

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

July 15, 2002

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Will Options Open Up in Geriatrics Care?

Media coverage of health care often emphasizes a belief that, as the population continues to age, the United States will face a shortage of geriatricians. The nature of this shortage is a matter of debate.

Some experts argue that increasing numbers of geriatricians will be needed to care for the growing number of older Americans, especially the frailest elderly; other observers contend that certain specialists and even primary care physicians will assume more of the responsibility for this care as their patients age.

Either way, geriatrics may hold interest for PCPs and other physicians looking to develop a specialized expertise.

A Demographics Issue

"We are experiencing a dramatic change in the demographics of our country," observes Keith Rapp, MD, a certified medical director and the immediate past president of the American Medical Directors Association (AMDA), in Columbia, Md. Rapp is a family physician whose practice in Houston focuses exclusively on geriatrics and long-term care medicine.

In 1900, average life expectancy was lower than it is today; currently, it is about 80 years, Rapp says. "We now face a dramatic need to care for older people, a need that did not exist before," he adds.

In reality, little geriatric care is

done by geriatricians, counters Richard Cooper, MD, a hematologist and director of the Health Policy Institute at the Medical College of Wisconsin. "Most internists are geriatricians because the elderly comprise a large portion of their patient base," Cooper says. "In fact, almost every specialist treats geriatric patients. For example, geriatric surgery is performed by general surgeons, geriatric cardiology is performed by cardiologists, and geriatric gastroenterology is performed by gastroenterologists. Although there are few geriatricians per se, the supply of geriatric care is not too low.

"The elderly represent a growing number of patients who will continue to occupy a large portion of physicians' time," Cooper acknowledges, noting that average health care expenditures per capita are under \$4,000, while health care expenditures per capita in the Medicare population reach more than \$8,000. But, he adds, it is just not practical to train a discrete group of physicians to care for great numbers of elderly patients.

"From a physician staffing perspective, there is no way to build a specific work force capable of doing any more than a tiny amount of the care that the elderly will require," Cooper asserts. "Rather, they will fall under the care of physicians generally, who will have to become skilled at dealing with some of the issues of aging. The bottom line is that physicians are going to respond to the needs of their

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Senior Citizens Face New Health Challenges

For many Americans age 50 and older, health security is out of reach, according to a new report from the AARP. The number of people in this age group who are without coverage for needed services has increased, average health care costs per person have grown, the expanded role of prescription drugs is placing a particular out-of-pocket burden on people without adequate drug coverage, and there are serious deficiencies in health care quality, says the report, *Beyond 50: A Report to the Nation on Trends in Health Security*.

For physicians, the report points out important trends about health among older Americans: People age 50 and older are living longer, for example, and generally report being healthier than their predecessors. In fact, at age 50, Americans can expect to live for 30 more years, almost nine years longer than the life expectancy in 1900, the report says. But most Americans who are age 50 and older have at least one chronic condition.

When compared with their predecessors, fewer people in this age bracket smoke, and more of them are exercising and using health services designed to prevent illness. On the other hand, the report says that a large portion of this age group is obese, and possibly as a result of rising obesity rates, diabetes has been increasing among older men and women, particularly among 50- to 64-year-olds.

Americans between age 50 and 64 tend to be more skeptical and have higher expectations about the health care system than those age 65 and older, the report says. People age 50 to 64 tend to be more demanding patients; for example, they are much more likely than those age 65 and older to want to participate actively in health care treatment decisions with their physicians. What's more, they are less likely to believe their doctors will tell them about medical mistakes, and they are more likely to use complementary and alternative medicine. Also, they are more likely to use the Internet to get medical information, the report says.

The report also points out that more people age 50 to 64 are uninsured today than was true in the past. The lack of insurance coverage is particularly troubling because total health care costs for Americans in this age bracket have risen substantially from the levels of 20 years ago, even after adjusting for general inflation, the report says. Health care costs pose a particular burden for those in need of prescription drugs or long-term care and those with low incomes who do not have Medicaid.

The message from this report for physicians is clear: Many patients in this age group are likely to want to participate more in their care, to be more informed, and to be more health conscious than their predecessors. Unfortunately, many of them will also struggle to find adequate health insurance coverage.



Richard L. Reece, MD
 Editor in chief
 Phone: 860/395-1501
 Fax: 860/395-1512
 E-mail: Rreece@premierhealthcare.com

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Publisher
 Premier Healthcare Resource, Inc.
 150 Washington St.
 Morristown, NJ 07960
 888/457-8800; 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, P.A.
 Minneapolis

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

Paul H. Keckley
President and CEO
 webEBM
 Nashville, Tenn.

Peter R. Kongstvedt, MD
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 Cap Gemini Ernst & Young
 McLean, Va.

Richard Liliedahl, MD
National Director of Clinical Economics
 Ernst & Young
 San Diego, Calif.

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 New Brunswick, N.J.

Jacque Sokolov, MD
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 Los Angeles

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Managing Director and CEO
 Townsend Frew & Co., LLC
 Investment Banking
 Durham, N.C.

Solo Practitioner Promotes Collective Bargaining in New Jersey

A number of physician practices that have amassed significant market share—thereby bolstering their bargaining leverage with managed care plans—have been prosecuted under federal antitrust statutes. In some states, efforts are underway to exempt physicians from these antitrust regulations.

One leader of this effort is George Petruncio, MD, a solo family practice physician in Turnersville, N.J. Petruncio backed a state bill—the New Jersey Joint Negotiations Bill—that would exempt physician collective bargaining from antitrust scrutiny.

Antitrust Exemption

“My activities started about three years ago, after the Texas state legislature instituted a joint negotiation bill at the behest of the Texas Medical Association,” Petruncio explains. “According to the Texas regulation, collective bargaining by physicians was allowed as an exemption from antitrust regulations as long as the contractual arrangements were reviewed by the state attorney general. I quickly realized that physicians in New Jersey could benefit from a similar regulation in our state.”

To obtain passage of the New Jersey Joint Negotiations Bill, it was necessary to secure the endorsement of the state medical society. “I introduced the issue to our county medical soci-

ety, which endorsed it for approval by the state medical society,” Petruncio explains. “The state society then approved and listed the issue as a top priority in its lobbying efforts with the state for the coming year.”

