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*November 2004*

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## Reimbursement System Needs an Overhaul

**E**ight years ago, the disease management industry barely existed. Last year, it generated \$715 million in revenue, an increase of 24% over the revenue it generated in 2002. DM grew quickly because it filled a void. Delivering care to patients with chronic conditions in episodic office visits is both inefficient and ineffective. These patients need continuous support and monitoring, the kind that is given in home care settings and outside of settings that deliver care to patients with acute conditions. Managed care organizations saw this need, developed the infrastructure to fill it, and did so without including physicians, except as medical directors or in other necessary and limited capacities.

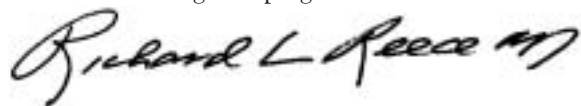
DM grew quickly also because it replaced utilization review, which had displeased patients and physicians and was considered one of the most onerous aspects of the early versions of managed care. By replacing utilization review with DM, managed care organizations found they could increase the quality of care they delivered to patients and cut their costs.

So, the gap between episodic office visits and patients living with diseases at home was seen as a vast uncovered niche. Patients with chronic, progressive diseases had been virtually ignored and were often getting sicker, sometimes experiencing problems requiring more timely interventions. Most of these problems occurred between doctor visits. These patients were beyond the reach of doctors, who were trapped inside their offices by a system tying reimbursement to face-to-face office visits.

When it became apparent that nurses could communicate with patients and track them through home visits, telephone follow-ups, Internet instructions, and home-monitoring devices, the role of nurses grew. They were asked to educate patients, foster self-care, monitor compliance with treatment modalities, and identify the need for intervention in time to avert ER visits and hospital stays.

DM has successfully improved care and cut costs, but it has done so largely without physicians. While delivering care in their offices, physicians do not have the time, data, information systems, or communication technology to deliver DM effectively. They are also limited by a reimbursement system that does not pay them to coordinate care across specialties. Some doctors support DM programs because they see that such programs produce better outcomes and improve patients' knowledge about their conditions.

What's needed is a radical overhaul of the financial reimbursement system. While the current system worked in the 1950s, it's time to develop one that meets the needs of the 21st century—one that allows physicians to contract with DM companies and to be paid for achieving better outcomes and for overseeing and administering DM programs.



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# Technology Engages Consumers, Improves Physician Productivity

By Richard L. Reece, MD, editor in chief

Over the past 10 years, Americans have become familiar with a wide variety of technologies—ATMs, touch screens, the Web—to meet various financial, personal, and other needs. For physicians, consumer comfort with technology may help to reduce their workload. After all, consumers who use computers can get a list of physicians sorted by Zip code and specialty, gather data about the quality and performance of doctors and hospitals, and obtain extensive information on a wide variety of health topics.

## Self-Service

Technology fosters self-service—or, as some technology experts say, it allows “automated consumer entry documentation,” meaning consumers do the work. If, for example, they are entering data that physicians or their staff would have to enter otherwise, they are allowing the practice to do what it does best: provide patient care.

Recognizing these benefits, information systems engineers in health care organizations are employing convenient tools to lure consumers, build customer loyalty, cut costs, and improve access and quality. These systems also are being used to enhance productivity. Usually, productivity is defined as the amount of

output per unit of input (labor, equipment, and capital). In a medical practice, productivity might be measured based on the revenue generated by a physician divided by his or her salary. In factories and corporations, productivity is a measure of the facility’s ability to build goods from a given amount of labor, capital, materials, resources, knowledge, time, or any combination of these factors.

To date, attention on productivity for physicians has focused on the use of electronic medical records. Some practices that use EMRs have seen increases in patient flow, profitability, and outcomes of 15% to 20%. What’s more, these systems are helping to improve communication and patient safety. Recently, when a pharmaceutical company pulled a pain medication off the market due to patient safety concerns, practices with EMRs were able to quickly find and notify their patients. Otherwise, it would have taken weeks for them to search their records and notify patients of such concerns.

## Increased Productivity

The Carilion Health System in Roanoke, Va., used its EMR to identify and notify its patients of the recall. Carilion has 186 physicians spread out over 250 square miles who are connected by a common EMR,

says James Nuckolls, MD, the medical director. Using the EMR, Carilion identified the doctors who had prescribed the medication and the names of more than 10,000 patients to whom they had prescribed the drug. The day of the announcement, Nuckolls knew which physicians and which patients were involved. This example shows how an EMR can increase productivity and possibly prevent an adverse outcome as well.

Productivity, for physicians, is a significant issue. Under managed care, they are asked to see more patients each day than they ever have in the past. At the same time, they are under increased pressure to document the care they deliver so that they can avoid the scrutiny of federal and other fraud investigators. To document care, physicians or their staff must do the work themselves, which can be inconvenient, inaccurate, slow, and expensive. EMRs can help them document care accurately and at the point of care.

## Engaging Consumers

In the near future, consumers will be helping to increase physician productivity. One way to do so is to have patients doing their own demographic and historical documentation. Patients will visit their physician’s Web site and use a secure code to

*(Continued on page 4)*

**Using an EMR, a medical group identified the doctors who had prescribed a recalled medication, and the names of more than 10,000 patients to whom they had prescribed the drug. The day of the recall, the practice knew which physicians and which patients were involved.**

(Continued from page 3)

open a medical records page where they can enter their demographic data, chief complaints, and medical histories by using medical history software. Also, they will be able to schedule their appointments, request prescription refills online, and send e-mail to their doctors asking for online consultations.

### **Empowering Change**

Allen Wenner, MD, a family physician in a four-physician group in Columbia, S.C., says many physicians do not encourage patients to create their own histories before an office visit. Through a company he founded, Primetime Medical Software Inc., he created software (Instant Medical History) that uses “yes” or “no” algorithms to allow patients to create their own histories on home computers or on a laptop in the reception area. Using these systems, patients arrive in the examining room having documented their chief complaints, signs and symptoms, and the required demographic data.

