician practices among our clients and each of these practices can make the numbers work for the three reasons outlined below. Their new practices may look much different from the practices they once had, but they now can bypass the crushing financial burden of start-up costs and find ways to cut expensive overhead. As hospitals ratchet down physician salaries and present new hoops from them to jump through, more and more physicians will look to these new tools for independence and financial viability.

## Free EMR

In 2008 I was living in Seattle and I attended a conference at Microsoft in Redmond, Washington. It was there that I met Dr. Bill Crounse, the Senior Director of Worldwide Health for Microsoft. He was kind enough to sit down for a few minutes and talk to me about the future of physician practices. He told me something at the time that I didn’t really understand. He said, “Something is about to happen that will be  game

changer for physicians." At the time I didn't understand what he meant, but today I believe he was hinting of the pending launch of **Practice Fusion**, the first free electronic medical record (EMR.)

The free EMR has indeed been a game changer for physicians. The ability to e-prescribe and report PQRS to avoid Medicare financial penalties and to collect the EHR Stimulus money (aka Meaningful Use) without the typical $25 -$30K outlay per physician has been a boon for many practices. How can an EMR be free? With advertising and the agreement that they blind and sell your data to third parties. (Have EMR companies been doing this all along and not telling you? A topic for another post.)

Physicians still need a billing system to run their businesses, but today software vendors are bundling billing packages with practice management and/or EMR software. For anywhere from 2.9% – 5% of net revenue, physicians can use the software and receive insurance billing services as a package. The two largest vendors providing this service are **Athena** and **eClinical Works.**

## Social Media

The second reason physicians can start a private practice is the replacement of traditional (quite expensive) traditional marketing with social media. For a fraction of the cost of a direct mail campaign, a physician can use social media to establish a digital presence via a website, blog, YouTube and Facebook. These mediums are not free, but they are long tail, meaning that they will continue to drive patients to the practice long after a direct mail postcard has been thrown in the trash.

# New Practice Models

Physicians and other care providers have a choice of self-employed practice models today.  Here are a few choices they have:

- **Concierge** – concierge can mean different things to different people, but I am using it to describe a practice that accepts insurance and also requires an additional fee from all patients on top of insurance payments.
- **Medicare Subscription** – similar to concierge, but applies the additional fee for Medicare patients only to pay for additional services not covered by Medicare, particularly an annual physical examination.
- **Direct Pay** – this is a primary care model where patients pay a monthly fee each month that covers unlimited primary care (sick and well visits) and some in-house laboratory services. This model also includes direct-contracting with employers.
- **Telemedicine** – gaining popularity for more than just rural specialty care, telemedicine is seeing patients via a secure video connection.
- **House Calls** – this model is coming back as a pure practice model because physicians and other care providers do not have to invest in a brick and mortar office. Coupled with the ability to accept payments via their smartphones and the influx of baby boomers, this model is gaining popularity quickly.
- **Nursing Home** – Another “rounding” type of practice like the House Call practice, physicians spend 100% of their time in nursing homes seeing patients.
- **On Call Specialty Practice** – specialty physicians, typically surgeons, see patients pre and post-

surgery in the office of the referring physician and have no brick and mortar office.

- **Cash Practice** – this is a 100% cash model with no insurance payments accepted. Typically, physicians will provide patients with what they need to be reimbursed from their insurance plan. Because insurance is not filed, the practice can afford to discount their prices.
- **Co-op Practice** – this is a time-share-type practice where one practice or a non-physician owner leases space to physicians, providing everything for one fee except billing, EMR and a medical assistant.
- **Micropractice** – an even skinnier form of the co-op practice, the physician works without any assistants and does everything him/herself with just a computer, utilizing one exam room. Micropractice physicians see on average 8 to 10 patients a day.

For more information on different practice models, see our posts **Yes, You Can and Should Start a Solo Medical Practice in 2013!**, **How Physicians Can Offer Direct Primary Care to Employers: An Interview with Dr. Samir Qamar of MedLion**, **The Direct Pay Physician Practice Model: An Interview With Scott Borden** and **Physicians are Leaving Hospital Employment and Starting New Practices on Their Own Terms.**

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# 12 Ways to Supercharge Your Practice in 2012: #4 Consider Running an Urgent Care Within Your Practice


If physician practices are not currently hard at work creating a strategy for the future, focusing on service expansion, technology, and affiliations, they should get started. Pronto!

