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CONTENTS

Features

Commentary
Health Systems in Other Countries Offer Strategies for U.S., Author Says 3

Strategy
New Methods of Chronic Care Needed 10

Interview
Battles Brewing as Physicians Build Specialty Centers, Consultant Says 13

Departments

Editorial
Physicians, Hospitals Can Share New Ventures 2

Practice Management
Risks Seen in Asset-Protection Plans 6

For Gastroenterologists, Hepatitis C Can Be a Viable Area of Practice

Many gastroenterologists in private practice do not treat a large number of patients who have hepatitis C because most of these patients see physicians affiliated with academic medical centers. But community gastroenterologists can make the care of these patients a viable focus of their practices if they adopt strategies to treat these patients cost effectively.

"Many gastroenterologists believe that the time required to care for patients with hepatitis C is enormous in light of the financial remuneration for this care," says gastroenterologist Natarajan Ravendhran, MD. "As a result, many are reluctant to include patients with hepatitis C in their practice. But a gastroenterologist who manages these patients efficiently can make this portion of the practice financially viable. Concerns that treating these patients will not generate positive revenue over the course of care are not necessarily valid." Ravendhran practices with Digestive Disease Associates, a 12-physician, single-specialty group practice with two offices in Baltimore and Columbia, Md.

A Viable Strategy

Being a member of a large single-specialty group has made it easier for Ravendhran to pursue his interest in hepatology and hepatitis C. "Currently, about 25% to 30% of my practice involves the care of patients with hepatitis C," he says, and most of these patients are covered by commercial insurance plans. Developing a focus on hepatitis C care could also be a viable strategy for a community gastroenterologist, but if he or she is a solo practitioner, it will be much harder to do so, he observes.

First, a large practice can generate a sufficient number of patients to enable a gastroenterologist to subspecialize in hepatology, thereby developing an expertise that can lead to greater efficiency and higher quality of care. By caring for the 200 to 300 patients with hepatitis C who have been triaged to him by his partners, Ravendhran has developed significant expertise in the condition and an algorithm to help him improve efficiency.

Second, the patient volume for hepatitis C that the group generates has enabled Ravendhran to hire a nurse practitioner, who spends about 80% of her time with patients who have hepatitis C. "By enhancing my efficiency, the nurse practitioner makes it more financially viable for me to care for this group of patients," he says.

A gastroenterologist in solo practice might find it difficult to absorb the cost of employing a nurse practitioner, at least until patient volume

(Continued on page 8)

EDITORIAL

Physicians, Hospitals Can Share New Ventures

Technological advances are making it possible for many procedures to be performed outside of hospitals—in doctors' offices, freestanding ambulatory care centers, and specialty centers. As revenue for both general, acute-care hospitals and physicians continues to decline while costs continue to rise, hospitals and physicians are being forced to seek innovative partnerships to increase revenue, cut costs, and streamline operations.

Over the past decade, many organizations in which physicians and hospitals were integrated (such as hospital-owned physician practices) lost money in part because the hospitals managed the physician practices in a heavy-handed and ineffective manner. Today, such integrated organizations need to involve more partnership between the two sides.

Hospital boards and senior physician staff in these organizations must make new forms of integration work because the health care system is moving from a tightly controlled managed care system to one in which consumers have greater control. Since physicians, not hospitals, usually direct patients to the site of care, hospital administrators should talk with physicians about how to prepare for more demanding consumers.

Hospital administrators also need to cultivate physician relationships by talking formally and informally with key leaders of physician groups about how hospitals and physicians might work together to capitalize on changing market conditions.

Administrators should ask physicians for suggestions on how hospitals can help doctors make clinical office practices more efficient, as well as how hospitals can be made more efficient. They should also seek new ways of helping physicians, for example, by offering them more diagnostic equipment or support for documentation in their practices.

On their end of this *rapprochement*, physicians should tell hospital CEOs about the difficulties they face when working in hospitals and how policies could be changed or facilities redesigned to improve performance and attract more patients. Physicians should also be candid with administrators about the technological advances that are making it easier and more profitable for them to perform procedures in physician offices, ambulatory centers, and specialty hospitals. For this reason, equity partnerships between general hospitals and physician groups may help both sides succeed as the market changes.

In fact, the fundamentals of the market favor dynamic change, and physicians are capable of rapid change in ownership even without the participation of local hospitals. But, together, hospitals and physicians have the potential to develop win-win relationships.

