

Visit [www.MDOptions.com](http://www.MDOptions.com)

# PHYSICIAN PRACTICE OPTIONS™

---

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

---

*June 2008*

## INNOVATIONS

Will Disruptive Innovations Change Health Care? 2

---

## STRATEGY

Seven Questions Managers Should Ask 3

---

## POINT-COUNTERPOINT

Can We Increase the Numbers of  
Nurses and Doctors Providing Care? 6

---

## COMMENTARY

Book Tells How to Navigate the Maze 10

---

## CAPITAL IDEAS

Best Option: "S" or "C" Corp? 12

---

## PRACTICE MANAGEMENT

Report: Large Groups Are More Efficient 14

## Will Disruptive Innovations Change Health Care?

By Richard L. Reece, MD, *editor-in-chief*

A recent issue of the *Harvard Business Review on Managing Health Care* was devoted to innovations. The 84-page publication contained a compilation of some of the most compelling articles from the venerable business journal on health care innovations in the past few years. In particular, the publication was interesting because of two articles that stood out:

- “Why Innovation in Health Care is So Hard,” May 2006, about why rules, regulations, and turf battles defeat innovation.
- “Will Disruptive Innovations Cure Health Care?” September-October 2000, about how simpler, cheaper, and more convenient innovations can transform health care.

As I read the book I wondered, if disruptive innovations are so hot, why aren't they working to lower overall health costs? Also, I wondered if health care costs are so high, why are so many hospitals struggling financially?

Health costs rose about 4 times faster than the rate of general inflation from 2002 to 2007. In the article about disruptive innovations, Clayton Christensen, the author of the book, *The Innovator's Dilemma* (Harper Business, 2000), explained why health care costs may remain so high. Christensen has defined a disruptive innovation as a technology, process, or business model that is much more affordable or much simpler to use than other technologies, processes or models and thus displaces its predecessor in the market. “Nurse practitioners, general practitioners, and even patients can do things in less-expensive, centralized settings that could once be performed only by expensive specialists in centralized, inconvenient locations,” he wrote. “But established institutions—teaching hospitals, medical schools, insurance companies, and managed care facilities—are fighting these innovations tooth and nail. Instead of embracing change, they're turning the thumb-screws on their old processes—laying off workers, delaying payments, and merging. Not only is this at the root of consumer dissatisfaction with the present system, it sows the seed of its own destruction.”

Christensen may be right. After all, he helped to popularize the term “disruptive innovations.” But what works against innovation is a medical establishment that is unlikely to change. Its leaders are heavily invested in specialized facilities.

In the past eight years, Congress has made high deductible plans with health savings accounts more widely available. In the same period, consumer-driven care has progressed slowly, hospitals have started to decentralize, physicians have invested in specialty hospitals and other facilities, and large employers have established worksite clinics. Also, big retailers such as Wal-Mart, CVS, and Walgreens have opened retail health clinics. At the same, the Internet has helped to bring extensive volumes of information to patients and family members so that it is now possible to look up almost any symptom and get reams of data from some of the world's foremost medical experts.

Thanks to disruptive innovations, the health system is undergoing dynamic changes, but the medical establishment's addiction to the status quo has slowed progress and innovation to a crawl.

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

This newsletter is published by Premier Healthcare Resource, Inc., Morristown, NJ.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

### Publisher

Premier Healthcare Resource, Inc.  
150 Washington St.  
Morristown, NJ 07960  
973/682-9003; Fax: 973/682-9077  
publisher@premierhealthcare.com

### Editor

Joseph Burns  
508/495-0246  
editor@premierhealthcare.com

Neil Baum, MD  
Urologist  
New Orleans

Daniel Beckham  
President  
The Beckham Co.  
Physician and Hospital Consultants  
Whitefish Bay, Wis.

Thomas M. Gorey, JD  
President and CEO  
Policy Planning Associates  
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA  
Executive Vice President  
Premier, Inc. and  
Premier Practice Management  
San Diego

Harold B. Kaiser, MD  
Allergy & Asthma Specialists, PA  
Minneapolis

Nathan Kaufman  
President  
The Kaufman Group  
Division of Superior Consultant Co. Inc.  
Physician and Hospital Consultants  
San Diego

Paul H. Keckley, PhD  
Executive Director  
Vanderbilt Center for  
Evidence-based Medicine  
Nashville

Peter R. Kongstvedt, MD, FACP  
Senior Executive  
Accenture  
Health & Life Sciences Consulting  
Reston, Va.

John W. McDaniel  
President and CEO  
Peak Performance Physicians, LLC  
New Orleans

Lee Newcomer, MD, MHA  
Senior Vice President, Oncology  
UnitedHealthcare  
Minneapolis

James G. Nuckolls, MD  
Medical Director  
Carilion Healthcare Corp.  
Roanoke, Va.

Bernard Rineberg, MD  
Physician Consultant  
BAR Health Strategies  
New Brunswick, N.J.

James M. Schibanoff, MD  
Editor-in-chief  
Milliman Care Guidelines  
Milliman USA  
San Diego

Jacque Sokolov, MD  
Chairman  
Sokolov, Sokolov, Burgess  
Scottsdale, Ariz.

# Seven Questions Managers Should Ask

**G**iven the pressures gastroenterology practices confront everyday, many gastroenterologists are finding it is critical to strive for effective and efficient management of every aspect of their practices.

“Per-service revenue continues to decline, expenses keep rising, and the demand for services remains high,” explains Cecile M. Katzoff, MGA, CGCS, vice president of the American Gastroenterological Association (AGA) in Bethesda, Md. “Taken together, these factors make practice efficiency a critical goal for all gastroenterologists.”

An expert in gastroenterology practice management and director of the Center for GI Practice Management and Economics, Katzoff says, “Typically, gastroenterologists are concerned about scheduling patient appointments and procedures as quickly as possible. The long wait times that are typical of most gastroenterology practices are detrimental to patient care, relationships with referring physicians, and patient satisfaction.”

## Management Needed

A second common concern relates to staffing efficiency, particularly the number and type of staff members the practice employs. “Gastroenterologists want to be sure that the right people are doing the right tasks in the most efficient manner possible,” Katzoff adds. To ensure that gastroenterology practices run smoothly and at maximum efficiency, Katzoff suggests physicians and practice managers ask themselves these seven questions:

1. Do you know where your problems are?
2. Are you (truly) negotiating contracts?
3. Are you responsive to your referral sources?
4. Do all services require an office visit?
5. Do all services require a gastroenterologist?
6. Are billing, coding, and documentation accurate and thorough?
7. Are you ready for an EMR?

In addition, Katzoff suggests that gastroenterologists make time for strategic planning (see sidebar).