Physicians have traditionally expanded their service offerings through ancillaries that function with the oversight—but not the presence—of the physician. Despite ongoing federal interventions discouraging service expansion, physicians have developed ancillary services such as laboratories; imaging; pharmacies; durable medical equipment and nutriceutical offerings; ambulatory surgery centers; and services provided by social workers, nutritionists, physician assistants, and advanced practice nurses, to name a few.

Physicians, as well as hospitals and franchise owners, have experienced mixed success adding Urgent Care Centers to their menus, but the time has come for physicians in particular to revisit the concept. This is due to the recently revised and released Accountable Care Organization (ACO) regulations. The final regulations are much more physician-friendly, making it possible and probable for physicians to lead, own, or participate in an ACO. Based on the goals of ACOs to deliver

higher-quality care at a lower price, physician practices should consider positioning themselves as attractive partners to hospitals or other ACO owners. Regardless of whether the practice chooses to participate in an ACO, it's a good to have as many offers to dance, as is possible.

One quality of an attractive ACO partner in the new paradigm of gain sharing is the ability to provide a continuum of primary care, wellness education, and support that keeps patients out of the emergency room and/or hospital for all but the most appropriate situations (that is, true "limb or life-threatening" situations). The Urgent Care model has the potential to provide an alternative to the emergency department (ED) because all but the most acute illnesses or injuries can be handled in an Urgent Care setting.

## Patients Prefer Urgent Care to the ED

There is controversy over the claim that EDs are overcrowded based on uninsured and Medicaid patients' inappropriate use of the resource. A *Kaiser Health News/Washington Post* article recently noted, "States are focusing on Medicaid recipients in part because these patients use ERs three times as much as people with private insurance and twice as much as people with no health insurance, according to federal researchers."

When patients are insured—especially when they are paying a large co-pay at the ED, or have a high-deductible health plan (i.e. they are paying out of pocket for the first $1,000 to $10,000 dollars spent on health care in a plan year)—they are much less likely to seek care in the ED. The research firm Rand found last year that approximately 17 percent of visits to EDs were unnecessary, which added $4.4 billion in annual health care costs. A 2010 study in *Health Affairs* found that up to 27 percent of all emergency room visits could take place at urgent-care centers or retail health clinics.

Insurers are redirecting patients away from ERs by educating

beneficiaries about their after-hours options. Wellpoint, Inc., the largest health plan company in the Blue Cross and Blue Shield Association and the largest U. S. health insurer based on enrollment, is getting creative by offering patients in Calif., Colo., Conn., Ga., Ind., Ky., Maine, Nev., N.H., N.Y., Ohio, Wis., and some parts of Miss. and Va. nearby alternatives to the emergency room via Google Maps. Patients can locate providers approved by their health plan near their home address, or any address where they or a family member (think college kids) happen to be.

## Physicians Can Fill the Urgent Care Gap

The Urgent Care Association of America reports that of Americans who *do* have a regular physician, "only 57 percent of Americans report having access to same or next-day appointments with that physician and 63 percent report difficulty getting access to care on nights, weekends or holidays without going to the emergency room. Twenty percent of adults waited six days or more to see a doctor when they were sick in 2010."

We glean from this statement that patients may know the appropriate use of the ED, but must use it when other means of getting care are not available. Practices can step into this gap and make urgent care a part of their service to position themselves as attractive to ACOs, as well as to achieve other goals:

- Make service convenient for their patients so they do not need to resort to the ED, which is unnecessarily expensive and may block other patients from emergency care.
- Meet the needs of working families that have difficulty attending appointments during working hours and appreciate a practice that has its own urgent care.
- Capture income that they are currently losing to retail clinics or other urgent care centers.

- Improve quality of life for physicians due to reduced after-hours patient calls when urgent care services are available.
- Drive down the fixed-cost expense (such as rent/mortgage, utilities, insurance and equipment) per patient, if the Urgent Care co-exists in the practice space.
- Make it easy for young adult patients to establish care with a medical home and become acquainted with wellness principles.
- Improve the quality and consistency of care for patients through immediate access to the medical record, if the urgent care and the record are located in the same site, or if an electronic medical record (EMR) is in use.
- Recent studies have found that the average cost of an urgent care visit is slightly *below* the average primary care visit: $155 vs. $165. This can be seen as a real win-win for the model that is trying to reduce the cost of health care for the benefit of all stakeholders
- It is not unusual for Urgent Care Centers to augment their walk-in services by providing occupational medicine services, travel medicine services, and sports and school physicals.