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COMMENTARY

Health Systems in Other Countries Offer Strategies for U.S., Author Says

By Richard L. Reece, MD, editor in chief

As the cost of health care continues to rise and critics call for new ways to manage care, it is appropriate to consider how other countries manage health care. A new book offers lessons from other countries that may help to improve the U.S. health care system.

Epidemic of Care was written by George Halvorson, chairman and CEO of Kaiser Permanente, the largest nonprofit health system in the United States, and by George Isham, MD, medical director and chief health officer of HealthPartners, one of the largest health systems in Minnesota. Their book was published earlier this year by Jossey-Bass Publishers in Hoboken, N.J.

Halvorson's goal in writing *Epidemic of Care* was to foster more understanding of what he calls the nonsystem of health care that exists in the United States. "It's time for a fully informed public discussion of some key health care issues," he says. "George and I want to help inform the debate. We also want to advocate for some solutions. The book is arguing for systematic care with full computer support for physicians, for example."

The Cost of Miracles

In one chapter, "Miracles Cost Money," the authors explain the costs of a dozen different medical miracles, such as implants, transplants, wonder drugs, and almost magical imaging technologies. "We set forth the argument that the public has no sense that, even though they are spending a significant amount of money on health care, they are actually getting a lot of value for that money," Halvorson asserts. "After all, there are many wonderful procedures being performed by the U.S. health care system, and many great technologies are at our disposal. Therefore, we argue in our book that, as a country, we should not be critical of costs without acknowledging what our money is actually buying us."

In another chapter, "Unsafe at Any Cost," the authors discuss the Institute of Medicine's study about patient safety and best practices, and the latest research by the Rand Corp. and by John Wennberg, MD, showing the immense levels of variation in health care practices. "Basically, the chapter summarizes the implication of these studies, which is that despite all our wonderful technology, far too many patients are not getting appropriate routine or follow-up care," Halvorson says. "For example, two thirds of patients with diabetes do not receive appropriate follow-up care, and this has crucial cost and quality implications, since these people must face unnecessary complications as a result of their condition."

Other chapters cover topics such as sources of funding, government programs, and the need for automated physician support systems.

The United States is the only country that focuses on information technology, data collection, and best practices as an antidote for costs, says George Halvorson, of Kaiser Permanente. "Everyone else addresses costs by rationing care in some way," Halvorson notes.

Lessons to Learn

In doing the research for the book, Halvorson learned interesting lessons when comparing the U.S. health care system with the health systems in other countries. "We explore how other countries manage to operate with much lower health care costs and yet still achieve a relatively high level of satisfaction," he explains. "This is possible because a very small proportion of people account for a large proportion of health care costs. So, for example, Great Britain has a wonderful primary care system that satisfies 75% of the people, who account for 15% of total health care costs. However, people there who need a heart-lung transplant may not get one. In effect, Great Britain has basically eliminated the care provided to 1% of the population that in the United States consumes 30% of the cost." If the U.S. health care systems took similar steps, they could cut costs by 30% overnight, he notes.

Primary care is made available by the governments in other countries

(Continued on page 4)

(Continued from page 3)

because they know that their citizens will be unhappy if they don't have easy access to such care, Halvorson says. "In the British system, for example, every single person in Great Britain has a primary care doctor," he points out. "All citizens are part of a doctor's panel. Physicians work for the government, and they do a very nice job of meeting the primary care needs of their patients."

Conversely, if a patient in Great Britain needs a hip transplant, he or she will have to wait a year and a half. "Subspecialty care does not exist," Halvorson points out. "In Spain, the waiting time for a pathologist to look at a woman who has been defined as having a problematic mammogram runs three to six months for the follow-up visit to have a pathologist do and read a biopsy. In the United States, that delay would be malpractice."

Levels of Coverage

Caregivers, policymakers, and consumers in the United States could learn from the health systems of other countries, such as Chile. There, the government has established a plan for universal coverage under a model in which a percentage of each individual's earnings is retained to pay for coverage. "The system offers different coverage levels based on each worker's paycheck," Halvorson explains. Under this system, the government has been able to meet the citizens' basic health care needs.

Brazil has allowed clinics to form their own limited-benefit health plans. "This is an interesting model that can potentially work in some rural areas of the United States," Halvorson states. "In fact, HealthPartners is doing something similar in a small, northwestern Minnesota town named Thief River Falls, where local employers and citizens have formed a small cooperative health plan built around the community itself."