For such patients, Wenner says, no receptionist is needed to greet them. Patients can proceed directly to their doctor, who has their prerecorded history on a computer screen. The doctor can then conduct the physical and record findings by computer. Patients leave the office with a completely documented medical record, which can then be sent to the payer. Using this approach, Wenner says, doctors can see 20% more patients each day, require 30% less office personnel, code more accurately and at a higher rate, and complete records without the need for costly and time-consuming dictation. As a result, profitability increases.

By getting patients more involved in their health care, physicians can be engaging consumers like never before. Health leaders and information systems engineers believe that getting consumers involved in managing their own care is an important step in improving care and cutting costs. In general, consumers are responsive to timely educational advice, particularly when that advice is delivered in a friendly fashion at the patient’s convenience. Studies show that when patients practice self-care, they become more cognizant of likely complications, they display gratitude and loyalty toward their caregivers, and they get better faster.

When patients with congestive heart failure are given easy-to-operate bedside video and monitoring units allowing them to communicate with physicians and nurses, they become more aware of their weight and vital signs and tend to take better care of themselves, according to those who have developed such systems. These patients have demonstrated remarkable drops in readmission rates to emergency rooms and hospitals. This is just one example of how technology, when used properly, can dramatically affect physician productivity and improve care. Also, by keeping patients out of the hospital and preventing visits to the ER, costs come down.

### **Educating Patients**

Physicians and other providers have long been involved in educating patients through previsit phone calls, instruction sheets for each diagnosis, and hospital discharge literature. Today, some physician practices sup-

plement these materials with educational forums given by nurse practitioners, physician assistants, or disease management experts. Other physicians give educational material in the form of automated computer printouts and educational videos.

Getting the right medical information to the right patient at the right time can boost patient satisfaction and retention, improve quality of care, and protect against medical malpractice claims, says Donald W. Kemper, CEO and founder of Healthwise Inc., a nonprofit organization in Boise, Idaho, that produces consumer-oriented health information.

### **Information Therapy**

Information therapy (or Ix, as Healthwise calls it) goes beyond simply giving patients preprinted pamphlets on certain diseases, such as cholesterol or asthma.

“Information therapy is the prescription of specific, evidence-based medical information to a specific patient, caregiver, or consumer at just the right time to help that person make a specific health decision or behavior change,” writes Kemper in the white paper, *The Business Case for Information Therapy*. Among the companies offering information therapy to physicians is HealthBanks (at [www.healthbanks.com](http://www.healthbanks.com)) in Burlington, Mass..

Providing patients with complete, appropriate, and understandable information about their health or condition doesn’t happen nearly enough, says HealthBanks Medical Director Michael Bihari. Using material from HealthBanks, physician practices can create their own secure Web sites or add links to an

**When patients with congestive heart failure are given easy-to-operate bedside video and monitoring units that allow them to communicate with physicians and nurses, they have demonstrated remarkable drops in readmission rates.**

# Inefficiency Plagues the Health Care System

In her book *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers*, Regina Herzlinger argues that health care productivity has remained stagnant for 25 years. During this time, other service industries have experienced a 30% increase in productivity, says Herzlinger, a professor of business at Harvard University. She recommends consumer-driven innovations, such as integrated record systems, focused-factories, and personalized care, as strategies for getting out of the current stagnation.

"In response to consumer demands, health care providers will create three types of important innovations: focused factories that integrate formerly fragmented providers around the patients; systems of care that improve long-term health status; integrated information records that consolidate the many dribs and drabs of medical information that exist for each individual in a cohesive style and personalized medical technologies designed for individual needs," Herzlinger contends in her book, which was published by Jossey-Bass earlier this year.

Victor B. Villagra, MD, a disease management consultant and president of Health & Technology Vector Inc., in Farmington, Conn., observes that primary care office overhead remains at 55% to 60%, the same as it was in the mid-1980s. The reason: Doctors are trapped in the same physical practice model that includes an office building, a receptionist, a staff, and a payment system that depends on seeing patients face-to-face, he says. Villagra's particular solution is for doctors to use disease management firms as their back office so that teams of nurses can follow chronic disease patients between doctor visits, thus allowing doctors to see patients only when those patients need to be seen. Seeing ill patients with real problems identified by nurses, Villagra says, will enhance the cost-effectiveness and productivity of physicians.

—RLR

(Continued from page 4)

existing one. HealthBanks customizes the site to provide information about the practice, as well as reputable health information about a wide range of health topics. A practice's site can be further customized by adding links to other sites and by adapting the content supplied by HealthBanks.

Digital videos also are available for physicians to use in both hospital and ambulatory settings. Like the printed material, these videos can be shown anytime on a television or computer screen. One company offering such information on video is Patientedu.com, a 25-year-old patient education company in

Nashville, Tenn. Two years ago, it started offering digital videos and now has more than 1,000 videos in its inventory.

Hospitals can show these videos on televisions in patients' rooms, give them or send them to patients after discharge, and send video copies to the patients' doctors. Doctors, in turn, can order videos for their own patients. Hospitals often give discharged patients educational videos. The Cleveland Clinic created a series of videos for cardiology patients, and offers videos on other topics as well.

Like material that is available online, digital video can be sent to a Web site, relayed to a patient's home PC, or made available over a hospital server so that they can be shown on televisions in patients' rooms. Just as one would update a manuscript, the digital video format allows the production company to update videos as needed, replace them, and customize them for individual hospitals and patients. Physicians could modify or customize the videos to suit their needs. Keith Van de Castle, MD, medical director of patientedu.com, says the videos can protect doctors from malpractice exposure because they can be used to educate patients regarding procedures and their benefits and risks, as well as validate the informed consent process by testing patient understanding.

The Joint Commission for Accreditation of Healthcare Organizations, in Chicago, has announced that by January, hospitals will need to document that they provide patient education.