Many stakeholders are questioning what the advent of insurance for all Americans in 2014 will mean for those who have not had access to a medical home and coordinated care. The primary care physician is the *de facto* center of the ACO model, and the hub of care coordination. The influx of patients being encouraged (and hopefully wanting) to abandon the ED for a practice with expanded hours may overwhelm primary caregivers who do not have the potential to provide care seven days per week.

## Challenges of Urgent Care

There are barriers to Urgent Care Centers that practices may

need to seek advice or assistance to overcome:

- For many patients, going to the ED is a community norm, and one that may be difficult to redirect. The marketing budget for the Urgent Care may need to be significant to overcome long-standing community routines and to educate patients about the new Urgent Care.
- Practices operating as Urgent Cares at the same location will have to communicate with all contracted payers to see what their rules on Urgent Care Centers are, and may need to renegotiate the contract before opening the Urgent Care.
- For the practice operating Urgent Care hours at the same location as non-urgent care services, patients may find it frustrating to understand when the practice is a practice and when it is an urgent care. Patients may also resent that an appointment at 4:30 p.m. has a co-pay of $25 and walking in for service at 5:00 may require a $50 co-pay.
- Urgent Care Centers are not the appropriate venue for all medical problems. Patients who have recently been in auto accidents or have chronic back pain should establish with a medical home. Because of the nature of the Urgent Care setting, it is not unusual for drug-seekers to walk in: Front desk staff needs to be savvy about patient screening. Staff also needs to be at the ready to call 911 if a patient presents with chest pain or shortness of breath.

Other models of care that practices should contemplate, as adjuncts to face-to-face care, are a robust nurse triage program, telemedicine, and virtual visits.

## Statistics on Urgent Care in America

**Courtesy of Urgent Care Association of America's "Urgent Care Industry Information Kit, 2011" (www.ucaoa.org):**

**Number of Urgent Care Centers in the U.S. – 8,700**

**Number of visits per center per week – 342**

**Ownership – 50 percent physicians/physician group, 13.5 percent corporation, 7.7 percent hospital**

**Comparative Visit Fees – Urgent Care Center $156, Primary Care Physician Clinic $166, Emergency Room $414**

*UCAOA provides educational programs, the monthly Journal of Urgent Care Medicine (www.jucm.com), and a variety of different resources for starting a new urgent care center, providing clinical care in the urgent care setting, and running a successful urgent care practice.*

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# Natural Language Processing, First Steps Towards Telehealth, and a Single App to Read any EHR in another edition of Manage My Practice's 2.0 Tuesday!

As managers, providers and employees, we always have to be looking ahead at how the technology on our horizon will affect how our organizations administer health care. In the spirit of looking forward to the future, we present "2.0 Tuesday", a feature on Manage My Practice about how technology is impacting our practices, and our patient and population outcomes.

We hope you enjoy looking ahead with us, and share your ideas, reactions and comments below!

## Natural Language Processing Advances Allow for Improved Insight into Public Health

Writing for KevinMD, Jaan Sidorov, author of the Disease Management Care Blog highlights several examples of how Natural Language Processing- the idea of teaching computer programs to understand the relationship between words in human speech (teaching them to not just hear us, but understand us- like Watson understood the clues on Jeopardy) is being be

applied to the Electronic Health Record to predict and prepare for public health trends, as well as to correct mistakes present in the electronic record due to human error. Recent developments like the CDC's Biosense program allow public health officials at local, state and federal levels to monitor big picture trends in public health by the words and diagnoses reported in medical documentation- keeping an ear on health trends, by "listening" to data about reported health incidents.

## 10 Best Practices for Implementing Telemedicine in Hospitals

Sabrina Rodak at Becker Orthopedic, Spine and Pain Management has put together a fantastic list of the steps and assessments involved in implementing a telemedicine program in a hospital setting. Although written with Orthopods in mind, the questions that need to be answered, and the steps that need to be taken to develop a strong, lasting program are similar across many different programs and specialties. With so much excitement in the field, it is very nice to see someone talk about the process of taking these technologies from drawing board excitement to nuts-and-bolts execution.

(via FierceHealthIT)

## San Diego Health System Seeks to Develop Single App to Access Any EMR

Presenting at a Toronto Mobile Healthcare Summit Last Week, Dr. Benjamin Kanter, CIO of Palomar Pomerado Health presented the two-hospital system's plans to develop their own native mobile application to view as many different Electronic

Medical Records as possible from a single mobile interface. In other words, this fairly small health system, who has only devoted three employees to the project, is taking on one of the biggest, and toughest challenges in HIT by simply saying "We can do it ourselves!", and from some of the reactions from the conference attendees who saw the presentation, they are off to quite a strong start. The first version of the program should launch for Android in March, and the system already has a deal in place with vendor Cerner to access their systems. Stay tuned!