Before doing the research for this book, Halvorson wondered how governments in other countries could operate health care delivery systems that represent 6% or 7% of the gross domestic product, while health care in the United States accounts for 14% of GDP. "The health systems in these countries do not have MRIs or other expensive diagnostics and procedures," he observes. "Rather, they finance an extensive primary care network and ration care for the very ill."

The United States is the only country that focuses on information technology, data collection, and best practices as an antidote for costs. "Everyone else addresses costs by rationing care in some way," states Halvorson. "For example, the British system does not do many transplants. Canadian hospitals virtually close in December because they have run out of budget. When they run out of money, they stop delivering care, except for emergency care."

Luxury or Entitlement?

One problem in the United States is that many Americans view MRIs and other diagnostic procedures as an entitlement or as a requirement for good care, believing that the medical examination is not complete until the patient has had an MRI, Halvorson says. It will be hard to reverse such thinking, he adds. "The only option is to use MRIs and other expensive diagnostic procedures appropriately," he adds. "Everyone used to get an x-ray; although it probably was not good for people, it was a standard diagnostic tool. The use of x-rays for the right patients is not a bad thing, just as using the MRI for the right patients is not a bad thing. However, using MRIs when there is no need is a waste of resources."

Medical information systems are helping U.S. health plans manage costs through careful use of resources, Halvorson continues. "If patients have some sense of what their disease is, they are going to get information about the appropriate and best treatment for that disease," he explains. "As long as the information about what constitutes appropriate care comes from credible sources, asking for this kind of prophylactic MRI is not likely to be an issue."

Furthermore, as long as care is given appropriately, cost management will improve regardless of whether care is provided by PCPs or specialists. In the United States, only about one third of all physicians are generalists, while two thirds are specialists. The income of PCPs is one third to two thirds lower than that of specialists. But overuse of specialty care is not the main driver of health care costs, as many people assume.

"Physicians comprise only 17% to 18% of the total health care expense," says Halvorson. "That's not the cost problem in the United States. The highest health care expense is the provision of unneces-

Many Americans view MRIs and other diagnostic procedures as an entitlement or as a requirement for good care, believing that the medical examination is not complete without them. It will be hard to reverse such thinking, Halvorson says.

sary care, such as treatment of the complications of diabetes, which should have been avoided. So costs are not largely driven by the type of doctor giving care, but by whether or not the best care is delivered."

Appropriate Care

Halvorson bolsters his argument by referring to Paul Brat, MD, retired medical director of HealthPartners. Brat wanted chest pain patients to go directly to a cardiologist, Halvorson notes, because he believed that cardiologists could assess and treat chest pain more quickly than would be the case if patients were first sent to a PCP and then to a cardiologist. "Brat believed that the whole process of having a cardiologist appear early would improve quality and reduce costs," he says. "Rather than have a PCP be a surrogate or a replacement for the cardiologist, Brat believed the cardiologist was more likely to make a reasonable, quick, and even conservative decision on care. The issue isn't specialists versus primary care. It's doing the right thing for each patient."

In fact, a significant part of the managed care backlash was a reaction against gatekeeper systems. Sophisticated U.S. consumers want to self-refer to a specialist. "Redefining the gatekeeper as being a facilitator of access is a model that works better," Halvorson believes. "Some managed care models tried to have a gatekeeper be a restriction to care, and that's not a good model for patients. A very good model for patients is to have a primary care doctor who knows them well, who has been interacting with them for years, and has a good sense of their medical history. Then, when patients present with a complaint, the doctor can treat it 80% to 90% of the time, or immediately refer them to a specialist."

One of the most difficult cost issues to resolve involves paying for the care of the uninsured. The United States has more than 40 million uninsured citizens, and as the number climbs, more Americans find fault with the current health care financing system, Halvorson says. "There needs to be some way of getting coverage for those folks," he adds. "Using tax-rebate types of strategies to help people get coverage will be irrelevant for many people because a large portion of the uninsured do not pay taxes. In California, we have more than 7 million uninsured people. Given the magnitude of that problem, we will not be able to resolve it with a market-based solution such as vouchers or tax credits. A lot of those people don't need insurance. They need care. People in Great Britain would not necessarily say they were insured, but they would say that they have access to primary care."

More Clinics

A problem that is related to the issue of the uninsured is that of the health care infrastructure in U.S. cities, which needs to be strengthened, the authors say. "We need more community clinics and more hospital support," Halvorson comments. "Furthermore, we see this as an opportunity to train nurses, technicians, and other caregivers. This could be similar to programs instituted at the end of the Korean War when we tripled the number of teachers in this country by paying for their education on the condition that if they taught for a certain number of years, their loans would be forgiven.