The bill was signed into law on Jan. 7, by Acting Gov. Donald DeFrancesco, and became effective March 7. It allows for voluntary negotiations between insurers and groups of physicians in New Jersey.

“It is hoped that both sides will negotiate in good faith under the review of the attorney general,” Petruncio says. “The state oversight mechanism will be set up similar to the mechanism set up for a utility, under the purview of the attorney general, who can review both sides and come to a fair resolution of the contract negotiations. “The attorney general will have to meet with the medical society’s representatives and representatives of the insurers to draft the rules and regulations for negotiations.”

New federal legislation could bring greater equity to managed care contract negotiations. In March, U.S. Representatives Bob Barr (R-Ga.) and John Conyers, Jr. (D-Mich.) introduced the Health Care Antitrust Improvements Act of 2002, which would amend federal antitrust law to allow physicians and other health care professionals in small and solo practices to negotiate jointly

with health plans. Negotiations would be evaluated on a standard of reasonableness, and patient access and quality of care would be considered in addition to the effect of any joint negotiations on competition. The law would provide for demonstration projects in certain states; under these projects, caregivers could negotiate with health plans without violating the antitrust laws.

Petruncio believes that the new state law allowing physicians to bargain collectively is a significant development in New Jersey. “The need for physicians to have greater leverage in contract negotiations would not have arisen if the insurers had been negotiating in good faith,” he says. What’s more, with Medicare reimbursement rates falling precipitously over the past several years, the problem has been exacerbated because many commercial health plans base their reimbursement rates on Medicare rates.

Monopoly Power

Other states, such as California, are known for having a few major HMOs that can exert control over physicians during contract negotiations. A similar situation is true in New Jersey, Petruncio says.

The federal government has antitrust oversight and can prosecute corporations that have amassed

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“The need for physicians to have greater leverage in contract negotiations would not have arisen if the insurers had been negotiating in good faith.”

—George Petruncio, MD, solo practitioner

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monopoly power in certain markets, but it has not adequately explained how a geographic region is defined for purposes of determining excessive market share, Petrucio contends. "There has been selective prosecutions of physicians—a few hundred cases nationwide—in which physicians have been determined by the government to have amassed excessive market share," he says. Perhaps the Federal Trade Commission should pursue antitrust prosecutions against insurers that have a concentration in certain markets, he adds.

centration of market share in more than 50% of the major city markets and in more than 40% of all markets.

Struggling to Compete

The ability to bargain on a level playing field is crucial to all physicians, and especially to family physicians, says Petrucio. "Family physicians may fade into oblivion because their total overhead is approaching 65%, making the business of family practice extremely difficult financially," he says. "Eventually, many patients will be cared for by nurse practition-

will begin to affect physicians in New Jersey. "The malpractice rates are tripling in Pennsylvania, causing physicians to leave that state and relocate to New Jersey," he says. "This trend means increased competition and possibly lower contract rates for New Jersey physicians."

Politics and Policy

Politics will shape the collective bargaining issue, medical malpractice reform, and other issues affecting physicians, Petrucio contends. Some members of Congress are reluctant to support patients' rights legislation because doing so could mean losing the support of the insurance industry, he explains. "But the situation will ultimately be resolved because the American public will demand safe and high-quality care," he says.

Despite the problems plaguing health care, Petrucio believes that the public will not support a move to a government-run health system. "The American public will not tolerate the waiting times that occur in a socialized system, in which individuals must be put on a waiting list for procedures," he says. "The public is certainly frustrated with the current system, but people will never want to give up direct access to care or allow the government to hold their health care records."

There are more effective ways to control rising costs, Petrucio says, pointing to the salaries of health care executives as an example. "The annual salary of one executive at a large health care plan is \$54 million and his stock options are worth \$357 million," Petrucio says. "Health care industry dollars are not all spent on health care. The HMO industry is largely for profit. It runs by the rules of corporate America, which rewards its top executives lavishly."

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

"We will end up with a two-tiered medical system, with the more affluent individuals having direct access to the physician and the individuals who are not as well off being seen by another caregiver," says Petrucio.

At least one insurer has market share of more than 55% in several New Jersey counties, Petrucio says. "Such levels of market share raise concerns over how the FTC determines what constitutes a violation of antitrust law," he asserts. "But the New Jersey Attorney General's Office cannot investigate that monopoly position because such an investigation must be handled on a federal level."

Most major metropolitan areas have a dominant insurer that has amassed significant market share and therefore could be construed to have monopoly power, says the AMA. After using the federal government's preferred measure of market concentration—the Herfindahl-Hirshman Index—to demonstrate the market strength of health plans, the AMA found that in 40 large urban markets with a population of more than one million and in 19 less densely populated states, health plans had a high con-

ers or physician assistants, rather than by family physicians. Insurers wish to decrease the cost of care without regard for the quality of care. We will end up with a two-tiered medical system, with the more affluent individuals having direct access to the physician and the individuals who are not as well off being seen by another caregiver."

The recent congressional cut of 5.4% in Medicare fees hits family practice physicians hard, Petrucio says. The cut is particularly worrisome because the formula for calculating Medicare fees is derived from the Gross Domestic Product, he explains. "Since there has been a projected decline in GDP, fees are declining," he says. "In fact, the real decline may be higher." Any cuts in Medicare rates affect rates that other insurers pay.

The increase in malpractice rates also is a serious concern, says Petrucio, who believes the malpractice insurance crisis in Pennsylvania

Here's What Physician Groups Can Do to Prepare for HIPAA

By Donna Padnos

All physician groups should be thinking about and planning for the effects that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will have on their practices. Their planning should encompass the administrative, operational, and clinical changes required under the law.

Under the act, a physician group is defined as a covered entity if it electronically transmits or receives one or more of the designated HIPAA transaction sets. These transmissions may be made directly or indirectly through a billing service or a clearinghouse. This definition of physicians and providers as covered entities applies to the privacy and security components of HIPAA.