(via ITWorldCanada)

## Be sure to check back soon for another 2.0 Tuesday!

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# Talking With Matthew Browning, RN, Family Nurse Practitioner and Founder of

# “Your Nurse Is On”

When Matthew Browning first described YNIO (Your Nurse Is On), I was really surprised to learn what his product was. I don’t know what I expected, but it wasn’t the elegant solution to staffing he described.

Here’s the description from the YNIO website:

> ***Your Nurse Is On***™ *was developed in 2000 by a trained Family Nurse Practitioner in response to the inefficient relief staffing procedures found in healthcare today. With today’s challenging environment of cost savings and instant communications it became apparent that calling replacement staff one at a time was no longer an adequate solution.*
>
> *With the improvements in internet telephony that occurred around 2005, we created a system that allows you to call any available nurse to fill your vacant shift. You now have the power to contact many nurses, in any order you choose, on whatever device they prefer. Since the nurses on our system make their availability known in advance, you will never disturb another unavailable nurse or waste your time calling them.*

I could really relate to this solution! Who among us hasn’t spent hours on the phone filling staff slots, getting coverage for unexpected medical leaves, and trying to piece together coverage for routine vacations?

YNIO distills the product down to four easy steps:

1. Scheduler creates a request for staff.
2. YNIO contacts all available staff – instantly.
3. Staff receives the request and accepts or rejects the shift.
4. Scheduler is immediately notified.

And what are the proposed benefits to a facility using YNIO?

- Save time – system can call dozens of nurses simultaneously
- Save money – no more dollars wasted calling nurses who are unavailable
- Fill shift vacancies – expanded pool of available nurses
- Increased employee morale – decreased shift vacancies can decrease shift call outs, injuries and burnout
- Increased efficiency – leverage technology to save money, save time, quickly fill shift vacancies and save paperwork with our paperless billing and performance tracking systems.

This sounds like a needed solution for practices, nursing homes, hospitals, and home health agencies. I am also fascinated by the creative process of innovation and delivery to the market and asked Matt a few questions about the development of his product.

**MARY PAT: Matt, what does it take (emotionally, financially and otherwise) to conceive an idea and bring it to the market?**

**MATT:** I believe it begins with a personality that is inclined to analyze situations and procedures with an eye toward improvement. "How can we make this, or do this, better than we are today?" As this behavior becomes internalized and part of our daily routine, we begin to generate ideas, "maybe this could work" type of thoughts that can result in some solid ideas, proposals and hypotheses. This stage of innovative thought is rather common and many people have an idea that could "change the world," however an idea at this stage is often lacking a "vision" of how it can interact with our current realities, change existing processes, improve outcomes, save time and reduce expenses. The basic business infrastructure, legal processes, finances and team that are very important considerations to bring an idea from conception to market are often not understood, at this point of the

innovation cycle, by the inventor and are definite challenges. These challenges may be the reason that many potential innovations are never brought to market.

So, besides an idea, and a ”˜vision’ of how it fits into the world, flexibility, determination and persistence may be the most required traits for the innovator. The key to this game is teamwork, assemble the highest quality team you can, rely on experts for knowledge outside of your personal domain and remember that the objective is bringing the product or process to the world to make it a better, safer, more enjoyable place for as many people as possible. Success is often a direct result of service to others and bringing your innovation to the world can be a great service.

On the emotional and financial fronts, expect the endeavor to take twice as long as you expect and to cost twice as much as you expect. Having an awesome team and a supportive social network are invaluable to the eventual success. I am fortunate to have a very supportive family that believes in me and our innovation and they have been very tolerant of the extraordinary amount of hours and obligations that are part and parcel of this innovator’s life. To summarize, I believe a good idea can become a vision that with a very dedicated individual can become a team working toward the release of an innovation commercially. Hard work, perseverance, flexibility, ability to learn and the ability to delegate are all requisite as well.