"We recommend a similar program for medical technicians and nurses because there is a huge nursing shortage that will get worse as time goes on," Halvorson continues. "Many people might not go to nursing school now because they cannot afford the tuition. Therefore we suggest subsidized programs to train the necessary personnel, and then give these professionals jobs in community health care."

This type of program is similar to the Physician Service Corps, which has subsidized the medical education of 2,000 physicians who provide care in underserved areas. "We need that type of program much more broadly throughout the health care system," states Halvorson. "We also need more sites for care. We do not have enough caregivers in the inner city. As a result, people are avoiding care until they are really sick. Then they go to the emergency room, where the health care system is financing their care anyway.

"It's not true that the health care system does not provide care to the uninsured," Halvorson concludes. "Rather, we provide it when it is too late, inconvenient, and sometimes dangerous. We would be better off with a formal system of care that draws on best practices, using computer support."

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

"The highest health care expense is the provision of unnecessary care, such as treatment of complications, which should have been avoided. So costs are not largely driven by the type of doctor giving care, but by whether or not the best care is delivered."

Risks Seen in Asset-Protection Plans

By Christopher R. Jarvis, MBA, and David B. Mandell, JD, MBA

The litigious nature of our society, combined with the current crisis in malpractice insurance rates for physicians, may prompt many medical groups to consider various strategies to protect one of their most valuable practice assets: their accounts receivable. Although asset protection plans can be constructed so that participating physicians receive retirement income, some plans may not provide the protection from tax liability that some tax advisers suggest they should provide.

What's more, financial managers are finding some of the strategies being used by physicians to shield their accounts receivable to be troublesome: If physicians seeking to protect their accounts receivable from being taken in a lawsuit fail to use the proper strategies, they could face costly tax consequences.

Gaining Leverage

Most physicians have large accounts receivable balances on the practice's balance sheet. This exposed asset could be the practice's most vulnerable asset in a malpractice or other lawsuit against a physician or one of the physician's partners. Therefore, the accounts receivable must be shielded, even before the practice engages in any asset protection strategies involving the personal assets of the physicians.

A number of asset protection strategies make false promises about the ensuing tax implications. Many professionals who suggest such strategies and state that implementing them involves no present-year taxation put physicians in a serious tax risk because significant tax liabilities may occur. Here's how: In almost all accounts receivable protection strategies, the practice receives a loan on its accounts receivable and pledges the accounts receivable as collateral. The practice must invest the loan proceeds in an asset-protected manner (often through an asset protected investment, such as life insurance or an annuity) but not so that they would be exposed to the practice's creditors.

In a typical accounts receivable financing strategy, the practice uses the loan proceeds to fund a deferred compensation plan for the physicians. The interest on the loan is allegedly tax deductible, making the financial cost of the loan 40% to 50% less than it would be otherwise. As part of the deferred compensation plan, the practice buys annuities or life insurance policies on each physician's life. Also, the lender takes a security interest in the policy or annuity.

Once the practice has the funds, it does one of two things: It either transfers the annuity or policy to the physician while retaining some nominal rights in the annuity or policy, or it allows the physician to take out loans against the annuity or policy. At retirement, the physician can liquidate the annuity or policy and repay the loan principal to the practice, which then pays off the lender. The physician then can access the annuity or policy value remaining during retirement.

Taxing Liabilities

Although thousands of physicians have implemented such plans, many tax attorneys and financial managers contend that this arrangement is not an effective tax strategy. They argue that the IRS will rule that these plans typically produce taxable income for the practice. The IRS could decide, under Section 83 of its regulations involving constructive receipt principles, that the nominal rights that the practice has in the annuity or policy mean that each year the practice should treat any transfer to a physician as taxable income to the physician. The problem with this plan is that if a physician hasn't paid taxes on the income until retirement in year 20, at which time the IRS takes this position, the physician could be liable for taxes, interest, and penalties going back 20 years.