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

**Getting the right medical information to the right patient at the right time can boost patient satisfaction and retention, improve quality of care, and protect against medical malpractice claims, says Donald W. Kemper, of Healthwise Inc.**

# Report: DM Programs Don't Cut Costs

**A**fter conducting a literature review to determine whether disease management programs reduce the cost of health care and how Medicare might use such programs, the Congressional Budget Office recently concluded there is not much evidence that disease management reduces health care spending. CBO is a nonpartisan government agency that prepares policy analysis reports at the request of members of Congress. Last month, it published its findings on DM in a report, *An Analysis of Literature on Disease Management Programs* (available online at <http://www.cbo.gov>).

The CBO conclusions are contrary to the findings of employers, health plans, and DM companies, which have shown that these programs help reduce costs and improve quality. What's more, the studies the CBO examined are out of date, says Al Lewis, executive director of the Disease Management Purchasing Consortium, in Wellesley, Mass. Since the studies the CBO analyzed were published, other research has demonstrated the value of disease management, he adds.

## Old Data

"The studies the CBO used are, on average, two and a half years old, and based on study designs a year and a half older than that," says Lewis. "So these are data that are four years old in an industry that's only eight years old. In a new industry like this one, each year is like a dog year of experience, so the gap of four years between the data reviewed and today is a very long time. The CBO report is the equivalent of trashing the automobile

industry after trying to use a crank to get a car going on a cold morning."

Instead of reviewing the literature on disease management, CBO researchers could have done a more accurate analysis of the cost-effectiveness of disease management by meeting with and interviewing disease management experts, Lewis adds.

"If the CBO wants to know whether or not disease management programs save money, it should talk to people who use these programs," says Lewis, "and not rely on old data that fails to provide accurate, current information. This industry keeps growing, and an industry that fails to save money won't survive."

Even though the report concludes that such programs may not reduce costs, DM may still be worthwhile, said CBO Director Douglas Holtz-Eakin. The CBO examined studies of disease management programs for congestive heart failure, coronary artery disease, and diabetes, selected because they are highly prevalent among Medicare beneficiaries. The CBO also reviewed articles on cost-effectiveness in such medical journals as *JAMA*, the *British Medical Journal*, and *Diabetes Care*.

"We focused on the question of whether those programs could pay for themselves," Holtz-Eakin said in a letter to Sen. Don Nickles (R-Okla.), the chairman of the Senate Budget Committee who requested the report. "The proposition that decreased use of acute care services might offset the costs of the screening, monitoring, and educational services in disease management programs is clearly appealing, but, unfortunately, much of the literature on those programs does not directly address health care costs."

The federal Centers for Disease Control and Prevention in Atlanta estimates that the treatment of chronic diseases accounts for more than 75% of the nation's \$1.4 trillion annual cost of medical care. The goal of DM programs is to educate patients about their disease and help them manage its symptoms by, for example, taking steps to control blood sugar in patients with diabetes in order to stave off blindness, kidney failure, and other circulatory problems.

## High-Cost Care

A survey of employers by Mercer Human Resource Consulting in New York shows that DM programs are growing quickly among purchasers. In a report on the survey, *Mercer's National Survey of Employer-Sponsored Health Plans 2003*, Mercer says the percentage of employer-sponsored health plans offering DM programs grew to 58% last year from 41% the year before.

A number of health plans outsource such work to more than 100 companies that have crowded into the market. Typically, chronically ill patients are monitored over the phone via nurse call centers, which work with information provided by labs, doctors, and pharmacies. DM programs are now expanding to include depression, cancer, kidney disease, obesity, and low-back pain.

Nickles requested the CBO review last year after lawmakers included a provision in the Medicare Prescription Drug Improvement and Modernization Act that created a demonstration program for beneficiaries to evaluate whether preventive efforts can improve clinical results

**The CBO conclusions are contrary to the findings of employers, health plans, and disease management companies.**

and decrease costs. If the demonstration is successful, DM programs could become a permanent part of Medicare, according to officials at the federal Centers for Medicare & Medicaid Services. The lead demonstration project will include about a dozen sites across the country, each covering 20,000 or more patients. The CBO says in its report that it will monitor that demonstration project and use its data to revisit the issue of whether DM programs can save Medicare any money.

### **Savings Unproven**

But, at least as of now, the CBO has found that there is scant evidence the programs are cost-effective. Its report concludes that the focus of DM programs is often on the processes of care or on intermediate measures of health. As a result, the CBO report says, it is difficult to determine from such data whether overall savings have occurred. In the report, CBO researchers also note that the few studies reporting that DM programs reduce costs do so for controlled settings and generally fail to account for all health care costs, including the cost of the intervention itself.

Therefore, the CBO concludes, if DM programs are applied to broader populations, any reported savings might not be attainable and the programs could raise costs. CBO's final conclusion is that although some studies indicate that DM programs reduce health costs for select groups of patients in the short term, "little research directly addresses the issues that would arise in applying DM to the older and sicker Medicare population."

In its report, CBO notes that since the most common health consequences of diabetes are chronic rather than acute, diabetes disease management programs (DDMPs)

should be evaluated for savings over the long term. "There is strong evidence that disease management interventions for diabetes reduce patients' HbA<sub>1c</sub> levels and increase their compliance in getting recommended examinations and screening (such as foot and eye examinations)," the report says. "However, there is not comparable evidence to conclude that disease management programs achieve other medical management targets (such as lowering weight, blood pressure, and cholesterol levels) or improve health outcomes (such as reducing rates of blindness or kidney failure)."

The CBO reports that a few studies found that programs for diabetes can save money in the short run. It quotes an April 2002 article in *Diabetes Care* ("Does Diabetes Disease Management Save Money and Improve Outcomes?") that reports lower costs and utilization for patients enrolled in an HMO's DM program. The savings described in that study were \$395 per member per month in average paid claims for patients in the program, compared with \$502 for other patients, but then notes that "the results from this study have limitations, including possible selection bias from optional enrollment and the limited applicability of the HMO setting. Also, the reported savings did not include the cost of the DM program."

The CBO also cites a study published in the January 10, 2001, issue of *JAMA* ("Effect of Improved Glycemic Control on Health Care Costs and Utilization"), in which savings of \$685 to \$950 per patient per year were reported for patients with improved HbA<sub>1c</sub> levels. That study compared patients who had their HbA<sub>1c</sub> levels decrease at least 1% during the first year of the study and remain at that point for an addi-

tional year (about 15% of the study sample) with patients who did not. "But patients who saw improvements in their HbA<sub>1c</sub> levels probably differed from patients who did not in many other ways that would affect their health costs, so the reported results may have little to do with the effects of DM," the study says.