**Identifying problems.** While gastroenterologists typically sense that they need to improve practice efficiency, they may not formally analyze where real problems lie. Katzoff encourages practices to examine all processes formally. Doing so helps them determine where to target their efforts to improve efficiency.

Formal practice assessment involves a detailed look at all areas of practice performance. “When the AGA performs a practice assessment, we first interview the physicians and staff members to find out what their concerns are,” Katzoff explains. “Then we spend time observing the staff and how they do their work. We also sit in the waiting area to get a feel for the patients’ experience as they go through the practice; we follow patients from the time they arrive to the time they check out.

“We consider a number of potential problems, such as whether patients experience excessive waits at any time, whether appropriate informa-

tion is collected at the front desk and at check out, and whether co-pays are collected,” Katzoff continues. “We also consider whether the interaction between patients and staff is positive, and whether the staff is efficient in overseeing patient flow.” A practice assessment can take two to four days.

Even after practices identify their problems, many fail to realize that two of the most common problems are overlooked despite the physicians’ best intentions. These problems involve negotiating contracts with payers and being responsive to referral sources.

**Contract negotiations.** Often, gastroenterologists will sign contracts that are not beneficial. “Many gastroenterologists do not realize that they can actively negotiate their contracts,” Katzoff says. “Rather, they approach each contract as a ‘take it or leave it’ situation. They will accept whatever is offered to them because they are afraid of losing payer relationships, referral sources, and patient volume.”

In most practices, walking away from a contract is often not an option. “If a large payer in the community controls much of the patient volume, it would be very detrimental to remove the practice from that contract,” Katzoff notes.

Payers are typically willing to negotiate, however, particularly if the gastroenterologists come to the negotiation armed with data. “Gastroenterologists should be prepared with financial data and patient volume estimates that reflect the actual cost of

*(Continued on page 4)*

**“We consider a number of potential problems, such as whether patients experience excessive waits at any time, whether appropriate information is collected at the front desk and at check out, and whether co-pays are collected,” Katzoff continues.**

(Continued from page 3)

providing gastroenterology services and present the physician's requested reimbursement," she says.

**Responding to referral sources.** The other commonly overlooked problem involves being unresponsive to referral sources. Just as all physicians must do, gastroenterologists need to cultivate good relationships with referring physicians.

"The way to maintain referral source satisfaction is to ensure that patients are seen as quickly as possible and then provide excellent clinical and service quality," Katzoff comments. "Patients will certainly provide feedback to the referring physician, who will then decide whether to continue referring based on that feedback."

Service to the referring physician is critical as well, and includes relaying diagnostic findings or patient updates promptly. "In addition, gastroenterol-

ogy practices should ensure that referring physicians and their staff can easily reach the gastroenterologist by telephone," she adds. "Telephone lines should be open all day to accommodate calls from referring physicians, and their calls should be taken as quickly as possible."

Other problems gastroenterologists face may not be as pressing as these two, but they are still quite common.

**Is each office visit necessary?** The high demand for gastroenterology services means most patients must wait a long time to get an appointment and that gastroenterologists should ensure that patient services are provided in the most efficient manner possible.

"Gastroenterologists should look carefully at the kinds of services the practice provides to patients, and how best to offer those services so that the physicians' time is leveraged appropri-

ately," Katzoff comments. "For example, many patients who are recommended for a screening colonoscopy are perfectly healthy and have just seen their PCPs. These patients may not require a pre-screening visit with the gastroenterologist. Rather, a nurse could telephone patients prior to the procedure to explain the pre-procedure preparation, describe the procedure, and address patient questions and concerns. By eliminating those visits, gastroenterology practices open up their schedules, allowing gastroenterologists to perform more procedures and treat more complicated patients."

**Do all services require a gastroenterologist?** "The main signal that it is time to consider hiring more providers is that, after practice efficiency has been maximized given current resources, the wait time for appointments or procedures is still excessive,"

## Steps to Take When Preparing for an EMR

For physician practices, electronic medical record (EMR) systems offer numerous benefits.

"EMRs allow gastroenterologists to access complete information at any time and from any location, a feature that is particularly important in larger practices, where gastroenterologists often travel to different office locations," says Cecile M. Katzoff, MGA, CGCS, vice president of the American Gastroenterological Association (AGA). "EMRs can enhance quality of patient care, because records and test results are never lost and are accessible when needed. Furthermore, EMRs can help practices meet the quality tracking requirements and recommendations of Medicare and private payers."

Unfortunately, many practices adopt EMRs but then don't use them, or don't use them effectively. Many practices have physicians who do not want to use them. "For instance, a physician will continue to dictate and someone transcribes the information into the EMR, a process that is highly inefficient," she adds. "Some practices are still in the process of scanning all their paper records into the EMR and have hired an army of scanners, which is extremely costly.

"To prevent these problems, gastroenterologists have to do their homework," she explains. "They should determine what they want out of the EMR before they

start going through the search, and should select a system that works well for their practice. They also should understand that it will take some time before the EMR is operational. There may be some inefficiencies initially, but hopefully down the road the EMR will help increase efficiency."

Only about 30% of practices (and these are typically larger practices) have adopted EMRs, Katzoff estimates.

"Many practices are looking into EMR adoption, but are deterred by a number of barriers," she says. One barrier is the expense. Another is the time to learn the new system. A third is the lack of gastroenterology-specific EMRs available.

The AGA has appointed a task force to work with an EMR expert to evaluate products currently on the market and identify systems that could meet gastroenterologists' needs or that could be customized. The task force plans to make its recommendations this month.

In the meantime, Katzoff suggests some features the task force could consider for an effective EMR. "The EMR certainly should have templates for documentation, be able to track patients by diagnosis, and produce a variety of reports that are easily accessible and easy to read," she says. "It should link with the practice management and scheduling systems. —DJN

Katzoff explains. "If you can't fit a patient with an urgent but not emergent problem into the schedule within a day or two, and a patient who does not have an urgent problem cannot be seen within two to three weeks, then the gastroenterologist should consider hiring more staff."

Given the current shortage of gastroenterologists, hiring another physician may be unrealistic. "Mid-level health providers are a natural choice for expansion," Katzoff says. "The numbers of nurse practitioners (NPs) and physician assistants (PAs) in gastroenterology practices have been expanding in recent years."

Gastroenterologists who hire mid-level providers should seek to leverage their skills. "Unfortunately, many physicians are reluctant to let mid-level providers treat patients independently, even when the providers are thoroughly trained," she says.

In August, the AGA will offer a gastroenterology-specific training program for mid-level providers.