What's more, it is likely that these plans do not adequately protect the

Christopher R. Jarvis, MBA, *and* **David B. Mandell, JD, MBA**, *are the authors of* The Doctor's Wealth Protection Guide *(John Wiley & Sons, New York, 2000), and* Wealth Protection: Build & Preserve Your Financial Fortress *(Wiley, 2002). They also are principals at Jarvis & Mandell, LLC, a company in Los Angeles that specializes in developing wealth protection strategies for professionals and business owners. Readers may call them (at 800/554-7233) or visit their Web site (at www.jarvisandmandell.com).*

Accounts receivable balances could be the most vulnerable asset in a malpractice or other lawsuit because any claim against a physician or one of the physician's partners could threaten the practice's AR.

practice's accounts receivable assets because the legal documentation supporting the plans would probably not withstand a creditor's challenge.

The key issue in a challenge would involve whether the loan document securing the accounts receivable protects the accounts receivable as primary collateral or whether the loan document focuses more on providing an annuity or insurance policy. In the plans we have reviewed, the accounts receivable is not the primary collateral, thus it is not adequately protected.

Limiting Liability

In a properly structured accounts receivable financing strategy, the practice invests the loan proceeds in a limited liability corporation created for a legitimate business purpose (that is, getting a market return on its investment) not simply to own life insurance. Any physician who wishes to participate could also invest after-tax dollars in the limited liability corporation. The limited liability corporation then purchases a life insurance policy on the physician member. If the limited liability corporation is structured correctly and the actuarial assumptions in the policy are properly substantiated, there is no taxable transfer of value between the practice and the physician at any time.

Under the limited liability corporation agreement, the physician would own any cash value position in the life insurance policy and the practice would own the death benefit. When the physician retires, the limited liability corporation takes a loan from the policy and pays the practice the loan principal. The practice then pays off the lender. The physician owns the remaining cash balance in the policy through the limited liability corporation, meaning he or she can take tax-free loans from the policy throughout retirement. The practice gets the death benefit when the physician dies, and the benefit can be used in a number of buy-out scenarios, such as the practice buying out the physician's interest in a partnership or group from a deceased physician's family.

This structure satisfies tax regulations involving deferred compensation, risk of forfeiture, and Section 83. Also, when this strategy is implemented with the proper security agreements, the practice's assets will be protected in the event of a lawsuit.

—Readers may get the Special Report on the Malpractice Crisis *from Jarvis and Mandell. It includes an in-depth discussion on accounts receivable protection strategies. To receive a copy of the report, call 800/554-7233 or visit the Web (at www.jarvisandmandell.com). More physician practice strategies are available on our Web site* *(see page 16).*

Another Insurer Leaves Malpractice Business

The Farmers Insurance Group of Companies in Los Angeles announced in September that it would stop offering medical malpractice insurance. Effective immediately, it would no longer write new medical malpractice coverage, and after Dec. 31 would not renew physicians' existing policies, the company said. The Farmers has medical malpractice policies with physicians in 18 states.

"We will work attentively with our clients and their agents to address any concerns and challenges that arise during this transition," said Jeff Reinig, vice president of Farmers' Healthcare Professional Liability business. "As necessary, we will assist our customers in locating alternate carriers."

Farmers has recently been affected by significant underwriting losses, a spokesperson told the Associated Press in an article in *The Houston Chronicle*. The company has $94.5 million worth of active malpractice policies, a sharp decline from the $231 million in policies in force last year, the newspaper reported. The company lost more than $100 million on its malpractice policies last year and is losing a similar amount this year. The company plans to redirect its focus to its primary lines of life, business, home, and auto insurance.

For physicians, the loss of Farmers narrows the market for malpractice insurance still further, experts said. In 2001, the St. Paul Companies, a multiple-line insurer in St. Paul, Minn., exited the medical malpractice insurance business after it lost $940 million on premium income of about $530 million.

In addition to the tax problems inherent in some asset-protection plans, it is also likely that these plans do not protect the accounts receivable assets adequately because the legal documentation supporting the plans is not likely to withstand a creditor's challenge.

(Continued from page 1)

could support such an investment, Ravendhran says. "Certainly, a solo practitioner would need a nurse practitioner to help support hepatitis C care, although it may take a gastroenterologist three or four years to build the patient volume that would be sufficient to hire a nurse practitioner," he notes.

Improving Compliance

Once Ravendhran and his patients decide to start treatment, the nurse practitioner counsels them about managing their drug regimen. "I used to handle patient education, but I trained the nurse practitioner to assume this responsibility," Ravendhran explains. "Delegating saves me the 30 minutes I used to spend with each patient explaining the side effects of the therapy and how to self-administer the injections."

The nurse practitioner also follows up with the laboratory to obtain test results and helps manage all successive visits for patients with hepatitis C. "If I did not have the nurse practitioner's help, I would have to handle 50 to 60 follow-up patient visits per month," Ravendhran says. "These follow-up visits would take a considerable amount of my time—a full week or more."