Officials with the Disease Management Association of America said the CBO report fails to include recent studies that demonstrate cost benefits. In a conference last month in Orlando, several studies were presented that showed cost savings from 10 different diabetes management programs and 11 asthma management programs, according to Christobel Selecky, DMAA president.

In an article in the July/August issue of *Health Affairs*, researchers reached conclusions that appear to contradict the findings of the CBO review. In an article, "Effectiveness of a Disease Management Program for Patients With Diabetes," researchers analyzed the first-year results of a multistate DDMP sponsored by Cigna Corp., a national managed care organization in Philadelphia. They concluded that the overall costs of care were significantly lower in DDMP sites, and Cigna saved more than it spent on the program. Pharmacy costs showed mixed results. Quality of care scores, such as the number of diabetes patients who regularly checked their blood sugar levels, were significantly better at the DDMP sites than at sites without the program. "These programs have a profound impact on the quality of care and costs on a short- to intermediate-term basis," Allen Woolf, Cigna's national medical director told *The Wall Street Journal* in a Oct. 20 article about DM. —Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice strategies is on our Web site (see page 16).

**One report concluded that the overall costs of care were significantly lower at diabetes disease management sites.**

# Variation in Quality Exists Nationwide

By Richard L. Reece, MD, editor in chief

**W**ide variation in the quality of hospital care and outcomes for Medicare recipients with the same chronic conditions exists throughout the country, according to researchers at Dartmouth Medical School in Hanover, N.H. Their research is featured in "Use of Medicare Claims Data to Monitor Provider-Specific Performance Among Patients With Severe Chronic Illness," an article in the Oct. 7 edition of *Health Affairs*.

In an analysis of Medicare claims at 77 hospitals, the researchers found that the frequency of physician visits, the number of diagnostic tests, and the rate of hospital and intensive care unit stays varied widely. In what the authors say is the most significant finding of their study, "a higher intensity of care and larger amounts of spending don't mean better quality or longer survival times," says John E. Wennberg, MD, an epidemiologist who directs the Center for the Evaluative Clinical Sciences at Dartmouth.

## Data Analysis

Wennberg led the study and is the principal investigator and series editor of the *Dartmouth Atlas*, published by CECS and funded by the Robert Wood Johnson Foundation, a philanthropy in Princeton, N.J. The *Atlas* has documented significant geographic variations in medical practice since the early 1970s. The researchers use large health care claims databases (including those from Medicare and Blue Cross and Blue Shield plans) to analyze national, regional, and small area variations in medical practice in 306 hospital referral regions (HRRs). The researchers compare utilization rates for several diseases and acute medical conditions, such as coronary artery bypass graft surgery and hip

fractures. They also examine the regional practice rates for such standards of care as blood tests and eye exams for patients with diabetes.

The *Atlas* was last published in 1999 and a new edition is planned for late this year or early next. "We demonstrate that in American health care, geography is destiny," says Wennberg. "Both the amounts and kinds of care provided to residents of the United States are highly dependent on two factors: the capacity of the local health care system (which influences how much care is provided) and the practice style of local physicians (which determines what kind of care is provided)."

In the current series of studies published in *Health Affairs* (the results of which will be featured in the next *Atlas* edition), Wennberg and colleagues evaluated the efficiency of the 77 hospitals for geriatric care and heart and pulmonary disease in man-

both in quality of care and cost," says Wennberg.

For example, despite evidence that the survival rate is the same for patients with lumpectomies as it is for patients with mastectomies, the rates of mastectomy for breast cancer per 1,000 Medicare enrollees in Pennsylvania in 1999 varied in the state's 13 HRRs from 0.8 to 2.4 per 1,000 female Medicare enrollees. Surgery for benign prostatic hyperplasia (transurethral prostatectomy) varied from 4.4 to 11.1 per 1,000 male Medicare enrollees.

Because both procedures have alternatives of apparently equal medical value (lumpectomies instead of mastectomies and no surgery instead of TURP), the data suggest that the medical opinions of local physicians concerning the value of these treatments vary, Wennberg says. "The wide variations in surgical rates suggest that physician, rather than

**One study found that more care and money don't mean better quality or longer survival.**

aging chronically ill Medicare patients during the last six months of life. The authors looked at variations in care for more than 90,616 patients, age 65 and older, who suffered from solid tumor cancers, congestive heart failure, and chronic obstructive pulmonary disease. Then, they compared the illness-adjusted frequency of physician visits, hospitalizations, and ICU stays.

## Comparing Numbers

What they found reinforces the conclusions Wennberg reached in previous research on practice variation, he says. "Variation remains one of the greatest problems facing health care,

patient, preferences are the deciding factor in most cases," he explains.

## Patient Choice

The inference to be taken from such data is that health plans and provider organizations might reduce variation by informing patients about their options, using evidence-based medicine as a guide. "Unwarranted variation cannot be explained on the basis of illness or the preferences of patients," says Wennberg. "Such variations result from influences that the supply side exercises on the patterns of practice."

A second article in the Oct. 7 edi-

tion of *Health Affairs* addresses treatment decisionmaking. In "Policy Support for Patient-Centered Care: The Need for Measurable Improvements in Decision Quality," the authors, led by researchers at the Health Decision Research Unit of Massachusetts General Hospital in Boston, conclude that "the phenomenon of practice variation draws attention to the need for better management of clinical decision making as a means of ensuring quality. Different policies to address variations, including guidelines and measures of appropriateness, have had little demonstrable impact on variation itself or on the underlying quality problems. Variations in rates of interventions raise questions about the patient-centeredness of decisions that determine what care is provided to whom."

Certain agencies—such as the Centers for Medicare & Medicaid Services in Baltimore; the Agency for Healthcare Research and Quality in Rockville, Md.; and the National Committee for Quality Assurance (NCQA) in Washington, D.C.—should develop policies that encourage patient involvement in treatment decisionmaking, the authors say.