Currently, a physician, group, or clinic may not be defined as a covered entity under HIPAA. A physician, group, or clinic may not be required to comply with the privacy and security components of HIPAA if none of the specified functions is conducted electronically (meaning the group uses only paper, the fax, or a telephone to store and send infor-

mation) or the method of reimbursement does not require use of any of the transaction standards. However, all physician groups, regardless of whether they are covered entities, should understand the basics of the HIPAA transactions and code sets.

mandate the use of electronic claims or make it good business sense to do so.

Privacy and Security

Patients expect the same standards for confidentiality and protection of their medical data regardless of

Physician groups should understand the basics of the HIPAA transactions and code sets and be knowledgeable about the principles of its privacy and security regulations.

They should also be knowledgeable about the principles of the HIPAA privacy and security regulations and be aware of the effect these regulations have on their practices.

The Effect on Groups

Beginning Oct. 16, 2003, the Centers for Medicare and Medicaid Services will require all physicians and other providers with 10 or more full-time employees to file Medicare claims electronically, unless extenuating circumstances prevent them from doing so. This requirement will cause some physicians to become covered entities if they want to receive payment for services they provide to Medicare patients.

HIPAA requires the elimination of local codes; and as new codes replace local codes, payers may begin using one set of codes for both electronic and paper transactions. All providers will have to make changes to their billing systems to accommodate the new codes. In some states, such as Utah and New Jersey, state regulations are establishing standards that either

whether their physicians are defined as covered entities under HIPAA. An individual has no cause of action in court if his or her rights are violated under HIPAA but can sue under state law. Courts may apply the privacy rule as the standard of care for privacy and security violations.

Although the components of HIPAA are being promulgated by the federal Department of Health and Human Services piecemeal and not all of the elements are complete, some items and dates have been finalized. The compliance date for standard transactions, code sets, and identifiers is Oct. 16, 2002. A covered entity may apply for an extension until Oct. 16, 2003, to be in compliance with the transaction-related rules. Entities should apply for this extension for two main reasons.

First, HIPAA readiness requires programming, modification, and testing by software vendors, clearinghouses, and payers (called trading partners) for the exchange of the standard transactions in the ANSI X12N format specified by HIPAA. If

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Donna Padnos is a senior management consultant with Superior Consultant Co., in Southfield, Mich. She has more than 20 years of health care management experience with physicians' groups and teaching hospitals. Her interest in HIPAA began in 1993 when she served as a member of WEDI (Workgroup for Electronic Data Interchange); now she provides educational workshops and assessments on HIPAA to physicians and other providers.

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any of these organizations are not ready by Oct. 16, 2002, the provider will have to rely on current, possibly noncompliant, formats and codes to continue to conduct business with its trading partners. Coordination and interoperability will be difficult until all the covered entities are working under the same set of guidelines, which must occur by Oct. 16, 2003.

Second, modifications, called "addenda," to the approved implementation guides for the HIPAA standard transactions have been proposed, but not published. In addition, the industry recognizes the difficulty of replacing the J codes (except for retail pharmacy) with the 10-digit

Vendors and Clearinghouses

Given that some of what's required for HIPAA is not yet in place, here's what a physician group can do now:

- Complete and file the Administrative Simplification Compliance Act (ASCA) extension form.
- Communicate with the vendor for your practice management system and the clearinghouses you use. Understand the changes being made to accommodate the standard transactions and code sets and their plans for a testing program to validate these changes.
- Determine the compliance status of your major payers. Obtain your payers' companion guides and work

and the risk to the organization of a privacy or security breach. Risk may involve issues related to patient care, the organization's reputation, finances, data and information, operations, fines, or any other legal or regulatory violation.

This spring, the government published proposed modifications to the privacy standards. If approved, these changes would have the following effects:

- The existing mandatory requirement for consent for treatment, payment, and health care operations will become optional.
- Patients will be asked to acknowledge receipt of the notice-of-privacy practices.
- An individual's authorization will be required before a group can send that person marketing materials. This requirement will not impair the ability of providers to discuss treatment options and other health-related information.
- The time for providers to change existing business associate agreements will be extended by one year (until April 14, 2004).
- Researchers will be able to use a single combined form to accomplish both HIPAA and informed consent objectives.
- State law and professional judgment will govern disclosures to parents about their child's medical records.
- A single type of authorization form could be used to obtain a patient's permission for a specific use or disclosure that otherwise would not be permitted under the privacy rule.
- Providers could disclose protected health information for the treatment, payment, and certain health care activities of another entity or health care provider.
- Disclosure of information will be permitted to nongovernment entities about the quality, safety, and effectiveness of FDA-regulated products and activities.

One of the privacy requirements provides for "administrative, physical, and technical safeguards" of patient protected information, and thus links the privacy rule to the security rule.

NDCs (national drug codes) for describing medications in billing. Most physician practice management systems cannot accommodate the NDCs. Secretary of Health and Human Services Tommy Thompson has agreed to repeal the requirement for NDCs, but the repeal has not yet been published.

Declaring oneself compliant by Oct. 16, 2002, means using the currently approved implementation guides for the designated electronic transactions and using the NDCs in those transactions. It would be better to wait until all of the proposed modifications are published and effective, and then test and implement all of the changes to the systems generating standard transactions. By now, however, planning and programming should have already begun in order to execute aspects of the standard transactions and code sets that are not expected to change.

with your vendor and clearinghouses to ensure that their systems can properly handle the allowable payer-specific requirements.

- Conduct a cost-benefit analysis to determine the value of using the electronic transactions.