### **Using Providers Effectively**

"The most effective use of mid-level providers in terms of revenue generation is to allow them to treat established patients with chronic conditions such as hepatitis C, Crohn's disease, colitis, and GERD," Katzoff says. "These patients return to the practice periodically for laboratory tests, prescription refills, and general monitoring, and tend to do very well with mid-level providers. Mid-level providers also can be in the office treating patients while the physicians are performing procedures, thereby generating appointment revenue during the time when procedure revenue is also being generated."

**Coding accuracy.** Any formal practice assessment should almost always include a review of medical records. "A medical record review involves looking at a sample of services and comparing the documenta-

## Make Time for Strategic Planning

Typically, physicians are so steeped in the pressures of daily responsibilities that they often do not make time to consider the future of their practices. "Strategic planning is critical to practice viability, and should be formally pursued at least every three years," says Cecile M. Katzoff, MGA, CGCS, vice president of the American Gastroenterological Association (AGA) in Bethesda, Md.

During each strategic planning session, the physicians should analyze a number of issues, including the general health care environment, new technologies under development, and reimbursement trends. Many physicians consider it useful to review the practice's strengths, weaknesses, opportunities, and threats. Such a process is called a SWOT analysis.

—DJN

tion in the medical record with the billing codes to make sure the documentation supports the levels of service and the categories of service billed," Katzoff explains. "The review should also determine whether there are any missed charges with regard to procedure billing."

During a medical record review, physicians are likely to discover undercoding, systems that are inadequate to ensure accuracy, and insufficient documentation in patient charts. "Sometimes, given the nature of a patient's problem, we would expect the level of service to be higher," she says. "However, the documentation is often missing key components that would allow the physician to bill at a higher level of service."

The most common error Katzoff finds with regard to coding patient appointments is that all new patients are coded as a consultation. "Some of these patients do not meet the definition of a consultation and the documentation will not support a consultation, which creates the potential for audit liability," Katzoff states.

Another problem is that gastroenterologists and staff often do not understand that they can bill for multiple procedures during the same endoscopy. "If they do not bill for all

procedures, gastroenterologists are foregoing the incremental fee they could earn on each of those procedures," she explains.

### **Template Driven Solutions**

Physicians and staff should be educated as to what the different categories of services mean, the documentation required for each category, and the documentation required for each level of service, Katzoff says. A second solution is to use a template that prompts the physician to use the proper documentation to support each code.

"Gastroenterologists who do not have an electronic medical record (EMR) system can use a paper template," Katzoff adds. While EMRs typically incorporate templates, Katzoff asserts that an expert in coding and documentation guidelines should review any templates customized for gastroenterology to ensure that all the components required for documentation are included.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on the Center for GI Practice Management and Economics is available at [www.gastro.org](http://www.gastro.org). More information on physician practice strategies is available on our Web site (see page 16).

# Can We Increase the Numbers of Nurses and Doctors Providing Care?

By Richard L. Reece, MD, editor-in-chief

One of the most pressing problems the health system faces is the shortage of trained professional staff to deliver care. Both nurses and physicians are in short supply. To address this issue, we asked two experts to discuss how the shortage of physicians and nurses is affecting care and how to increase the numbers of both professionals.

One expert is James Hawkins, MBA, who has served as CEO for two hospitals, as a health policy expert, a consultant, an entrepreneur, and as a practice manager for a multispecialty medical group. Currently, he is the practice and compliance manager for the nurse faculty practice plan at the University of Georgia School of Nursing.

He understands the dilemmas the current shortage poses and the role nurses can play in providing care. While nurses currently play a vital role in health care, Hawkins believes their contributions will be even more important in the future. They will be asked to deliver more care in more settings than ever before. And physicians need to recognize the value nurses and nurse practitioners offer, he adds.

“The key is letting the physicians concentrate on what they, and only they, are capable of doing, and using technology and other professionals to support and meet the needs of patients,” Hawkins says.

The second expert is Phillip Miller, vice-president of communications for

Merritt Hawkins & Associates, Inc., physician recruiters in Irving, Texas. Miller and his colleagues were among the first to warn of the physician shortage. This shortage is now reaching a critical phase and may undermine expansion of health care coverage. “The physician shortage is serious, and it’s growing more serious,” Miller says. In 2004, he wrote a book, *Will the Last Physician in America Please Turn Off the Lights? A Look at America’s Looming Physician Shortage* and then last year he wrote, *Merritt, Hawkins & Associates Guide to Physician Recruiting*. In both books, he discussed the physician shortage at length.

Both experts agree that if the health care system is going to provide efficient and effective care, nurses and physicians need to work together.

## A Vital Role

“Nurses offer an essential and cost-effective means of caring for patients,” Hawkins says. “There are about 600,000 practicing physicians, and more than three million nurses. We need both. Doctors and nurses go together, and you can’t separate their roles.

“In the future, nurses, and nurse practitioners in particular, will play a wide and vital role,” he explains. “When delivering health care, there are three primary needs: quality, access, and low cost. Nurses clearly improve satisfaction, a big part of

quality. They also accelerate and increase access, as they’re now doing in retail clinics and chronic disease settings. And, they provide care at an affordable price.

“In addition, health care experts are putting a lot of stock in new technology to ease the physician shortage, such as systems to allow self-care through the Internet and computer monitoring of home-bound patients,” he adds. “Nurses can monitor patients at home through bedside audio and video units. Remote monitoring has a lot of potential, and will constitute a major change of direction in the future. Remote monitoring does something that is absolutely crucial to put information at the point of decision making. If there’s a need for attention, specialized alerts can be given, and complications can be avoided. Such real-time information transcends the information gathered during an office visit. This is a field in which doctors and nurses can work effectively in tandem.

## Managed Care Centers

“In addition, schools of nursing and nonprofit organizations have started nursing managed care centers,” Hawkins continues. “Typically these centers serve the uninsured, the mentally ill, and others who have had limited access to care. They sometimes have difficulty maintaining funding. Nevertheless, these centers

**“The key is letting the physicians concentrate on what they, and only they, are capable of doing, and using technology and other professionals to support and meet the needs of the public.”**

**—James Hawkins, MBA, University of Georgia School of Nursing**

remain an essential part of the safety net. One example of these organizations is the National Nursing Centers Consortium (NNCC) in Philadelphia (at [www.nncc.us](http://www.nncc.us)), which advocates for nurse practitioners as primary providers of health care.

“Another sector of health care where nurses are providing some relief from the doctor shortage is in chronic disease management,” he says. “About 15% of patients with chronic disease generate 70% of costs, and many patients are best treated at home and other settings removed from physician offices. These nurses monitor and deliver care, either face to face in patients’ homes, or by monitoring patient progress online or by telephone.

“Chronic care and other types of case management services are a very efficient, effective means of caring for patients,” Hawkins says. “Such management keeps patients out of nursing homes and hospitals. Nurses are very good at managing care, and their efforts lower costs and increase patient satisfaction.