Instead, the efficiency gained by using a nurse practitioner to support the care of patients with hepatitis C allows Ravendhran to maximize the time he can spend performing procedures for patients who have other conditions, including performing endoscopies and other more lucrative procedures. "By treating other patients, I can keep up my productivity within the group," he says.

Steps in Care

Overall, providing efficient care to patients with hepatitis C and particularly those who have recently been diagnosed is key to achieving positive financial gains. Doing so means ensuring that all laboratory tests are completed and that all lab reports are in the patient chart before the patient's next visit. "One of the most frustrating scenarios for any physician is to find no lab reports in the file when a patient arrives for the visit," Ravendhran notes. "Gastroenterologists treating patients with hepatitis C should train their staff to check whether the patient's lab values are in the chart immediately after the patient calls for the appointment, and if not, to ensure that those reports are received before the visit."

Another step in enhancing efficiency involves providing patient education during the initial visit. "During this visit, I discuss the patient's condition, the treatment options, and the possible plan of treatment," Ravendhran says. "I also give the patient an information package that includes a description of the condition and treatment options." He also discusses whether to do a liver biopsy. "If the gastroenterologist can decide during the first visit whether a biopsy is needed, he or she can avoid a delay before starting treatment," he notes.

During the second visit, physicians should address patient questions, results from the liver biopsy (if any), and treatment options. "I ask my patients to bring their significant other (such as a close friend, spouse, or both) to the second visit," Ravendhran explains. "During this visit, we discuss the side effects, complications, and possible outcomes of the treatment options and create a plan for treatment." A friend or loved one can help the patient recall the information discussed and can support the patient in making treatment decisions.

The information given at the first visit helps improve efficiency during the second visit. "When the patient receives comprehensive written information after the first visit, he or she becomes informed and educated about the condition," Ravendhran notes. "In fact, time is a crucial factor when caring for patients with hepatitis C. These patients tend to have many questions, and answering those questions can take up to 25 minutes of visit time. The need to address basic questions can be avoided if we give patients full information the first time they walk out of the office." In this way, the second visit is more efficient because general yet thorough information has been provided up front, so the next discussion can focus on more complex questions, he points out.

On the third visit, treatment is started. "Once treatment is started, I see the patient in two weeks, then four weeks, and subsequently about every six weeks," Ravendhran explains. "After the fourth or fifth visit, the physician tends to gain a good understanding of the patient, so later visits could possibly be scheduled with a longer lag time, increasing the efficiency of treating these patients."

The initial visits of patients with hepatitis C can take considerable time, but gastroenterologists can be

(Continued on page 9)

Time is a crucial factor when caring for patients with hepatitis C, says Natarajan Ravendhran, MD, adding that these patients have many questions, and answering those questions can take up to 25 minutes.

(Continued from page 8)

reimbursed for this time through proper documentation and coding of the visit. “If I give a consultation that takes 30 minutes, I am careful to document the amount of time spent and the topics covered: natural history, treatment options, side effects, and complications,” Ravendhran says. “That type of conversation cannot be handled quickly. If gastroenterologists document very thoroughly the amount of time they spend with their patients who have hepatitis C, they can enhance the likelihood that their time will not be undervalued by payers.”

Also, gastroenterologists should be selective in the patients with hepatitis C who they accept in their practice, Ravendhran counsels. “Physicians should try to determine which patients are likely to comply with treatment regimens and schedule follow-up visits,” he says. “They or their nurse practitioner may be able to screen for this characteristic. If gastroenterologists accept patients who do not comply with treatment, the initial investment of time in counseling the patient will be wasted.”

Balancing Care

Another important issue involves balancing the care given to patients with hepatitis C with the care delivered to other patients. “I set some limits as to how many patients with hepatitis C I accept so that I can maintain a general gastroenterology practice,” Ravendhran says. “For example, I accept only 16 to 20 new patients with hepatitis C each month. If I accepted every new patient, my appointment waiting time might be as high as six weeks. Patients with hepatitis C simply require more time and care, especially right after diagnosis, and they require ongoing care as well. This care does not generate any procedures, so a physician’s financial productivity will be limited if a majority of the practice consists of patients with hepatitis C. By limiting the new patients with hepatitis C who I accept, I can better balance my ratio of general gastroenterology to hepatology patients.”