Rule Revisions

Under HIPAA, all physicians and other providers will need to comply with the privacy requirements by April 14, 2003. In light of these requirements, every physician group, whether or not it is a covered entity, needs to conduct some form of due diligence, education, and assessment. Physicians will find the privacy and proposed security standards can be reasonable based on the type, size, and scope of the covered organization. The type and number of remediation activities will depend on the financial, technical, and personnel resources available to make changes

Nine Steps to Take Now

For physician groups seeking to comply with the privacy requirements of HIPAA, here are nine steps to take now:

1. Appoint a privacy officer to coordinate and oversee the HIPAA activities.
2. Find a respected source for ongoing HIPAA information, since this is a developing activity.
3. Look to professional associations for assistance, since they will provide interpretations of the HIPAA requirements that affect the group's medical specialty.
4. Name the HIPAA contact person and expand the group's patient grievance process to include the complaint process required under HIPAA.
5. Design and implement a training program on HIPAA for all current and new employees that relates to the group's type of organization in terms of content and method of delivery. The group should be sure that all employees and medical staff understand how the HIPAA requirements affect their roles in the group's setting. Although not required, it is a good idea to have each person sign a certificate of completion following training, as well as a confidentiality agreement.
6. Understand the flow of patient information for use and disclosure. Ensure that the staff responsible for the release of information know when a consent form or authorization form is required from a patient or a patient's representative. Devise a method to track specified disclosures of protected health information in order to respond to a patient's legal request for a log of such disclosures.
7. Develop procedures for patients to access or obtain a copy of their medical records; to request an amendment of their medical records; to request confidential communication; and to request

Key HIPAA Dates

- *Oct. 16, 2002*: Compliance date for standard transactions, code sets, and identifiers
- *Oct. 16, 2003*: CMS compliance date for all physicians and other providers with 10 or more full-time employees to file Medicare claims electronically, unless extenuating circumstances prevent them from doing so
- *Oct. 16, 2003*: Deadline to be in compliance with the transaction-related rules for those entities that got an extension.
- *April 14, 2003*: Deadline for all physicians and other providers to comply with the privacy requirements
- *April 14, 2004*: Deadline (if approved) for extension for all physicians and other providers to change existing business associate agreements

restrictions on the use and disclosure of their medical information for treatment, payment, or health care operations.

8. Establish the notice of privacy practices and determine the means of distribution.
9. Compile a list of business associates; prepare an addendum to these contracts and execute this addendum as the contracts are renewed.

State Preemption

When more stringent legislation applies, it is necessary to understand the applicable state statutes and regulations and the effect of preemption. More stringent legislation requires greater protection of health information or provides greater rights of access or of amendment to one's own records. Since this is a complex issue, physicians and medical groups should work with the state medical society or other local or state organizations in comparing federal HIPAA requirements regarding state legislation for protection of patient information and access by patients to their information.

The proposed HIPAA security rule was published in August 1998 and requires that appropriate measures be established to maintain the confiden-

tiality, integrity, and availability of identifiable patient information. One of the privacy requirements provides for "administrative, physical, and technical safeguards" of patient protected information and thus links the privacy rule to the security rule. As of late May, the security rule had not been finalized, but physicians should implement standards of good practice to ensure the security of protected health information and of the equipment and networks used to store and transmit these data.

A provider organization that is well run with established policies and procedures for the use and disclosure of patient information and respect for the confidentiality of protected health information will have to take fewer steps to prepare for HIPAA than organizations that lack these policies and procedures. In addition, a provider organization that is already maximizing the use of electronic transactions with its payer partners understands the benefits in terms of improved cash flow, reduced accounts receivable, and decreased staff time and overhead for billing and collection activities. In effect, HIPAA offers physician groups and opportunity to improve practice operations. ■

Systems Provide Efficiency Returns, Physician-Researcher Reports

Intermountain Health Care, a large health care system in Salt Lake City, has achieved significant financial and quality benefits by pursuing computerization. These benefits have been achieved in part through the efforts of the Institute for Health Care Delivery Research, a research arm of the health care system that focuses on cost-effective, high-quality methods of health care delivery.

Such a focus on health care delivery is especially important for a large system like Intermountain Health Care, which includes 22 hospitals and almost 100 clinics. Of the core group of 1,200 physicians, who provide about 95% of all inpatient and outpatient care delivery, approximately one third are employed in

offers lessons for physicians in practices of all sizes.

Lessons Learned

“The Institute for Health Care Delivery Research began in 1989,” says Brent C. James, MD, vice president for medical research and continuing medical education and executive director of the institute. “We conduct operational, health care delivery research that directly benefits patients who are treated within Intermountain Health Care. That is, we conduct research in support of care delivery. We examine the cost of care, medical outcomes, and strategies for delivering care efficiently and effectively. We also run a series of training programs designed to teach quality improve-

our return on investment for clinical improvement projects to date has been quite positive—for many projects, in the 5-to-1 and 10-to-1 range. We have been able to prove that our clinical improvement strategies have reduced costs of operations.”

The financial return did not come easily, however. “The one problem we encountered—a problem that required a very carefully coordinated solution—was that our revenue dropped as far as or further than our costs did,” James notes.

“Perverse payment mechanisms created windfall profits for major purchasers, whether they were insurers or self-insured employers,” James continues. “We had to devise strategies that would allow us to bring

“Because quality improvement can significantly lower costs, our return on investment for clinical improvement projects to date has been quite positive—for many projects, in the 5- to- 1 and 10- to- 1 range.”

Intermountain’s physician division. The system contracts with an additional 1,800 physicians who either have privileges within IHC facilities or provide care to patients of IHC health plans. In addition, the system maintains an extensive patient transport network, a durable medical equipment group, a home health division, and a major purchasing collaborative. With an annual budget of more than \$2 billion, IHC supplies more than 50% of all clinical care delivered in the region.

While IHC is a large operation, its experience with computerization and with the return on investment that is possible from information systems

ment methods to administrators, clinicians, and technicians at every level of our company.”

James is a co-author of the Institute of Medicine’s report, *To Err Is Human: Building a Safer Health System* (National Academy Press, Washington, D.C., 2000). He is also a biostatistician who holds a master’s degree in statistics, training that has honed his focus on improving quality and cutting costs.

“Clinical quality improvement has become Intermountain Health Care’s strategic focus, and this has been a very successful business strategy,” James says. “Because quality improvement can significantly lower costs,

some of those savings back to our institution so that we could afford to continue our efforts. We have been fairly successful, but it took a degree of coordination between our clinical teams and our administrative teams that we had never attempted before.”