“While nurses are very good at management, one lesson I’ve learned in working with nurses is that many of them harbor negative attitudes toward doctors,” he adds. “I had an inkling of this attitude while serving as a CEO of hospitals and while managing a medical practice, but I didn’t appreciate the scope of it until now. Most doctors appreciate the work of other doctors, but they may not have a high regard for nurses. Also, nurses regard many doctors as arrogant, dismissive non-listeners. In my opinion, doctors could be a lot more productive and effective if they listened more closely to nurses and their

## New Systems Create Opportunities for Providers

A changing delivery system creates opportunities for nurses in retail health clinics and other settings, where nurses can deliver a limited range of services at lower costs, says James Hawkins, MBA, a consultant and expert in nursing care. “I emphasize the word ‘limited’ because in many instances, the final decision on what nurses do rests with physicians,” he says.

“In the last five years, retail clinics have grown explosively,” Hawkins adds. “Such retail giants as CVS, Wal-Mart, Walgreens, and other discount stores and chains have entered the market. In my brief time working with nurses, I have seen that they are excited about the potential of these clinics and other nurse-managed care centers. Nurse-managed care centers are generally more comprehensive than retail clinics and tend to serve the poor, the mentally troubled, and others who lack adequate access to health care.

“Retail health clinics are part of a broad move in our society for more freedom of choice at lower costs,” Hawkins continues. “I suspect these clinics will go through a boom and bust cycle, then boom again. Some retail chains will succeed, and some will become spectacular failures. But the supply of nurse practitioners will grow. It takes less time to expand a nursing school and to produce a nurse practitioner than it does to establish new medical schools and produce new physicians.

“But clearly, people want more care, and they want it conveniently,” Hawkins comments. “That’s why more people are getting information off the Internet and why there’s more home testing, more remote monitoring, and more patients assuming responsibility for their health.”

—RLR

observations about patients and treated them with the courtesy and respect they deserve.

“Given the shortage of physicians, there will be a need for both doctors and nurses to work together,” Hawkins comments. “If managed correctly, both sides will benefit. Physicians will be able to focus on patients with the greatest needs, and nurses and nurse practitioners will be able to take care of most patients’ more basic problems.

“Over the years, physicians have learned that working with nurse prac-

tioners boosts productivity and allows them to see more patients,” he says. “In that way, it’s a very complementary relationship. And, when physicians work with nurse practitioners, it improves patient satisfaction. Patients appreciate the work of nurse practitioners, and it generally works out to greater satisfaction for all parties. In some rural areas and other places where the physician shortage is more severe, we even see nurse practitioners in private practice.

“At the same time, there is a critical

*(Continued on page 8)*

**“Nurses regard many doctors as arrogant, dismissive non-listeners. In my opinion, doctors could be a lot more productive and effective if they listened more closely to nurses and their observations about patients and treated them with the courtesy and respect they deserve,” Hawkins says.**

(Continued from page 7)

shortage of nurses as well,” Hawkins explains. “There are a lot of factors creating demands for more nurses in hospitals. Nurses are growing older and retiring, and fewer are entering the profession. There’s a scramble to expand nursing schools and to graduate more nurses. There’s also a shortage of nursing faculty, which makes it difficult to expand nursing schools. In Georgia, for example, the goal is to expand the number of registered nurses who graduate by about 50% in just a few years but the faculty shortage will make that a daunting task.”

### A Policy Disagreement

Like Hawkins, Miller agrees that training the requisite number of health care providers that the system will need is a daunting endeavor. In fact, beginning in the early 1990s, it took more than 10 years simply to get health policy experts to acknowledge that a shortage of physicians was looming, he says.

“In 1992, we wrote our first article about the physician shortage, and we’ve been writing about it ever since,” Miller explains. “At the time, academics and policy makers were saying we had too many physicians. They also said we were going to have an excess of 165,000 physicians by 2000. That clashed with our experience and we were isolated in our opinion until 2002, when Richard Cooper, MD, wrote an article in *Health Affairs* that echoed what we had been saying. Now most policy makers agree a shortage exists. Cooper wrote that the experts had badly misjudged such demographic

factors as population growth, immigration, rising incomes, and increased demand, and that 15 new medical schools would be required to meet future needs. He estimated doctor shortages would reach 50,000 by 2010 and 200,000 by 2020. It takes 6 to 10 years to produce a newly minted physician, so the physician shortage is likely to persist.

“So, it’s good news that someone finally recognized the problem,” he adds. “The bad news is nothing is being done about it.

“Even though we are now raising the number of medical students, more students will have no effect on physician supply unless we increase residency training slots,” Miller explains. “At present, we are graduating about 17,000 U.S. trained medical students annually, but there are 25,000 residencies. Foreign graduates take the slots that U.S. graduates do not take. If you keep U.S. graduates constant and residencies constant, all you accomplish is displacing foreign medical graduates. Congress capped the number of residencies in 1997. That’s the bottleneck on the supply side.

“In addition, for a while after Sept. 11, 2001, we had decreasing numbers of foreign graduates because federal agencies stopped sponsoring doctors for their two-year residency requirements,” he explains. “But these doctors need to stay in the United States and not go home after two years. Federal officials believed they could not be responsible for the security clearances for these students, and that had an inhibiting effect.

### Cutting Back on Care

“Also, the time it takes to process green cards for these doctors has increased,” Miller continues. “As the global economy has improved, so too have the opportunities for these physicians. Many now have the option of going home where opportunity is plentiful. In India, that option has become more attractive as the economy has boomed. And other industrialized countries have doctor shortages and are attracting doctors back home or retaining them. These trends show that we can no longer depend on foreign-trained doctors to bail us out.

“Survey data show that nearly 50% of doctors over age 50, who are the workhorses of the profession, plan to retire or cut back their hours in the coming years,” Miller adds. “People who look at the supply issue focus on the number of graduates coming out of school, the aging population, and other demographic factors. But you also have to look at practicing physicians, how they practice, and what they are feeling. Many physicians who entered practice in the fee-for-service days are disenchanted, and many retire as early as they can. Among the doctors we surveyed, nearly half plan to retire, cut back on patient care, close their practices to new patients, or do temporary work in different places.

“In a recent survey, only about one-third of doctors over 50 said they wanted to work full time, and furthermore, we find most doctors would not recommend medicine as a career to their children or other young people,” he continues. “That’s significant because in medicine you

**“The way health care is paid for is becoming untenable for doctors. They are trying to find ways around it, either by abandoning payers, establishing boutique or concierge practices, getting into non-clinical roles, or getting out of medicine altogether. We have to create an environment that attracts intelligent, motivated people to become doctors.”**

**—Phillip Miller, Merritt Hawkins & Associates**

tend to have medical families, just as you have military families. In the past, doctors were the greatest advocates for pursuing a medical career.