Ravendhran advises gastroenterologists interested in caring for patients with hepatitis C to use the resources available from pharmaceutical companies to help educate these patients. “The drug companies have a commitment to care and offer good counseling services for patients,” he says. “For example, they offer toll-free telephone lines that patients can call for information. Patients can be encouraged to use these resources because the physician’s time is so limited.”

For Ravendhran, caring for patients with hepatitis C can be rewarding. “It is fulfilling to see patients who have been treated and who become clear of active disease,” he says. “I feel wonderful when a patient comes to a visit happy and thanks me for the care I provided. That is a joy, and makes my effort worthwhile.”

—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).

Biopsy Rates at Issue

While payers tend to reimburse gastroenterologists fairly for office visits, the reimbursement they receive for a liver biopsy is often low, says Natarajan Ravendhran, MD, a gastroenterologist with Digestive Disease Associates in Baltimore and Columbia, Md. As a result, radiologists, who receive higher reimbursement for the procedure than gastroenterologists, perform most liver biopsies.

When a gastroenterologist does the procedure, the biopsy may take 20 to 30 minutes and the postbiopsy management about three hours. “We keep the patient in the hospital and we are still responsible for him or her during that time,” Ravendhran observes. “Unfortunately, we do not bill for that time because there is no mechanism by which we can be reimbursed for that type of service.

“Perhaps if the reimbursement gastroenterologists receive for liver biopsies is increased because of the time needed to provide postoperative care for patients, more gastroenterologists would perform liver biopsies,” Ravendhran comments. Having a gastroenterologist do the procedure would streamline care for patients and provide additional revenue. The complication rates for physicians who do a biopsy versus those who do an ultrasound-guided procedure are roughly equivalent, he adds. Thus, if gastroenterologists do the procedure, there would be no adverse effect on quality, he says. —DJN

“If gastroenterologists accept patients who do not comply with treatment, the initial investment of time in counseling the patient will be wasted,” says Ravendhran.

New Methods of Chronic Care Needed

Given that about 125 million Americans suffer from a chronic medical condition and that they account for more that 75% of health care spending, the U.S. health care system needs more effective ways to treat them, experts say.

Gerard F. Anderson, MD, national program director for the Partnership for Solutions program at Johns Hopkins University in Baltimore, calls for a model of care that provides coordination and quality care for people living with chronic conditions. The model would also require physicians, policymakers, payers, and patients to work together to change the health care system.

Aggressive Treatment

"A good chronic condition response model is not unlike the response to the crisis of infectious diseases a century ago, in which public health measures were broadly constructed and applied to address a range of diseases," says Anderson. "It is this type of broad-based reform that we need to consider to improve care and quality of life for the growing number of people with chronic conditions." Such reform would benefit physicians, says Anderson, by encouraging them—possibly through reimbursement incentives—to treat patients with chronic conditions more aggressively.

Although many physicians take steps to educate and aggressively evaluate their chronically ill patients, much more needs to be done, according to the Foundation for Accountability, a health care research organization in Portland, Ore. About two thirds of all chronic populations surveyed report appropriate levels of counseling on self-care from their physician, say FACCT officials.

FACCT reports that although the great majority of patients express confidence in their doctors, only about one half of the patients it surveyed believe they were fully involved with their doctor in making decisions about their care or could translate that relationship into a confident sense of how to manage their illness, FACCT says. Among diabetes sufferers, for example, 42% reported that they were confused about or had never been advised about how to manage their illness.

"Americans with chronic illness are no more or less likely than others to choose healthy behaviors and lifestyles," says FACCT in a report issued last year, *A Portrait of the Chronically Ill in America*. The report is considered one of the most complete reviews of the treatment of chronically ill patients in private practices. "And physicians, while seeing these patients far more often than others, often fail to communicate the importance of healthy living and the mechanics of disease management skills to their patients," the report says.

"While the consequences of poor exercise, smoking, and alcohol misuse are far greater for people with depression, diabetes, and heart disease than for the general population, physicians do not seem to be aggressive in offering their patients counseling on changing these risky behaviors," the report says. For the report, FACCT researchers conducted a survey on the care of 6,000 chronically ill patients.

Many patients, despite being counseled, reported remaining confused and being unable to perform basic self-care activities after leaving their physician's office, FACCT says. What's more, many patients continued behaviors that had distinctively high risks for complications given their illnesses, FACCT says.