Efficient Implementation

High-quality care can create attractive financial returns, but achieving that level of care is often difficult. Physicians today confront new developments at the same time that managed care is putting pressure on practices to improve efficiencies. For example, the complexity and volume of medical advancements have cut

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“If we have a treatment that we know works, we should build that implementation into daily routine operations, freeing up physicians to deal with the complex, difficult issues in which they are customizing care to an individual patient’s needs.”

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into physicians’ time significantly. In general, the ability to practice high-quality medicine has become much more difficult and time consuming as medical knowledge has expanded exponentially, James explains.

“We have continued to add more scientific knowledge that can be applied in medical practice,” James says. “When I graduated from medical school 25 years ago, I had to understand the details of fewer than 100 medications. That knowledge base alone has increased by at least a factor of five during my lifetime, so that now I need to maintain solid knowledge of perhaps 500 medications in order to function effectively as a physician.”

Electronic Reminders

To address this trend, tools such as electronic reminder systems can help physicians practice more efficiently. “At IHC, we use reminders repeatedly and other strategies as well to improve quality of care,” James explains. “Reminders are an important support mechanism for overburdened physicians. It is simply unreasonable to demand that physicians remember everything they need to know, given the large scope of medical knowledge. The human mind is limited relative to the difficult, complex task of the practice of medicine.”

To illustrate this point, James notes that a study done in 1956, but not widely appreciated until recently, demonstrated that the best educated, well-trained, and well-rested physician can handle a maximum of between seven and nine factors in making a clinical decision. “In the early 1900s, that scope of factors was

pretty reasonable,” he says. “Today, it is hard to find a single area of practice in which a physician would not be required think of 10, 12, 15, or even 40 different factors in trying to choose a course of treatment for a patient.”

James says that health care expert David Eddy, MD, stated the problem succinctly when he said, “The current practice of American medicine exceeds the capacity of the unaided human mind.”

The limitation of the human mind is why the IOM’s report, *To Err Is Human*, emphasized that medical errors result from system failures. “If we have a treatment that we know works, why should we leave its implementation up to the recall of a harried physician?” James asks. “Rather, we should build that implementation into daily routine operations, freeing up physicians to deal with the issues that require their level of input—the complex, difficult issues in which they are customizing care to an individual patient’s needs. Reminder systems can help achieve that outcome.”

Still, James notes that the clinical informatics that enable computers to support decisionmaking is at best in its late adolescence. “It has been only in the last five or six years that we have developed clinical information systems to the point where we can build an effective electronic medical record,” he says. “We had previously developed bits and pieces, but we had not worked out the more complex, operational issues, such as how to structure the record and how to implement it. As everyone knows, it’s not just a matter of buying computers and putting them in hospitals. We need to make it possi-

ble for physicians to enter, review, extract, and organize data in order to support their decisions.”

Coding offers a clear example. “I know of about 15 or 20 different coding schemes for representing clinical experience, diagnosis, and treatment—for example, CPT-4 and ICD-9-CM codes,” James explains. “An entirely different set of coding schemes is used in Europe. The problem is that none of these coding systems is satisfactory. None does a decent job of fully describing the clinical experience of physicians. What’s more, they are massively complex in their own right; two or three physicians using these coding systems to describe their clinical experience will very often use different codes for the same treatment. The result is inconsistency.”

Coding Complexity

Coding is such a complex endeavor that health systems have not yet been able to build a closed system to describe the entirety of clinical experience, James believes. However, IHC has been making progress in this area.

“Over the last few years, we have realized that instead of investing massive amounts of time and money to develop a generic and all-inclusive system, we should develop codes for a subset of major diseases and generate a functioning system that works on a clinical level,” he says. “We analyzed key processes of clinical care and found that 62 conditions, among an initial list of more than 600 conditions, account for about 93% of all care delivered in our hospitals. We have started to focus on those rela-

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patient population. As the population ages, physicians of all specialties will respond to those needs.”

Specialty Skills

The development of the skills needed to treat elderly patients will involve an education process for all physicians. Cooper, who is 65, notes that when he attended medical school students were not trained in the care of 85- or 90-year-olds because most people did not live that long. “Along the way, we have had to learn the special circumstances represented by these patients,” Cooper says. For patients with special needs, geriatricians fill a crucial role.

“A small group of physicians with a particular interest in the care of the

the effect of multiple diseases on an individual, Rapp points out. “Also, geriatricians are particularly helpful in polypharmacy, the use of multiple medications for individual patients,” he says. “In some nursing homes, the average patient may take nine or more medications. Therefore, close monitoring of each patient’s drug regimen is required. Geriatricians are trained to focus on the problems of interaction with all of the medications prescribed by all of the patient’s doctors.”

As physicians face difficult issues involving the care of the elderly, they will need geriatricians who can offer advice and guidance. “Enough of these complex cases will arise in each community to keep a few geriatrici-

to the referring physician, who can learn by seeing the geriatrician’s recommendations. Much education about geriatric patients comes from these interactions. All physicians who treat a large number of older patients should take advantage of continuing medical education programs that focus on geriatric patient care.”

The AMDA has several initiatives to help educate physicians in geriatric care. “One recent project has involved developing a curriculum for attending physicians in nursing homes,” says Rapp, who served on the association’s education committee. “We are rolling out that initiative in pilot projects now. Eventually, we hope to offer that curriculum to other organizations, such as the American Academy of Family Physicians. This will serve as a formal opportunity to help other physicians practice more effectively in the nursing home environment.”

Geriatrics in Practice

Cooper advises physicians who want to enhance their care of the aging population to collaborate with nurse practitioners. “Most physicians will not materially increase their patient base simply by highlighting themselves as being involved in the care of the elderly,” he says. “Rather, what elderly patients want is someone to talk to them. That role is increasingly being filled by nurse practitioners. After all, people can become confused as they age, and the elderly tend to have multiple diseases and medications—so they have more to get confused about. They need someone who can help guide them through the complexities of their lives. This kind of service draws elderly patients to a practice and maintains their loyalty.”

Some primary care physicians, whether through perceived professional opportunities or personal interest, are pursuing training in geriatrics.

“In fact, almost every specialist treats geriatric patients. Although there are few geriatricians per se, the supply of geriatric care is not too low.”