### Steps to Take

“So, now the question becomes, how do we persuade Congress to lift the cap on graduate medical education funding?” Miller asks. “I’m not sure Congress is ready to do that. So, failing that, I would recommend first that we change how we deliver and pay for health care in the United States. We have a poorly organized health system, and the way we pay for care is becoming untenable for doctors. They are trying to find ways around it, either by abandoning payers, establishing boutique or concierge practices, getting into non-clinical roles, or getting out of medicine altogether. We have to create an environment that attracts intelligent, motivated people to become doctors.

“Second, we have to decide what kind of health care system we will have in the future,” he adds. “We have no formalized system for establishing a rational system, controlling it, or deciding how many doctors we need and what types. Are we going to have a single-payer system? Are we going to establish more consumer-driven care? Or, are we going to take other steps to reform the health care system? Once we figure that out, we’ll have a better understanding of the types of doctors and how many we need.

“Even though we are not reforming the health system, medicine is evolving so that physicians today are more likely to be employed than they were

## Survey To Address Effects of Cuts

The federal Centers for Medicare & Medicaid Services is scheduled to cut physician reimbursement by 10.1% on July 1 and 5.6% next year. Some health policy experts expect that cuts in reimbursement for physician services will affect the number of physicians willing to continue to accept Medicare and Medicaid patients and could prompt physicians to retire early.

“Currently, we’re working on a survey of doctors for the Physicians Foundation for Health Systems Excellence in Boston in which we’re trying to determine the effect of Medicare’s reimbursement cuts,” says Phillip Miller, vice-president of communications for Merritt Hawkins & Associates, Inc., a physician recruiting firm in Irving, Texas.

“We’re sending a survey to every primary care doctor in the country to find out where they stand on the issue and how long they will continue to practice under even more difficult economic circumstances,” he explains. “We cannot continue to say that we need to offer health care to everyone, and at the same time, send the signal to doctors that we are not going to pay them what we have been paying. There’s a basic contradiction between what we desire from doctors and what we pay them.

“Massachusetts is experiencing the first year of a program designed to provide universal coverage, but what they’re finding is that universal coverage without access is meaningless,” Miller continues. “What’s happening is that as Massachusetts seeks to increase access, some people are finding that there are not enough physicians to care for everyone who needs care. If people in Massachusetts can’t find a primary care doctor, and Massachusetts has more doctors per capita than any state in the union, then we have another problem that needs to be addressed.”

—RLR

years ago, to work 40 hour weeks, and to have regular vacations,” Miller explains. “When you’re employed, the whole mentality shifts toward shorter work hours. That doesn’t necessarily inhibit quality, but it certainly inhibits access. Young doctors want more regular hours, more vacations, and more control of their lives than older doctors have wanted. So, the net number of doctor work hours is diminishing.

“In addition, female doctors simply work fewer hours than male doctors

because of their dual roles as physicians and mothers,” he adds. “They also tend to retire earlier than male doctors do. When we are recruiting a female doctor, we know she will go on maternity leave at some point and will want flexible hours. Today, some 50% of students in medical schools are female, and that will have a profound effect. Years ago, there were fewer female students in medical school.”

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

**“Survey data show that nearly 50% of doctors over age 50, who are the workhorses of the profession, plan to retire or cut back their hours in the coming years,” Miller says. “Many physicians who entered practice in the fee-for-service days are disenchanted, and many retire early. Among the doctors we surveyed, nearly half plan to retire, cut back, close their practices to new patients, or do temporary work in different places.”**

# Book Tells How to Navigate the Maze

By Richard L. Reece, MD, editor-in-chief

**T**he health system is needlessly complex. In many ways, this system, which critics insist on calling a “non-system,” is the worst of all possible worlds. It’s a bewildering mix of arcane rules, Byzantine red tape, and obstructive legal entanglements. For patients, it involves long hours of waiting and uncertainty.

This new book is a result of lessons learned over the years. The book, *Navigating the Maze of Health Coverage and Access: A Quick Guide for Physicians*, contains 20 quick takes on health reform. It is for doctors and patients. I present it as questions and answers on leading reform issues of today. This manual is not intended to be exhaustive or inclusive, but rather to be instructive.

## Seeking Simplicity

The health system is complex. This book is simple. It follows the simple instructions to write about the what, why, when, how, where, and who.

The issue of universal coverage is one of the examples of complexity in the book. In March, *The New York Times* quoted health policy expert Joseph Antos, PhD, of the American Enterprise Institute, on the issue of health reform. “The pernicious aspect of this cry for universal coverage is that it is too easy for politicians,” Antos said in the article, “Coming Soon: Health Care Debate, Part 2,” published on March 2. “The hard work is getting at the underlying inefficiencies in the health system, the perverse incentives that

*This article is excerpted from Navigating the Maze of Health Coverage and Access: A Quick Guide for Physicians, by Richard L. Reece, MD. It is published by Practice Support Resources, Inc., 800-867-7790. www.practicesupport.com.*

**Many Americans may not be ready for a universally mandated system requiring every citizen to pay individually or face fines or higher taxes. They also may not be ready for garnished wages or coordinated efforts to track down non-payers.**

have everybody in the dark.”

It turns out that Antos was correct. Just over a month later, on April 5, *The Times* reported about how Massachusetts was implementing a plan of care for residents of the state who lacked health insurance coverage. In the article, “In Massachusetts, Universal Coverage Strains Care,” the newspaper reported that some patients would wait over a year to get an appointment with a primary care doctor. And this is in a state with more doctors per capita than any other state. Project this picture to states with far fewer doctors, and one can begin to appreciate the magnitude of the problem of providing universal coverage.

Despite the complexities of the health care system and the problems inherent in trying to provide coverage to the uninsured, I believe that intelligent, informed consumers and doctors using common sense will act together and use the patient-friendly information resources of the Internet to reform the system.

No one is closer to patients than physicians are. Together, with the help of electronic communication, redesigned practices, and more and better paid primary care doctors, patients and doctors can prevail.

## Health Reform

**What:** National health reform and government-sponsored coverage for all.

**Why:** After the economy and possibly the war in Iraq, health reform is the second or third most pressing political issue in this year’s presidential election campaign. By November, Democrats may rue the day they carried on at such length about the absolute necessity of universal coverage. If politicians succeed in reforming the health system, almost all Americans may be covered, and calls for individual mandates and higher taxes to enforce mandates may not sound so good. In addition, universal coverage will do nothing to remove the rampant inefficiencies and perverse incentives that led to rising costs in the first place.

**When:** Reform will not occur this year or next and maybe not occur even in the next decade. After all, Americans have been debating reform since 1912.