"The persistent widespread variation in rates of procedures will continue until there is a concerted effort to attend to the quality of individual decisions," the authors point out. "We recommend that improvement in the quality of patient decision making be given highest priority on the pay-for-performance agenda of private and public payers."

Wennberg encourages health plans and providers to use the measures in NCQA's Health Plan Employer Data and Information Set to improve physician and patient decisionmaking. Such basic measures as ensuring

that patients with diabetes get blood tests and eye exams and that victims of heart attack get aspirin and other medications will cut mortality and morbidity rates, he says.

### **Exceeding Demand**

Caution is required, however, when two possible treatment options appear to be of equal value, such as lumpectomies versus mastectomies. "Variation cannot be interpreted from the point of view of the patients' welfare, since it is not clear whether patients actually had much of a say in determining which treatment they received," explains Wennberg. Data suggest that the number of surgeries now provided in many regions exceeds what patients informed of the comparative efficacy of both procedures would demand, he says.

His conclusion is reflected in the study of Medicare claims data at the 77 hospitals. "This marks the first time Medicare claims data are being used to measure the performance of individual hospitals and identify hospitals that appear to be doing a better job managing chronic illness and patient care," Wennberg says. "We found that no matter how preeminent the hospital, care varies widely. What was particularly interesting is that we found quality is inversely correlated with the intensity of care and that the better hospitals are using fewer resources and providing fewer hospitalizations and physician visits."

The Dartmouth researchers identified hospitals where Medicare enrollees are receiving much more intensive care for common medical conditions, raising questions about usual methods of identifying so-called best hospitals, such as those named in an annual report by *U.S. News and World Report*, for example. The

authors used the 2001 *U.S. News* report to study the seven hospitals that ranked highest in geriatric care.

"Our performance measures provide a very different perspective than that provided by *U.S. News and World Report's* measures," the authors say. (The magazine bases its rankings in part on institution-specific measures, such as number of nurses per bed). "In addition to documenting marked variation across hospitals, our performance measures make transparent the relationship between management decisions that determine the size of the professional workforce and the numbers of hospital beds and other resources, on the one hand, and the costs and use of care, on the other," the researchers note.

### **Physician Visits**

Among other findings, the researchers say that patients receiving care from New York's Mount Sinai Medical Center spent almost twice as many days in the hospital as patients treated at the Mayo Clinic's St. Mary's Hospital in Rochester, Minn. They also found that patients in the Mount Sinai Medical Center and the UCLA Medical Center had twice as many visits from physicians as patients treated at Duke University Hospital in North Carolina. Days spent in intensive care units for patients at the UCLA Medical Center were three times as many as for ICU patients at MGH, the researchers found.

In addition to utilization variations, the quality of care for geriatric patients suffering terminal illnesses varied widely. The number of patients who died as hospital inpatients, rather than at home or in hospice, varied from 32% of all deaths to more than 52%. For example, patients at St. Louis University Hospital were nearly 70%

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**One study recommends that improving the quality of patient decision-making be given the highest priority.**

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more likely to spend time in intensive care than were people who died as inpatients at Mayo Clinic hospitals.

Practice variation also was significant among the nation's leading academic medical centers, including those ranked at the top of the *U.S. News and World Report's* lists of best hospitals for geriatric care, particularly in the numbers of different physicians who cared for patients during their last six months of life. The numbers of physicians responsible for managing chronic illness ranged from 12 per 1,000 decedents at Duke University and the Mayo Clinic, to 20 and 22 per 1,000 decedents at UCLA and Mount Sinai, the researchers said.

In addition, patients at UCLA and Duke were less likely to see a primary care physician than were patients at St. Louis University or Mount Sinai Medical Center, and patients at UCLA had 2.8 times more visits with specialist physicians than with primary care physicians.

## Patterns of Practice

In a third study, discussed in "Variations in the Longitudinal Efficiency of Academic Medical Centers," in the *Health Affairs* Oct. 7 edition, researchers reviewed the care patients received during their initial hospitalization for one of three reasons—heart attack, colorectal cancer, and hip fracture—in one of 299 hospitals that belong to the Council of Teaching Hospitals. The council is a policy development organization affiliated with the Association of American Medical Colleges in Washington, D.C., and has members from about 400 major teaching hospitals and health systems, including 64 Veterans Affairs Medical Centers.

Led by Wennberg's colleague Elliott Fisher, MD, a Dartmouth professor of community and family medicine, this study examined patterns of practice, quality of care, and health outcomes. Researchers found that the overall intensity of medical services delivered

to patients with serious chronic illnesses varied by as much as 60%. In determining intensity of care, they examined lengths of stay, procedures performed, and physician visits. They found that patients in the highest intensity hospitals spent more time in the hospital and the ICU, had more frequent physician visits in the inpatient setting, had more specialists involved in their care, and received more imaging services, diagnostic testing, and minor procedures.

Compared with the low-intensity group, those in the high-intensity group had

- Use of evaluation and management services that was 56% to 82% higher
- Diagnostic imaging that was 20% to 26% higher
- Diagnostic testing that was 73% to 94% higher, and
- Rates of hospital visits and new specialist consultations that were about twice as high.

Not surprisingly, costs were significantly higher in the high-intensity teaching hospitals for an acute care episode, the researchers say. Medicare reimbursement for hospital and physician services was 47% to 58% higher in the high-intensity teaching hospitals (such as New York University

example, among hip fracture patients, there were no significant differences in death rates across groups. In fact, among heart attack and colorectal cancer patients, there was a "small but statistically significant increase in the risk of death as intensity increased."

The most disturbing element of the Dartmouth research was evidence that a very high intensity of care for people with certain terminal medical conditions might hasten death, says Wennberg.

Some of the solutions Wennberg and his colleagues propose to help physicians and health plans reduce variation have long been considered effective, such as the use of evidence-based medicine to set standards of care. Others are more innovative and just recently considered good medicine, such as an emphasis on patient involvement in health care decision-making. And some are difficult to achieve, such as controlling capacity.