**—Richard A. Cooper, MD,
Medical College of Wisconsin**

elderly can help guide the rest of us,” Cooper says. “Geriatricians focus a light on the special issues of how diseases have manifested in the elderly and how this population should best be treated. There are specific care issues that are different in the elderly and require special attention. For example, some medications react differently in older individuals, and the healing process is different. Myriad considerations become important as people become older, and all physicians have to be cognizant of that fact. Geriatricians offer a great service by studying the special problems of the elderly and highlighting issues that all physicians must deal with.”

The geriatrician has the advantage of focusing only on geriatric syndromes, which may be the result of

cians busy, but not very many,” Cooper believes. “Some physicians can take advantage of this opportunity. Physicians who have an interest in geriatrics can learn about these issues and market themselves by highlighting their special knowledge in order to get referrals.”

Since so many of their patients in the future will be older, primary care physicians and specialists may wish to take advantage of the knowledge geriatricians have to offer, as well as educational programs focusing on geriatric care.

“Some geriatricians set up a geriatric assessment clinic that accepts referrals from other physicians,” Rapp says. “Also, when complicated geriatric patients are referred to them, geriatricians provide a report

"The number of geriatricians is increasing steadily, but it will take some time to catch up with the growth in the number of elderly people," says Rapp. "Today, eldercare is performed mostly by family physicians, general internists, and specialists. But family physicians and internists who receive extra training through geriatric fellowship programs enhance their skills in taking care of the frailest elderly, who have multiple chronic illnesses." Geriatric fellowship programs are one or two years long and require participants to be board eligible in either family practice or internal medicine, Rapp adds.

Rapp's practice, Geriatric Associates of America, is a group private practice model of physicians and NPs who provide medical care, advanced practice nursing, and medical direction to 77 nursing facilities, two hospices, and 3,000 residents. The group also serves as an educational training site for programs in family practice, internal medicine, geriatric fellowship programs, and nurse practitioner training.

Practice Rewards

For many physicians, income may be perceived as a barrier to pursuing geriatrics. "Even after going through a geriatrics program, a physician does not realize enhanced income from Medicare," Rapp explains. "However, job opportunities may be available in hospital systems or private practices that would not be open to physicians who have not gone through formal geriatric training. These geriatric-specific job opportunities are compensated at or better than typical family practice or internal medicine opportunities."

There are other rewards to geriatric practice, as well. "A primary care physician has to know something about many different medical specialties without ever being the final authority in any specialty," Rapp notes. "A PCP who becomes a geriatrician becomes a specialist with a knowledge base that other specialists do not have."

trician becomes a specialist with a knowledge base that other specialists do not have."

Patient Satisfaction

Patients and their families welcome the work of geriatricians. "Elderly patients, including nursing home residents and their families, are tremen-

care. Always, something can be done to help the patient, even when the illness can't be cured."

Finally, physicians may be interested in geriatrics because the issues in this specialty will at some time affect them personally. "Geriatrics is the ultimate adventure for all of us," Rapp observes. "If we are lucky, we

"Job opportunities may be available in hospital systems or private practices that would not be open to physicians who have not gone through formal geriatric training."

**—Keith Rapp, MD,
Geriatric Associates of America**

dously appreciative of help during this difficult time," says Rapp. "This deep appreciation is a very gratifying aspect of the care that we render."

Geriatric care is an important and valued part of medicine, Rapp continues. "There is an art to caring for end-of-life patients and to providing comfort in a compassionate way," he says. "The flawed perception of some is that because a patient has an incurable illness, nothing can be done for that patient. But there are tremendous opportunities to improve quality of life even for patients who have incurable diseases. The goal in this time of life is to optimize function and to provide aggressive comfort care even when the illness cannot be cured."

In fact, few illnesses are totally curable, Rapp notes. "Medicine is overwhelmingly the management of chronic illnesses," he says. "But because an illness can't be cured does not mean that the endeavor is not worthwhile. Even at the end of life, when the chronic condition can't be improved or stabilized, the focus shifts to palliative care, helping the family accept what is happening, and aggressively trying to provide comfort

will all end up being geriatric patients. Seeing how patients age may affect us from a personal standpoint, since we all will be dealing with these issues. How to optimize our function as long as we can is a worthwhile endeavor. This fact often enhances interest in the geriatric specialty."

Rapp's own practice, which focuses on nursing home care, also offers lifestyle benefits for physicians. "Our group of 11 physicians and 11 NPs is purely an outpatient practice," he says. "As a result, each physician is on call only four weekends a year and two nights during the month."

Rapp believes that the future of the geriatrics specialty is bright and will grow as the need expands. "The need for more formally trained geriatricians will increase," he says. "But the care of geriatric patients will predominantly be delivered by physicians who do not have geriatric training. Therefore, there is a tremendous need to improve geriatric training for nongeriatric physicians, particularly PCPs."

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

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tively few conditions. We should be able to describe certain ones, like labor and delivery or heart disease, fairly accurately, or at least sufficiently, with a coded computer system.”

Unfortunately, many physicians are so overburdened by their daily time commitments that they cannot focus on enhancing practice efficiency through computerization. Exacerbating this problem is that many computer systems are not yet user-friendly enough to meet physician needs.

“Physicians find that they are overwhelmed by their patient volume, but their current computer systems are inadequate to manage this volume or to offer greater efficiencies to medical practice,” says James. “The systems

are given a computer system that allows them to do what they want to do anyway, do it a little faster and a little easier, and do it at a lower cost, they buy into it quickly and completely.”

Recognizing the value of electronic medical records, IHC is accelerating the use of these tools, James says. “We were one of the first large organizations worldwide to start to use EMRs,” he says.

“More and more, our physicians are using and embracing the system,” James says. “They are becoming the main driver for more changes. Once physicians recognize that the appropriate use of the computer boosts their productivity and their profits

and eliminates compliance fears, the electronic medical scales will tip.”