**How:** Reform and universal coverage for all may require a depression, a world war, or an unprecedented natural disaster before politicians have enough political support to enact the required measures. In the meantime, many Americans may not be ready for a universally mandated system requiring every citizen to pay individually or face fines or higher taxes.

**Where:** Most likely reform measures will come from Washington, D.C., because state experiments have failed or are being overrun by unex-

pected costs. Imposing top-down command and control reform on the present system will be expensive, since future services will have to be delivered by the current providers. Universal mandates also may be alien to our individualistic, government-distrusting culture.

**Who:** A charismatic president with a veto-proof, lobby-proof Congress, a promise not to raise taxes, or harm special interests, and who gets cooperation from physicians.

**What physicians can do:** Make your voice heard in matters regarding health reform however and wherever you can, and offer constructive alternatives focusing on choice and freedom.

### **Consumer-Driven Care**

**What:** Consumer-driven health care (CDHC) usually refers to health plans that incorporate health spending accounts (HSAs), health retirement accounts (HRAs), and similar plans that cover routine health expenses with minimal interference in patient-physician relationships. Many of these plans feature low premiums, high deductibles, free preventive testing, and catastrophic coverage. Although the premiums for these plans may be lower than the premiums for more traditional HMOs and PPOs, patients pay more upfront.

**Why:** Proponents say CDHC offers consumers greater choice and freedom, relies on consumers to make more intelligent choices when spending their money, discourages overuse of services for minor problems, minimizes administrative costs, and has certain tax advantages for participants. Critics say these plans simply shift costs to plan participants and are unaffordable for people with chronic disease or low incomes.

**When:** CDHC has been evolving since the late 1990s. It is designed to get health consumers more engaged in understanding the cost and quality of care by using information avail-

## **Physicians can buy high deductible plans for their employees and family members and encourage patients to do the same.**

able on the Internet. As of last year, only about 4.5 million Americans were enrolled in HSA plans, about 5% of covered workers.

**How:** The Medicare Prescription Drug Improvement and Modernization Act of 2003 helped to make HSAs more widely available.

**Where:** Health insurance brokers are vigorously marketing high deductible plans with HSAs to small and medium-sized businesses to replace PPOs and HMOs. One fourth of current HSA holders were previously uninsured.

**Who:** Among the proponents of HSAs are John Goodman of the National Center for Policy Analysis, Regina Herzlinger of the Harvard Business School, Greg Scandlen of the Center of Health Consumer Choice, Grace Marie Turner of the Galen Institute, and President Bush.

**What physicians can do:** If physicians want to begin to eliminate third-party intervention from insurers, they can buy high deductible plans for their employees and family members and encourage patients to do the same.

### **Medicare Cutbacks**

**What:** As Congress and federal health policymakers seek to cut health care costs, they have continually made reductions in what the government pays physicians for treating Medicare beneficiaries.

**Why:** Medicare accounts for 25% of all federal spending and total expenditures for health care are expected to double to \$4.3 trillion by 2017. Among the reasons costs are rising is that the nation is getting older as baby boomers become eligible for Medicare. The costs of the program are expected to

increase to \$844 billion by 2017.

**When:** Congress has routinely cut Medicare costs over the past few years. In fact, physician payments are scheduled to be slashed by 10.1% this year and by 5% next year. Medicare no longer pays for some specialty hospital care, some errors (called “never events”), some medications for patients with cancer and anemia, and some high-tech surgical and imaging procedures. Also, Medicare is making cuts in the rate of growth for inpatient and outpatient care, skilled nursing facilities, teaching hospitals, inpatient rehab facilities, home health care, hospice care, and long-term care hospitals.

**How:** Many observers believe that deep cuts could foster a rebellion among senior citizens, especially assertive, aging baby boomers.

**Where:** Many of these battles are being waged in the halls of Congress and in the states. The results of this debate may depend on the outcome of the presidential and Congressional elections.

**Who:** Federal Health and Human Services Secretary Michael Leavitt is one of the leaders of the movement to reform Medicare. He is working with budget officials to make cuts and develop programs to promote electronic medical records, other information technology programs, and pay-for-performance programs.

**What physicians can do:** Write to your congressman and senator and tell them why these cuts are unjust and that they could result in reduced access to care for Medicare participants and fewer votes from constituents.

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

# Best Option: “S” or “C” Corp?

By Carole C. Foos, CPA, and David B. Mandell, JD, MBA

One of the most important decisions physicians make when starting a practice involves the tax structure. Most advisers to medical practices believe that the avoidance of potential double taxation makes the S Corporation the logical choice. Such conventional wisdom overlooks the potential benefits C Corporations offer. For physicians who want to reduce unnecessary taxes without subjecting their practice to double taxation and without having to change insurance or Medicare provider numbers, there are strategies to use.

To understand these strategies, physicians need to know the basics of practice organizations first. For physician practices, the most expedient form of organization is either an S or C Corporation. There is no reason to practice as a sole proprietor or in a general partnership. These forms result in unnecessary lawsuit risk, and do not allow the practice to take advantage of some of the useful tax-deductible business expenses.

## Comparing Alternatives

Next, compare C Corporations with S Corporations. All businesses that incorporate are automatically C Corporations if they do not elect to become an S Corporation. Both S and C Corporations require a separate tax identification number and the corporations must file tax returns

**Whether the income to an S Corporation is paid to the physician owners as salary or as a distribution will not affect the federal or state income tax rates applied to each physician’s income. There is never any tax to the corporation, therefore there is no double taxation for an S Corporation.**

with the federal and appropriate state tax agencies. Both entities have shareholders and can be created in any state in the country.

When a C Corporation earns a profit, it must pay tax at the corporate level. Profit is the difference between income and expenses. The corporation can deduct compensation paid to physicians, as long as it is reasonable and is deductible by the corporation on its tax return and is therefore not taxable to the corporation. The salary the owner receives is taxable to the owner as wages.

After the C Corporation pays taxes, distributions of earnings already taxed at the corporate level can be paid to the physician-owners in the form of dividends. Generally, these dividends would be taxed to the physician-owners as qualified dividends, thus leading to the double taxation of such earnings. For various reasons, however, this drawback often is overrated.

An S Corporation is also a separate entity that must file its own tax return. The S Corporation, however, often is referred to as a pass-through entity. Rather than paying tax at the corporate level, all income and deductions pass through to the shareholders, and the shareholders must pay tax on any S Corporation income at their individual rates. Whether the income to an S Corporation is paid to the physician owners as salary or as a distribution will not affect the federal or state income tax rates applied to each physician’s income. There is never any tax to the corporation; therefore there is no double taxation for an S Corporation.