Medical practice variation is "remarkably resistant to change," Wennberg explains, adding that there are steps physicians and others can take to begin to reduce disparities, such as rewarding providers for efficient, high-quality performance. A provision in the Medicare Prescription Drug Improvement and

## The MMA takes steps to address unwarranted variation in health care.

Medical Center, Cedars-Sinai Medical Center in Los Angeles, and Jackson Memorial Hospital in Miami) in comparison with the lowest intensity hospitals (including Mayo Clinic affiliate St. Mary's, Strong Memorial Hospital in Rochester, N.Y., and Richland Memorial Hospital in Columbia, S.C.).

The most significant finding was that there was no association between higher intensity of care and long-term mortality rates, the authors note. For

Modernization Act of 2003 (MMA) that creates a demonstration to test this idea is a significant step in the direction of addressing unwarranted variation in health care, he says.

—Edited by Martin Sipkoff, in Gettysburg, Pa. The Oct. 7 Web edition of *Health Affairs* is available at [www.healthaffairs.org](http://www.healthaffairs.org), and more information about the Dartmouth Atlas is available at [www.dartmouthatlas.org](http://www.dartmouthatlas.org). More information on practice strategies is available on our Web site (see page 16).

# Six Year-End Tax-Saving Ideas

By David B. Mandell, JD, MBA, and Steve P. Dunbar, CFP

**P**hysicians work too hard and have trained too long not to make tax planning a priority. The alternative is to spend 40% to 50% of their time working to pay taxes to federal and state governments. Still, most physicians do not dedicate even one day a month to developing and maintaining a strategy to reduce their tax liability. Since there are at least six strategies physicians should adopt now to save taxes on 2004 income, it is important that they devote at least some time to tax planning before the end of the fiscal year.

Physicians are like all citizens in that they need not overpay their taxes. Federal and state tax laws require physicians, individuals, and all businesses to pay their fair share of taxes. Developing legal ways to minimize one's tax liability is not a crime; it is simply smart business management. Or, as Judge Learned Hand once said, "There is no reason to pay more taxes than the law would provide; there isn't even a patriotic duty to do so."

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## Taking Deductions

The first step physicians should take when developing a tax-saving strategy is to ensure that they take a deduction for risk management and asset protection planning. Medical practices can use closely held insurance companies (CICs) when looking to make annual tax-deductible contributions of \$80,000 to \$175,000 for asset protection and risk management programs. These CICs typically are very small insurance companies that primarily insure the practice. CICs enjoy extremely beneficial tax treatment (made even better by an April 2004 law signed by President Bush) by allowing physician owners an opportunity to build tax-favored wealth, as opposed to giving profits to insurance companies or building wealth subject to income and capital gains taxes.

Physicians can use a CIC to insure all, or portions of, their practice's significant risks, such as medical malpractice liability protection, medical malpractice "defense only" policies, sexual harassment and wrongful termination claims, and audits by federal authorities (such as the Centers for Medicare & Medicaid Services).

## Asset Protection

The second step involves developing an asset protection plan for the practice's most valuable asset: the accounts receivable. Physicians are keenly aware of the malpractice liability crisis, but many may not realize that a large judgment against them or

against any of their partners could likely threaten all of the practice's accounts receivable.

Typically, accounts receivable are a medical practice's most valuable asset. For this reason, many physicians have implemented an asset-protecting strategy for their receivables. While the details of such a strategy can be quite extensive, for the purposes of this article, it should be mentioned that at least two of these strategies (financing and enhanced factoring) may allow a practice to protect this asset and reduce the practice's income tax burden as well.

A reduction in income taxes is possible because of the deductions this strategy generates. Thus, if asset protection—in addition to tax reduction—is a concern, most tax and financial professionals will recommend that physicians investigate their options in this area.

## Using NonQPs

Many tax advisers suggest that physicians use traditional tax-qualified investment plans, such as pension, profit-sharing, Keogh, and 401(k) plans. In fact, tens of millions of Americans participate in such plans each year. Since these plans are tax-qualified, most deposits into these plans are 100% deductible. Of course, the Internal Revenue Service has strict rules about how much one can put into such plans, which employees must be able to participate, and when one can get one's

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**Typically, accounts receivable will be a medical practice's most valuable asset. For this reason, many physicians have implemented an asset-protecting strategy for their receivables.**

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money out of these plans. Typically, there are tax penalties for early withdrawals.

On the other hand, nonqualified plans (sometimes called nonQPs) have few restrictions on how much can be contributed and who can participate, and have no penalties for early or late withdrawal. Unlike qualified plans, nonQPs are not well known, therefore few Americans participate in them because many employees are unaware that their employer offers them or because their employers have not created one.

Not developing a nonQP is a wasted opportunity, since nonQPs can provide tremendous tax and retirement benefits, while allowing maxi-

created by the FLLC or FLP to the limited partners or to members who are in lower tax brackets.

Most physicians are in a 40% tax bracket (for state and federal taxes) and many of them have children who are over age 14 and who are in a 10% or 15% tax bracket. For these physicians, an FLLC or FLP can save significant amounts on taxes for income earned by FLLC or FLP assets, such as mutual funds, real estate rentals, stocks, and bonds.

### Tax Deferrals

Another step in reducing taxes involves the use of annuities. There are two types of annuities: fixed annuities (which pay a fixed return over a

states that do exempt them, annuities are an ideal tool to safeguard wealth.

### Charitable Giving

Many Americans cherish the right to give to the charitable institutions of their choice. The problem, many times, is that they do not know how to give or they assume that their family will suffer as a result of their giving. There are many ways physicians can make charitable gifts while benefiting their families as well. The most common tool for giving in this way is to use a charitable remainder trust. A CRT is an irrevocable trust that makes annual or more frequent payments to the holder of the trust (meaning the physician, a family member, or both). The payments can be made until the holder dies. What remains in the trust then passes to a qualified charity of the holder's choice.

A number of advantages may flow from the CRT. First, the physician will obtain a current income tax deduction for the value of the charity's interest in the trust. The deduction is permitted when the trust is created, even though the charity may have to wait until death to receive anything.