Cultural Barriers

Clear financial benefits are not always enough to promote computerization; often, a physician group or health system must overcome important culture barriers as well. “About one third of our core physicians are employed by IHC, while two thirds are independent, community-based physicians,”

“Once physicians recognize that the appropriate use of the computer boosts their productivity and their profits and eliminates compliance fears, the electronic medical epidemic will tip.”

that are currently available simply do not give the right information in the right format when it is needed. We have repeatedly seen physicians who would not turn from one documentation system or written chart or a computer screen to a separate computer screen to pull up an information support system. The reason they would not do this is because of their patient load. They felt they were too busy to take those few extra steps, given that they believed that they already had adequate medical knowledge in their own minds. It is difficult to overcome this perception.”

Unneeded Steps

If a computer system adds extra steps, and there is not a clear immediate benefit either to the patient or to the physician, then physicians will not perform those extra steps, James believes. “Long-term, unseen benefits will not drive behavior change,” he says. “As a result, we must design clinical systems carefully. If physi-

and eliminates compliance fears, the electronic medical scales will tip.”

In fact, physician attitudes can promote the accelerated adoption of information technology. James offers an example to illustrate his point. “One of the surgeons on staff is a division director, and she is an effective, excellent operations leader,” James explains. “She is also very conservative in terms of expenditures and will not approve an expenditure unless she knows what the return will be.”

Several years ago, IHC began using clinical workstations with its outpatient EMR system as part of a long-term clinical computerization strategy. “We knew that it would pay off financially over the long term, but over the shorter term the investment would definitely be heavy,” James explains. “She understood the strategy and approved it, but she was not pushing for it to happen.”

What finally changed her perspective was that she saw how the clinical computer system could improve effi-

ciency, James says. “Then she started to push the clinical workstation hard, and that’s when I knew we were over the hurdle,” he adds. “At the same time, we got smarter about how we rolled out the clinical workstation to the physicians, so that they could plainly see that the advantages outweighed the disadvantages.”

While many obstacles were overcome, others remain, James concludes. But clearly the health system has seen a return on its investment and has recognized that computerization will improve care and physician satisfaction in the future.

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

Physician-Consultant Outlines Steps to Improve Distressed Hospitals



Richard Vernick, MD, FACC, is a senior vice president and principal with the Hunter Group, in St. Petersburg, Fla. Vernick received his MD from

Thomas Jefferson University in 1967, and he trained in internal medicine and cardiology at the Peter Bent Brigham Hospital and the Harvard Medical School in Boston. This interview was conducted by Richard L. Reece, MD, editor in chief.

Q: You are a principal consultant with the Hunter Group. What is the Hunter Group?

A: The Hunter Group is a consulting company of about 50 people who are physicians, finance executives, operation executives, and nurses. We consult with hospital systems, individual hospitals, and medical groups, and provide consulting services, process improvement plans, and interim management. We are probably best known for our efforts to turn around distressed hospitals, but we also provide proactive help for hospitals that do not want to become distressed.

Q: What led you to choose this type of career?

A: I'm a cardiologist who actively practiced for more than 25 years. I became involved in the administrative aspects of medicine through the group that I started in West Bridgewater, Mass., in 1975. That group grew from two physicians initially to 15 by the time it merged in 1992 with another group of 15 to become a group of 30. Also, I was on the board of directors of several

HMOs as well as my local hospital in the Boston area. When the opportunity came to spend more time in the organizational and administrative side of health care, I took advantage of it. I made this switch when I was 53, and I have been doing this for six years.

Q: How does what you do now differ from what you did when you were practicing medicine?

A: In medicine, you often look for a unitary cause of a given disease. In the case of hospitals and medical clinics, there usually is no single cause and no single solution, but rather multiple causes that require a solution that is the sum of all the fixes.

Q: Would you recommend consulting as a career option to other physicians? If so, what type of physician would be best suited to consulting?

A: Most of the physicians in the Hunter Group are in the latter

stages of their career. Above all, we want experienced physicians. It's very difficult to be credible as a physician consultant unless you have had experience in practice and in hospital work. So I would encourage physicians to practice medicine for most of their career and consider consulting as an end-of-career option.

What's more, the work is very intensive and requires concentrated teamwork by everyone involved. Each project is a large-scale effort because we want to turn things around as quickly as possible. This strategy is generally better for the institution, since what we do can be very disruptive to its staff. Frequently, these institutions are in deep trouble and the medical staff has only a limited amount of patience for getting the problem fixed, otherwise they are going to bail out.

Q: What do you do as a consultant to improve the processes and to rescue distressed hospitals?

A: To make an analogy, if you think of the hospital as the patient, the question becomes: How do you treat the patient? The treat-

“It's very difficult to be credible as a physician consultant unless you have had experience in practice and in hospital work.”

ment depends on the disease, which involves diagnosing the patient to figure out what's wrong. With institutions and medical groups, that can be anything from lousy contracts, to bad management, to poor billing practices, to inefficient operations, to high costs.

The first step in the diagnostic process is to identify the problem, the second step is to recommend an implementation process to fix it, and the third step is to implement that process. If the institution doesn't have the resources to do the imple-

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mentation on its own, it hires us for a brief time to help. We call this the implementation support role.

Sometimes we find that the best solution is to get the physicians back into private practice, where they will be responsible for the bottom line yet remain friendly with the hospital and continue to use the hospital as a resource.

Q: Sometimes you have to make some hard decisions in your work, don't you?

A: It depends entirely on what's wrong. In some instances, you can play the role of a plastic surgeon, and simply tell the hospital that it has to enhance its revenue with a few simple cosmetic measures. In other instances, the diagnosis is gangrene and you have to cut off a leg. When it comes to institutions with bloated expenses that have to be trimmed, downsizing is never pleasant. Often, the infrastructure was initially the right size but the revenue has shrunk, and it is necessary to downsize in order to adjust to the new business realities.

Q: It is a lot easier to grow an empire than it is to shrink it, isn't it?

A: That's absolutely right. And sometimes you have to shrink before you can regrow, and you may have grown in the wrong direction. In that case, you have to wait until you are financially solvent to expand in the right direction.

Q: In the good times, when reimbursements are high, some weaknesses can be concealed. Then, when something happens, such as passage of the Balanced Budget Act of 1997 or deeper managed care penetration, the fault lines are uncovered. Isn't that true?