## Much Ado About Nothing

Most physicians mistakenly assume S and C corporations offer the same benefits. Since the C Corporation has a potential double taxation, most doctors and their advisers choose S Corporations to avoid this problem. But the double taxation problem can be avoided easily by reducing practice profits to zero, or close to zero, at the end of the year. Also, C Corporations offer other benefits as well that far outweigh the cost (in time, not money) of zeroing out a C Corporation’s profits.

Contrary to conventional wisdom,

*Carole C. Foos, CPA, is an expert in tax analysis and tax planning services for O’Dell Jarvis Mandell, LLC, in Cincinnati. David B. Mandell, JD, MBA, is an attorney, lecturer, and author of Wealth Secrets: The Keys to Fortune Building and Asset Protection (John Wiley & Sons, 2008). Readers can get a free audio program on financial issues for doctors at [www.ojmgroupp.com](http://www.ojmgroupp.com) or contact the authors at 800/554-7233. For a free analysis of your situation to see how restructuring of your practice could help you reduce unnecessary taxes, please contact OJM at 800/554-7233. To purchase the book, For Doctors Only: A Guide to Working Less and Building More, visit [www.ojmgroupp.com](http://www.ojmgroupp.com).*

a C Corporation can be the right choice for many small entities because of the deductions it allows. The corporate deduction for fringe benefits paid to employees is generally limited for shareholders owning more than 2% of an S Corporation. But a C Corporation enjoys a full deduction for the cost of employees' (including owner employees) health insurance, group term life insurance of up to \$50,000 per employee, and even long-term care premiums without regard to aged based limitations.

The C Corporation also can deduct the cost of a medical reimbursement plan. If one has a small corporation and a lot of medical expenses that aren't covered by insurance, the corporation can establish a plan that results in all of those expenses being tax deductible. Fringe benefits such as employer provided vehicles and public transportation passes also are deductible.

In contrast, an S Corporation cannot deduct the cost of health insurance it provides to a more than 2% shareholder. Instead, the shareholder must generally take a self-employed health insurance deduction on his or her personal return. Also, an S Corporation cannot deduct the cost of long-term care premiums for these shareholders. When they take the deductions personally, the shareholders are subject to the age-based limitations.

### **Lower Tax Rates**

C Corporations enjoy their own graduated rates. The first \$50,000 of taxable income in the C Corporation is taxed at a 15% federal rate versus the top marginal rate of the shareholder (currently 35%) that the owner of an S Corporation must pay. Even if the owner of a C Corporation forgot to "zero out" the corporation and left \$50,000 in the entity, the corporate tax would be only \$7,500. A dividend of the remaining \$42,500 would be taxed at a rate of 15% (resulting in taxes of \$6,375) leaving

**What few practices know is that it is possible to take advantage of both the C Corporation and the S Corporation rules by setting up two distinct entities to operate different aspects of a practice.**

\$36,125 (or 72.2%). If that \$50,000 had been in an S Corporation and the owner had annual income over \$300,000, the federal tax rate would have been 35% (or \$17,500). In this example, leaving \$50,000 to be taxed in a C Corporation would actually have saved the owner over \$3,600 in taxes!

Personal service corporations (PSCs), such as those that attorneys, doctors and accountants use, do not receive the benefit of these graduated rates since PSCs are taxed at a flat 35% rate. Therefore, PSCs do not enjoy the same benefits that the graduated C Corporation rate structure provides. PSCs can, however, take advantage of the full expense deduction in writing off furniture and equipment in the year of purchase under Section 179. Depending on the circumstances, C Corporations may have a limit on the use of the Section 179 deduction in that S Corporation shareholders must accumulate the Section 179 deduction in each of its pass-through entities. Thus, the deduction could be limited in a given year.

If the practice has rental activity, a C Corporation which is not a PSC has the advantage of using rental losses to offset operating income. Shareholders of an S Corporation must treat rental losses as a passive activity subject to the passive loss and at-risk rules.

### **The Best of Both Worlds**

Clearly, there are advantages and disadvantages to using both the S Corporation and C Corporation structures in one's practice. What few

practices know, however, is that it is possible to take advantage of both the C Corporation and the S Corporation rules by setting up two distinct entities to operate different aspects of a practice. Perhaps the S Corporation would be used for the operations side of the practice, such as for the professional practice of medicine, while the C Corporation could be used for such management functions as billing and administration.

In this way, the practice as a whole would take advantage of both the tax deductions afforded a C Corporation and the flow through advantages of an S Corporation. Such a structure may provide some additional asset protection. As long as all formalities of incorporation are followed, as well as compliance with rules for employee participation in all benefit plans, medical practices can benefit from this dual corporate structure.

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

***Editor's Note:** The information contained in this article is general in nature and the reader should not act on this advice without getting further details or professional advice. Readers should seek specific advice related to their own tax situations from their personal tax advisers. New federal regulations require that the authors inform readers that commentary included herein does not constitute an opinion and is not intended or written to be used, and cannot be used, by any taxpayer for the purpose of avoiding penalties that may be imposed on the taxpayer.*

# Report: Large Groups Are More Efficient

A recent analysis of medical research on health care organizations suggests that larger and more organized physician groups offer the most efficient care. In essence, the analysis concludes that physician groups need to be larger, more cohesive, and more closely affiliated with each other than they are now.

In other words, the cottage industry of having largely disparate physician groups of all sizes is inefficient and contributes to some of the most difficult problems inherent in the health care system today, such as overuse, underuse, and misuse of care, the analysis shows. The analysis is contained in a report, *Physician Organization in Relation to Quality and Efficiency of Care: A Synthesis of Recent Literature*, by Laura A. Tollen, MPH, a senior health policy leader at the Kaiser Permanente Institute for Health Policy, in Oakland, Calif. The report was published by The Commonwealth Fund in New York (at [www.commonwealthfund.org](http://www.commonwealthfund.org)).

## Physicians at the Core

“Many experts believe that greater (and different) delivery system organization is fundamental to improved quality and efficiency,” the report said. For the report, Tollen summarized the recent research literature on the organizational attributes of delivery systems with a focus on physician groups, who represent the core of the health care system.

While health policy professionals agree that a more organized delivery system will help prevent underuse, overuse, and misuse of care and would foster the efficient delivery of evidence-based care, there is confusion over the definition of the term “organized delivery systems,” the report said. Also, a redesigned delivery system would require an infrastructure largely absent from the

## Fee for service payment may stand in the way of cooperation and collaboration across the delivery system.

predominant forms of physician practice today, it added.