**MARY PAT: What’s been your lowest moment to date in bringing your product to market and what has been your highest?**

**MATT:** My personal and corporate nadir occurred, ironically, during one of the best events of my life, the birth of my son, Arthur. Our product, YourNurseIsOn.com, was struggling through the “proof of concept”□ phase, after nearly a year in development and design, when my wife had an unexpected, emergent delivery of our son. We were traveling in Florida on

a doctor-approved combination business and family trip, when our son decided he was coming into the world, nine weeks early. Aside from a very difficult and dangerous birth experience, we were over 1500 miles from our home in New Haven, CT. Our company was being run from my laptop and mobile phone and I was juggling a fully packed calendar of business obligations all while running from ICU to NICU, for 5 weeks. It was two months before I was able to safely return my family to our home in New Haven. In addition the amazing amounts of time needed for both my wife, Phoebe, and my son, I still needed to meet with potential customers, conduct regular tech meetings, solicit further investment and continue to work on intellectual property issues, technological challenges and personnel needs.

We had invested our life's savings to get to this point and now, with this amazing, yet traumatic family event, we began to question many of the decisions that had brought us to this place and time. Out of time, out of money and out of my home, it was easy to think how much "˜better' it would be if I "˜just' worked as a Family Nurse Practitioner as I was trained to do and could bring home a regular ol' paycheck for "˜only' 40 hours. Those questions never last for long, the "˜vision,' never sleeps, it never relents and it can become all-encompassing and turn us into 4am to 11 pm machines but, occasionally, even entrepreneurs are human 

Conversely, our highest point to date has been our attendence at HIMSS 2010 this March. We were selected to present at the Healthcare IT Venture Fair and after an exciting presentation we were no longer unknowns to the major players in the healthcare arena. When big names like Intel, Blue Cross, GE, McKesson, Blank Rome and the United States of America take note of your product and want to engage in investment, customer and business development discussions, you begin to realize that the power of the innovation is becoming recognized. The time since HIMSS10 has been a constant blur of

inquiries, customer demos, partner requests, commercialization deals, amazing pilot discussions, customer implementations and, of course, investors.

**MARY PAT: Is this a product that can be affordably scaled for any customer, or do you anticipate the ROI being on target for a specific type/size of customer?**

**MATT:** Our product, YourNurseIsOn.com, is a Software as a Service (SaaS) product that helps allocate the right healthcare staff, where they are needed, when they are needed there, by instant, 2-way text, phone and/or email communications. We are a Software as a Service (SaaS) platform that allows for quick and easy adoption, keeps customer costs low and removes their maintenance responsibilities.

We offer a number of value propositions for the customers including faster speed of fulfillment, decreased nurse vacancy, reduced overtime spending, increased patient-provider contact hours, improved patient outcomes, license management, call order adherence, expanded communications capabilities and amazing compliance reporting performance. Flexible scheduling, with all the extra communications needed, has become a best practice for healthcare workforce recruitment and retention. YourNurseIsOn.com makes these communications effortless. For organizations that rely on communicating with a distributed workforce, to operate around the clock, our solution is quickly becoming indispensable.

The ROI metrics are being compiled presently and should prove to be favorable for any size organization. We expect the return on investment period to be very brief as we can provide over 8 hours of phone calling in under 30 minutes and provide the 2-way text and email channels for improved efficiencies. Our soon to be announced pilot with a nationally recognized health provider network will soundly demonstrate our scalability for any sized facility, organization or governmental body.

**MARY PAT: Where do you want YNIO to be in 5 years?**

**MATT:** YourNurseIsOn.com is focused on excellent customer experience, and service, for every single client that engages our services, and we will continue with that focus relentlessly as we continue to grow and scale our platform. YourNurseIsOn.com is well poised to become the de-facto communications method for healthcare organizations that need to contact and confirm their specialized, distributed workforces on demand. The ability to easily reach specific individuals, that are qualified and available for a specific function, in a quick and easy manner on any device of their choosing will only become more important given the coming increases in healthcare demand and simultaneous scarcity of all healthcare providers. YourNurseIson.com has the ability to efficiently deliver caregivers where they are needed, not only in institutional settings, but in the communities where the majority of care is being delivered. YNIO, with its international patent -pending status will be the communications ”˜glue’ that holds it all together.