A: Yes, margins become thinner, and in a thin margin business,

you have little room for error. Frequently, the expenses are fixed, and you can no longer feast on what's left over. Also, what's left over may have shrunk to nothing or negative numbers.

Q: About 30% of the nation's 5,000 nonprofit hospitals are losing money. Would you agree, then, that it is currently a tough time for these hospitals?

A: Yes, particularly in areas with deep managed care penetration. Hospitals have a tough time passing on rising costs to someone else. The other problem is that institutions try to catch the capitation wave, and the wave never hits, or they didn't understand it in the first place, such as the contracts or the infrastructure requirements involved. In fact, hospitals often don't understand the differences between managing a total population and managing individual patients.

Q: Does your firm get involved in advising hospitals on mergers and acquisitions?

A: We're involved in those too, including taking apart mergers and acquisitions that were put together by others. These "demergers" occur because significant expenses were incurred in trying to consolidate two different systems in two different institutions, resulting in inefficiencies, rather than the hoped-for efficiencies of scale. After the merger, the larger scale has led to even more investment rather than to savings being realized. What's more, there are often cultural clashes between the two organizations that we need to contend with.

Q: How often are the problems of distressed hospitals rooted in the

cultural dissonance between the hospital administrators and the medical staff?

A: Quite frequently. We've seen situations in which physicians are being squeezed and are taking profitable services from the hospital. We've also seen situations in which antagonism develops between the administrators and the doctors. In these cases, the doctors who are "splitters"—that is, they admit to more than one hospital—simply transfer their business to other hospitals. This situation can cause serious or insurmountable damage to the remaining hospital.

Q: Of America's 700,000 physicians, I am sure many are in distressed institutions. What constructive actions can these physicians take to save their hospitals?

A: Hospitals frequently lose sight of what they're there for and who should be running them. Sometimes hospital management goes awry, and the boards that are charged with fiduciary responsibility to the community need to become more involved to make sure that management is serving the community in an appropriate way.

To answer your question more directly: I think physicians who perceive that management has gone astray should communicate and work with the board to correct the situation. In instances where the management is well intentioned but ineffective, physicians can play a role in encouraging management to do the right things, which the physicians often recognize but are silent about.

Q: As a physician consultant, what is your role in dealing with the medical staff?

“Sometimes the best solution is to get the physicians back into private practice, where they will be responsible for the bottom line yet remain friendly with the hospital and continue to use it as a resource.”

“There has been a misunderstanding by hospitals of what it takes to run a low-margin practice. A physician practice is a close-to-the-vest business, but hospitals frequently put many amenities into the practice, which makes it less efficient.”

A: In the first place, the medical staff usually knows the diagnosis. Almost always, they know what’s wrong. My first step is to interview the medical staff extensively and glean from them what their perceptions of the problems are. The problem is in not implementing the solutions and not having the guts to make the tough decisions that everybody knows have to be made to bring the institutions back to health.

Q: *What are the common problems that the physicians know but that the hospital management or its board does not?*

A: Often, all sides are aware of the problem, but they are unwilling to tackle the political realities required to deal with it. For example, physicians often know if certain services in the hospital are not up to par, such as surgeons who frequently come late to the operating room and thereby cause delays that result in unnecessarily high expenses. Or, physicians know that the hospital delays in getting reports to them, which could be causing increased lengths of stay. They also know which managed care contracts are disadvantageous to both the hospital and the physicians. They know when hospitals make decisions that favor one group of physicians and antagonize the rest of the medical staff. In such examples as these, many of the alienated physicians may end up bailing out and moving to a different area.

Q: *From about the mid-1990s to 2000, hospitals acquired thousands of physician practices. It quickly*

became apparent to the acquired physicians that the hospital’s management of their practices was dysfunctional. In fact, hospitals lost hundreds of thousands of dollars per physician in managing these acquired practices. What’s more, physicians were often desperately unhappy. How can the situation be corrected?

A: There are a host of problems surrounding this issue, and we have frequently been involved in solving them. The first problem is

they were acquired. When these groups were taken over by hospitals, the ancillary testing, and the revenue from it, went to the hospital, which caused the physician practice’s bottom line to look worse.

It’s been our experience that acquired primary care practices cannot survive without somewhere between \$30,000 and \$50,000 subsidization per physician. Practices simply cannot make it on the basis of visit

“It’s been our experience that acquired primary care practices cannot survive without somewhere between \$30,000 and \$50,000 subsidization per physician.”

that there has been a misunderstanding by hospitals of what it takes to run a low-margin practice. A physician practice is a close-to-the-vest business, but hospitals frequently put many amenities into the practice, which makes it less efficient.

On the other hand, some physicians have taken advantage of the lack of fiscal responsibility by hospitals. For example, physicians may adopt a relaxed lifestyle, work no overtime, see patients somewhat leisurely, and care less about expenses than they did before the practice was acquired because they are no longer responsible for the bottom line.

Another significant factor is that practices, particularly group practices, were doing a reasonable amount of ancillary testing before

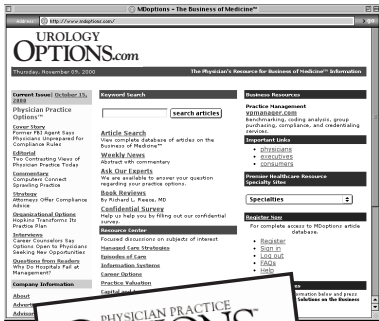
codes alone. We find that most of the practices we go to are losing huge amounts of money, somewhere in the vicinity of \$200,000 per doctor per year. Our job is to get the losses down to the \$30,000 to \$50,000 range.

Q: *Why is it that these practices have losses that are so significant?*

A: For some of the reasons I just mentioned. Frequently, we find that the contracts the hospital signed were not based on productivity. Also, physicians are often put into billing arrangements in which the collection rate is miserably low. Among other things, our job is to rectify the contractual arrangements and boost collections.

—Edited by Paula D. Grant, in Lincoln, Va. More information on physician practice strategies is available on our Web site (see page 16).

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