Three specific attributes of physician groups help define them as organized delivery systems and those groups that have these attributes have been studied in the research literature, the report said. These attributes are:

1. **Cohesion.** This term describes the degree to which physicians practice collaboratively in a group, with shared purpose, performance measures, and often finances, the report said. By itself, however, the term “cohesion” is rather ambiguous, as the report showed. Nevertheless, in the literature this quality is often defined by differentiating between the so-called “true” medical groups and independent practice associations, it said.
2. **Scale.** Separate from the degree of cohesion within a practice, a minimum practice size may be required to support the necessary infrastructure for quality and efficiency improvements. The report, however, did not define a minimum practice size, and said that above a certain size, there could be some diseconomies of scale.
3. **Affiliation.** This characteristic situates the practice in a larger context, the report said. “Is the practice part of a system that can provide infrastructure support? Such a system might be created, owned, or supported by a health plan, hospital, physician group, or independent entity,” the report added. An example might be Kaiser Permanente, a managed care organization that has physicians on staff.

## Quality and Efficiency

For the report, Tollen summarized several studies that had explored the relationship of quality of care to cohesion, scale, and affiliation among physician groups. “These attributes appear to contribute to quality, although the research is not entirely conclusive,” the report said. Rather, the findings of the studies begin to provide evidence for the theory that reforming the delivery system might begin with physician group organizations. “Today, the state of that evidence is not great, but it is good enough to be intriguing and to prompt further study,” the report said.

In addition, Tollen summarized the literature on the efficiency of organized delivery systems or physician groups. The report said the literature was somewhat limited but suggests that efficiency in health care delivery varies greatly. Elliot Fisher, MD, a researcher at the Dartmouth Medical School, and his colleagues have shown that if health care providers in all regions of the country were as efficient as those in the most efficient regions, the federal Medicare program could save 30% of the total that it spends on providing care.

“The challenge for efficiency-seekers is to identify which 30% of care is unnecessary and could be eliminated safely,” the report said. “It would be naïve to suggest that any health care provider has the key to doing this correctly. Some evidence indicates, however, that multispecialty or prepaid group practices use fewer resources—or get more for the resources they do expend—than do other providers.”

## Fee for Service Failings

One of the most obvious weaknesses in the health care system is payment for physician services, a weakness that health system reformers should address, the report said. “The pure fee for service (FFS) payment model can discourage the organized, integrated care that is the hallmark of systems,” the report said. “Under FFS, physicians and hospitals are rewarded for taking actions—doing procedures, prescribing drugs, and performing tests—regardless of whether the best evidence calls for such actions. FFS may also stand in the way of cooperation and collaboration across the delivery system, as each provider has an economic interest in providing more services for the patient, rather than in collectively determining how much and what mix of care is ideal.”

But the report added that changing payment systems to reward quality and efficiency requires making two significant and challenging changes. “First, payments should reward better care,” the report said. “Schemes designed to do this include prepayment (coupled with quality measurement and reporting) and pay for performance, which builds on FFS. Second, the unit of payment should be large enough to encourage providers to seek efficient combinations of resources. A bundled payment for a complete episode of care, for example, might encourage coordination of inpatient and post-acute care.”

## Looking Forward

The report concludes that there is enough evidence to suggest improved “systemness” fosters quality and efficiency. “Until a better understanding is reached of how specific organizational attributes contribute to systemness, however, policymakers should strive to create an environment that rewards quality itself (rather than tying incentives to organizational attributes),” the report said. “An important area of focus is the payment system. No amount of

# Attributes of the Best Health Organizations

In a recent report, Laura A. Tollen, MPH, a senior health policy leader at the Kaiser Permanente Institute for Health Policy, in Oakland, Calif., described seven characteristics that are key to the performance of high-performing delivery systems. The seven characteristics are:

1. Strong physician leadership. Many of the best-known integrated delivery systems and large multispecialty medical groups were founded by strong and charismatic physician leaders, the report said.
2. Organizational culture. Shared vision, values, and sense of mission around stewardship for both individual patients and populations is critical to performance.
3. Clear, shared aims. Clarity of aims allows for meaningful performance measurement and encourages internal, transparent sharing of performance data. Shared aims also ensure that different parts of the organization are not hampering the attempts of other parts of the organization to improve quality and efficiency.
4. Governance. This term refers to an organization’s ability to set goals purposefully and implement a plan to achieve them. A board of directors, for example, can lead the organization to act collectively and intentionally to improve quality or efficiency, the report said.
5. Accountability and transparency. Accountability to employers and patients, coupled with transparency of information, help improve quality of care. Research shows that groups that have financial or other external incentives for improving quality tend to score better on quality indices.
6. Workforce selection and planning. In organized delivery systems, leaders can select providers for participation, excluding those who do not meet standards. Organized systems also can target the mix of primary, specialty, or ancillary providers toward the needs of the population served.
7. Patient-centered teams. Multidisciplinary teams of providers may provide higher quality care than individual providers can offer. As physicians organize and affiliate with other parts of the delivery system, their one-on-one relationships with patients can be leveraged to connect each patient to a team of providers and to the delivery system as a whole. The report added, however, that teams also can detract from patient-centered care because relationships with a single provider becomes less important.

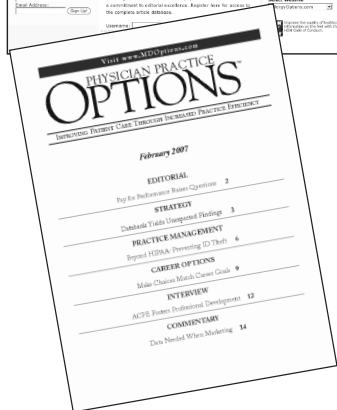
evidence of the superiority of systems will encourage providers to join group practices if payment incentives work in the opposite direction, as some do today.”

Also, while policymakers and purchasers focus on quality and efficiency outcomes, researchers should continue studying high-performing health systems to understand how

they produce value, the report said. “This work would provide a foundation for understanding how the best attributes of organized physician groups can be adapted for use in the broader, less-systematized health care mainstream,” it added.

—Readers can reach Tollen at [laura.a.tollen@kp.org](mailto:laura.a.tollen@kp.org). More information is available on our Web site (see page 16).

MD  
OPTIONS.com



**Our FREE online resource includes:**

- ▼ Strategies and tactics to build your practice
- ▼ A complete database searchable by keyword, subject, or issue
- ▼ Interaction with experts on all aspects of the Business of Medicine™
- ▼ Links to business resources, such as practice management, marketing, and CME
- ▼ E-mail updates on the latest developments in the Business of Medicine™


**E-MAIL UPDATES**

Let MDOptions.com come to you! MDOptions.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOptions.com or fill in your name and e-mail address below and fax it to us at **973-682-9077**.

**Name:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

# PHYSICIAN PRACTICE OPTIONS™

 Premier Healthcare Resource  
150 Washington St.  
Morristown, NJ 07960