**MARY PAT: Many people are predicting that NPs and other mid-level providers will be the future of primary care if physician shortages play out as expected. What do you think?**

**MATT:** Personally, as a nurse practitioner, I feel that this is all too often the focus of discussions about the future of healthcare and is, just as often the beginning of contentious debate that ends in a turf war between doctors and other providers. I do not believe that either of us are the future of healthcare. I believe that we cannot possibly train sufficient numbers of providers to care for the onslaught of demand that is quickly approaching. The future of primary care will lie in the hands of the individual, their families and their communities. This will be supported by tele-medicine, bio-sensors and smart homes to begin and eventually lead to caregiver robots and software algorithms diagnosing and treating your ailments:

- A wristwatch, scale and shoes that track your fitness regimen, downloaded nightly into your Personal Health Record and gently recommending tomorrow’s diet or workout schedule.
- Personal reminder software to gently prod you to take your medicine, engage in physical activity or to remember a wellness event or medical appointment.
- Accentuated reality software to help make informed dietary, activity or purchase selections based on wellness scales, provider recommendations or personal preferences.
- The ability to export this information to your Electronic Health Record to share with your providers, specialists or family
- A smart home with a bed that signals that Grandma woke up later than usual after a restless night, a chemical sensor toilet that signals she may be a bit dehydrated, a pill bottle that alerts when she hasn’t opened it- these types of events triggering personal reminders, check-in requests to a neighbor, visit requests to family, or send an alert to her community caregivers, etc. If no one is able to check on her status, emergency services could be automatically notified.

Couple these technologies with instant, 2-way, verifiable communications systems, and these networks will provide the bulk of care in the near future. There simply are not enough resources to provide care any other way. I hope to see NPs continue to expand their roles, earn autonomy and continue to provide excellent care to millions of people. NPs, MDs, therapists, etc. are all going to be in short supply and high demand. All of these professionals are important to the healthcare delivery team and will have to be allocated with, supported by and communicated to with advanced technologies to expand their practice reach, improve their collective effectiveness, begin to decrease costs, and continually improve outcomes.

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It was a real pleasure talking with Matt and getting to know more about YNIO and more about him (the geek in me enjoyed the geek in him!)  I truly appreciate how open he was in the interview. Thanks, Matt!

The YNIO (Your Nurse Is On) website is **here.** Matt recently guest posted on HealthcareIT Today which can be found **here.** You can connect with Matt here:

Email
Twitter
LinkedIn

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# The Medical Office of Today or Tomorrow

I've been thinking about the medical office of the future. How would you design a building today that is meant to take you into the future?  Here are my thoughts.

One of the hallmarks of a well-designed office, today or tomorrow, is **flexibility**.  You want as much functionality as you can possibly get out of each space and use each space for as many purposes as possible.

For instance, a large room with lots of voice and data jacks or wireless and electrical outlets might be used for:

1. Physician meetings, staff meetings or parties
2. Group patient visits
3. In-house health fair
4. Staff or patient training

5. Public meetings
6. War room for disaster management or ad hoc project (medical record scanning prior to an EMR go-live)
7. Conversion to workstations for a merger with another group
8. Place to do group sports or college physicals, flu shot clinics, DOT physicals

I see reception and waiting areas getting smaller as patients have less time and are less willing to wait. Patients may not have to wait at all if you are sending them a text message or Twitter when the doctor is ready to see them. Some practices will not have waiting areas as patients will be escorted directly into exam rooms where the entire visit, from soup to nuts, will take place. Instead of going to the lab, the lab might go to the patient.

Registration may be replaced by check-in kiosks that totally automate the process, including a vitals booth which takes the patient's weight, blood pressure, oxygen levels and temperature. Patients and their demographic and insurance information may be identified by fingerprints or iris scans. You may have a receptionist avatar greeting patients.

Fixtures are movable – storage cabinets are on wheels and not permanently attached to walls. Any room can be an exam room, a treatment room, a test room, a procedure room, simply by moving the cabinet with the needed items and the machines, which will be handheld. See an example **here.**

Providers' phones are their everything. Their mail, patient records, test results, journals, phone calls, and their family pictures are on their phone, so no need for an "office."

As always, non revenue-producing space is minimized and **revenue-producing space is maximized.**

The need for storage of paper (records, forms, etc.) is

minimized because everything is digitized and stored on the cloud.  The need for staff workstations is minimized because many staff work for the practice from home.

Medical records are not viewed on computer screens, they are projected onto walls in any room, at any time.  See the TED Talk on the Sixth Sense technology **here**.

Many patients are seen at home or in the nursing home, with the provider in the office using telemedicine technology or virtual office visits.

Medication samples will not be given at the physician office – they will be distributed at the pharmacy.  All medications will be samples (no cost) until it is established that it is the effective medication for that patient's problem.

Here's a neat video from Microsoft about healthcare of the future.  It will get your mind racing about the possibilities.

Microsoft Health – Future Vision from Microsoft Feed on Vimeo.

It's frightening and exciting – might there be no need at all for brick and mortar physician offices?  I think it's very likely.

What are your ideas about the medical office of the future?