Second, the CRT is a vehicle that can enhance the physician's investment return. Because the CRT pays no income taxes, the CRT can generally sell an appreciated asset without recognizing any gain, enabling the trustee to reinvest the full amount of the proceeds from a sale and generate larger payments.

Finally, the trust will be eligible for an estate tax deduction if it passes to one or more qualified charities upon the holder's death.

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

**An annuity will let a physician invest funds that would otherwise go to the government and defer taxes on the earnings until the physician retires, when the physician may be in a lower tax bracket.**

mum flexibility as well. Physicians can find out more about how nonQPs can help them invest wisely and get a tax advantage by asking their tax professionals about them.

### Shared Income

Often physicians use family limited liability companies (FLLCs) and family limited partnerships (FLPs) for asset protection. In addition to being useful as asset protection vehicles, FLLCs and FLPs can allow physicians to save thousands of dollars each year in income taxes. These plans help physicians cut their taxes through a strategy called income sharing, which means spreading the income

period of time) and variable annuities (which have an underlying value linked to an investment in the stock market). If physicians have assets that they do not intend to use until retirement, there is no reason not to use an annuity to defer income taxes.

Under realistic assumptions, a \$500,000 stock portfolio may generate an annual tax liability of \$10,000 to \$25,000. An annuity will let a physician invest funds that would otherwise go to the government and defer taxes on the earnings until the physician retires, when the physician may be in a lower tax bracket. Additionally, some states protect annuities from creditor claims. In the

**“There is no reason to pay more taxes than the law would provide; there isn't even a patriotic duty to do so.”**

**—Judge Learned Hand**

# DM Is Changing the Delivery of Chronic Care, Expert Says



**Victor Villagra, MD, FACP**, is president of Health & Technology Vector Inc., an independent health care consulting firm in Farmington, Conn. Villagra has extensive experience in managed care, disease management, and technology assessment. Previously, he was national medical director and vice president, quality and medical strategy at Cigna Health Care, and a past president of the Disease Management Association of America. Board certified in internal medicine and a fellow of the American College of Physicians, Villagra holds a faculty appointment at the University of Connecticut Health Center. In this interview, he speaks with Editor in chief Richard L. Reece, MD, about the role of physicians in disease management programs.

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**Q:** Recently, you said, “Now is the time to do medical management right.” What does that mean?

**A:** That statement referred to managing disease in the context of a managed care organization. It implies that managed care organizations may not have done medical management right, by concentrating on utilization management. “Doing medical management right” refers to applying clinical criteria and clinical reasoning to medical decisionmaking. Managing resources automatically follows good clinical practices. If the guidance used to manage disease is evidence-based, then you’re not likely to make mistakes.

**Q:** You have also said that disease management companies have

evolved. Can you explain how they have transformed the outpatient delivery system?

**A:** From the physician’s point of view, the outpatient delivery system has not changed at all. For example, when I was in practice 20 years ago, my practice overhead was 55%. The design of that clinic—the architecture, the workflow, the staff responsibilities, the receptionist, the physician assistant, the nurse practitioner, the physician, the technology supporting the practice—all of that has changed very little in the intervening years. Yet patients’ needs and expectations have changed. More of them present with chronic illnesses. Consumer-patients want to participate in their medical decisions more and more. They are more mobile and busier than ever, so going to the doctor must yield real value. The office environment has not adapted to these patients’ demands.

Few industries over the last 20 plus years have not changed. The “architecture of care,” particularly in primary care, has not evolved to lower production costs or overhead to increase efficiency and to meet patients’ needs. Physician practices will need to assimilate information and communication technology, redefine staff roles, and transform the physical architecture of the office space if the doctor’s office to meet the new kinds of patients’ needs and remain a viable entity. We must break away from the old model and be open to design a new one.

Not everything has been stagnant, however. Suddenly, out of left field, comes disease management. Its movers concede that people with chronic disease can’t be taken care of in 10-minute doctor visits three or four times a year. Instead, these patients need constant repetitive interaction using a variety of approaches to reach them, such as the telephone, faxes, mail, the Internet, and even remote monitoring devices installed in their homes. These communications tend to be highly structured, their contents are evidence-based, and nurses are the main overseers of care but always are respectful of the physician’s treatment plan.

**Q:** If you were a practicing physician in a clinic today would you use disease management techniques?

**A:** If I were a practicing physician in a clinic today, I would have modern disease management organizations as my back office. I would see patients, and I would continue to make decisions about their treatment course. But nearly all of the education, the reinforcement, the motivation, and the support for behavior change would come from my disease management back office. I would also need a computerized, expert decision support tool to help me manage the staggering amount of scientific information constantly being produced. My typical patient would likely be a Medicare patient with chronic obstructive lung disease, congestive heart failure, probably depressed, and would be seeing various specialists.

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**“From the physician’s point of view, the outpatient delivery system has not changed at all [over the past 20 years].”**

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So, my disease management back office would gather all the information from the various specialists seeing my patient, such as the cardiologist, pulmonologist, and endocrinologist, and organize it and present it to me efficiently. My role would be what we have always envisioned the primary care physician to be and that is the manager and coordinator of complex cases like this. But now I would have all the support I need to do it well.

To provide this type of care requires a radical redesign of the office space, the workflows, and the technology. So that is what I mean when I say that the outpatient delivery system has to be completely transformed, and the disease management community has provided a radically new template proven to be operationally and financially viable.

**Q:** *Disease management has grown rather quickly in the recent past, in part because it has been done without the knowledge or input of physicians. Is that correct?*

**A:** That is partially true. Physicians have been involved, but the kinds of physicians involved have been those who have stepped outside of the proverbial box. These physicians have teamed up with business people, information technology experts, data managers, and financial experts to create disease management organizations. So physicians have been involved, but they have completely broken outside the mold of the typical clinic-based system. Besides, their target went beyond a single patient and they focused on large populations of patients with like problems, such as diabetes or heart disease, for whom the burden of self-care can be overwhelming. These physicians realized that the battle against chronic disease is won or lost, not necessarily in the office, but in

the real world where people live and work.

**Q:** *Why are managed care organizations involved in disease management?*

**A:** Because managed care and any other payer has much to gain from better care. In addition, to run a disease management operation successfully, one needs access to large amounts of data and lots of patients with similar conditions. Managed care organizations have the data, and they are natural aggregators of insured individuals. So they can more easily than anyone else identify a critical mass of patients who need assistance with chronic care.

From the managed care organization's point of view, it makes good sense to hire a disease management company to meet its disease management needs. The investment to put together the infrastructure to offer disease management is so substantial that many companies buy the service from independent disease management organizations rather than building it. Individual physicians might never be in a position to match that. That's why it makes more sense for physicians to align themselves with disease management companies rather than to reproduce DM services in their offices.

Managed care should encourage DM companies to work more closely with treating physicians for several reasons. I'm concerned that if disease management companies fail to align themselves with physician practices, their legitimacy will remain in question. Furthermore, there is the general perception that managed care organizations are charged with a dual role of managing the financial risk (insurance) and medical decisions and this dual role poses an irreconcil-

able conflict of interest. Patients could extrapolate that perception to disease management. That's why one of my missions is to find a way to operationally realign disease management with practicing physicians more than with managed care.

One might wonder why I would ask managed care organizations to pay for disease management and abdicate the credit for dispensing medical-related advice to patients. The reason is that the public has never held the insurance industry as the most trusted source of medical information. Every survey I have ever seen exploring the issue of trust with medical matters places doctors and nurses at the top of the pyramid and managed care at the bottom. So why should managed care fight this strongly held secular belief? Why attempt to build "brand equity" dispensing medical advice when the real locus of trust resides elsewhere?

Managed care can certainly benefit from the lower cost of better care and those lower costs can in turn be passed on to consumers as lower premiums and richer benefits. Now, that is the role the public has entrusted to the insurance sector and therefore represents a more logical role for managed care to play.

**Q:** *Will the movement toward consumer-driven health plans affect disease management?*

**A:** Yes, and physicians need to be involved in the consumer movement. They can do so by aligning themselves with disease management organizations that can satisfy consumer-patients' information hunger anytime, anywhere. It's the only mechanism where you can have evidence-based-grade information disseminated to consumer-patients in a repetitive, structured, organized, multimodal fashion. No other system

**"If physicians are paid for how well their patients do, then physicians will begin to seek cost-effective ways to deliver good outcomes."**

does that today. You can't do it through advertising because advertising is not objective. The individual physician simply does not have the reach or the time in the office to do it. Seven minutes of time in front of a patient doesn't work. There is no other mechanism for reaching that many people.

**Q:** *You have used the term "evidence-based" often in this discussion. Do you mean that disease management uses evidence-based medicine more than the traditional system?*

**A:** Disease management evolved when evidence-based medicine was emerging as a way of delivering the right care. The disease management companies are among the most avid consumers of clinical guidelines anywhere, which just started to surface about 15 years ago. Now we have hundreds of guidelines. So, the disease management movement grew up at the same time that evidence-based medicine was the recommended best-practice norm.

But disease management also came along when consumerism in health care was emerging as an important trend. So, in addition to being evidence-based, and having sophisticated information technology embedded with guidelines, many disease management companies knew they had to be friendly toward consumers. They have what I call the Ritz-Carlton approach to interaction with patients. This consumer orientation, in tandem with scientific rigor, is a hugely important attribute of disease management companies and accounts for much of their popularity.

**Q:** *Doesn't remote monitoring break with the tradition of having the patient see the doctor in the office?*

**A:** Yes, it does, and for some things, it's absolutely impera-

tive that patients see their doctor. But for the majority of things that pertain to chronic care, the physician doesn't need to see the patient in person. Frankly, it's often the patient's inactions that drive most of the poor outcomes. The physician has to make the treatment decisions and that often requires seeing the patient. But from then on what matters most is the patients' compliance, how well they understand their disease, how motivated they are to adhere to lifestyle changes, and how they avoid complications by just taking their pills as told.

**Q:** *But since most doctors are reimbursed for seeing patients in their offices, how do they get paid when participating in disease management?*

**A:** You're asking a very good question. And the answer will have to come from payers. The payers, starting with the government all the way down to private insurers, need to recognize the value of interpersonal interaction regardless of whether that visit is in an office, over the phone, or some other type of remote interaction. There are several organizations that recognize this and already reimburse for online visits. That type of reimbursement needs to continue and grow.

Second, the attitude that physicians can get paid only if they see the patient needs to change. Instead, physicians should be paid for outcomes rather than for production. If we are paid for how well our patients do, then we will begin to seek more cost-effective ways to deliver good outcomes. This approach to physician payment would require dramatic changes in our medical reimbursement system and the change must begin immediately even if it takes years to refine.

**Q:** *How are the disease management companies reimbursed?*

**A:** DM programs are paid for outcomes. For example, if they agree to achieve a 15% improvement in a clinical outcomes, and if more than 90% of patients are satisfied with their service and they save 5% of costs by preventing avoidable admissions or ER use, they're rewarded. Right now, none of that income is shared with physicians. That's because doctors have not been involved in what disease management companies accomplish. But if doctors become directly involved and seek a more active role, then disease management companies ought to share their revenue. There is a vast repository of waste trapped in poor quality care that disease management companies and physicians, working together, can extract from the system and in the process, serve patients better and generate new revenue. Those revenues could be reinvested in modernizing the office infrastructure and expanding the practice.

But until we have a financial engine that makes the physician an active participant, we're not going to see a change. One method for fueling this change may be the pay-for-performance movement in effect across the country. That means the physician has a base pay and a portion of his or her compensation is variable based on attaining certain quality benchmarks or outcomes. High-performing physicians can add to their income, in some cases substantially.

Disease management companies could easily help physicians achieve those quality targets and then both entities could benefit financially from delivering good outcomes. Physicians and disease management companies should be natural allies in improving both care and compensation.

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

**“There is a vast repository of waste trapped in poor quality care that DM companies and physicians, working together, can extract.”**

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