For example, about two thirds of people with diabetes did not exercise regularly, and 38% had never had a doctor observe them monitoring their blood sugar; 26% of coronary disease sufferers surveyed continued to smoke, and only half of them had a doctor advise them to quit; 40% of people with hypertension said they had not been advised to limit salt intake or to control their weight, FACCT says.

Also, physicians often fail to instruct patients with asthma on how to take better care of themselves. The FACCT report found that one third of patients with asthma have not been shown how to use an inhaler or what to do during a severe attack.

Education Needed

One reason patients with chronic conditions are not adequately taught to care for themselves is that the system is designed for acute conditions rather than chronic care, says Thomas Bodenheimer, MD, a clinical professor in the Department of Family and Community Medicine at the University of California San Francisco Medical School. Bodenheimer has written extensively about treating chronically ill patients.

"Physician visits are short and

Broad-based reform is needed to improve care and quality of life for the growing number of people with chronic conditions, experts say.

without planning to make sure that chronic needs are addressed," Bodenheimer says. "Caring for chronic illness usually features uninformed and passive patients interacting with an unprepared practice team."

Ironically, part of the reason chronic care is so expensive is that physicians treat patients with acute conditions more effectively than they did in the past, says Anderson. "The upshot is that although people are living longer, they are now living with more chronic disease," he explains. "Adjusting the systems of financing and delivering care to better meet the needs of people with chronic conditions requires a focus on preventing diseases when possible, identifying diseases early when they occur, implementing secondary and tertiary prevention strategies that slow disease progression and the onset of activity limitations, and coordinating chronic care across the service continuum."

Health Care Costs Rise With Number of Conditions

For a patient with one chronic condition, health care spending is twice that of a person who does not have a chronic condition, says Gerard F. Anderson, MD, national program director for the Partnership for Solutions program at Johns Hopkins University in Baltimore. On average, a person with one chronic condition sees three different physicians and fills six prescriptions a year, he adds.

Patients with multiple chronic conditions have even more physician contact and are more likely to be hospitalized each year than those with only one chronic condition, Anderson says. Patients with five or more chronic conditions have an average of almost 15 physician visits and 50 prescriptions per year.

In an article in the *Archives of Internal Medicine* (Feb. 24, 2003), Anderson reported on a study in which researchers analyzed data on 1,663 people in the general population, 1,238 physicians, and 155 policymakers, who were all surveyed regarding how well the U.S. health care system addresses the needs of patients with chronic conditions. More than 90% of physicians and general citizens agreed that chronic conditions could affect men and women of any age, ethnicity, or income level. (Data were not available for policymakers on this point.)

A majority of respondents said it is difficult for chronically ill patients to obtain adequate health insurance, receive care from a medical specialist, obtain home assistance from family members, obtain needed prescription medications, and receive care from a primary care physician or other health care provider. —MS

The Physician's Role

A good example of the role individual physicians can play in improving the self-management of patients with chronic disease is advising them about smoking cessation, according to the federal Agency for Healthcare Research and Quality in Rockville, Md. The AHRQ says a substantial number of smokers who reported having a diagnosed chronic condition continue to smoke despite their health problems. Specifically, in 2000, about 37.9% of people with emphysema, 24.8% of people with asthma, 20% of people with hypertension or cardiovascular problems, and 18.5% of people with diabetes reported that they currently smoked.

Many physicians do discuss smoking with their patients, says AHRQ. In fact, three out of five smokers who have chronic conditions have reported that their physician had advised them in the previous 12 months to stop smoking, according to the AHRQ, and overall, about 57% of smokers who had a routine checkup in the previous 12 months were counseled by a physician to stop smoking.

The data come from a self-administered questionnaire added to AHRQ's Medical Expenditure Panel Survey in late 2000 and early 2001 to collect information on health care quality and patient satisfaction with health care. These data on smoking in the United States were derived by combining the results of the new questionnaire with data on the demographics, rate of chronic conditions, and preventive care information collected in the MEPS nationally representative survey of people over age 18 who are not in the military or living in institutions. More than 15,600 people responded to the survey questions, AHRQ says.

But do enough physicians address the issue of smoking with their chronically ill patients? Not according to FACCT, which collected data during the same period as the MEPS study and found that more than one third of people who were chronically ill and smoke had not been counseled by their physicians to quit. What's worse, according to FACCT, is that even in the face of serious respiratory illness, 31% of smokers with asthma reported that their physicians had not asked them to stop smoking. And two thirds of those who lead a sedentary lifestyle had never been asked to increase their regular physical activity, FACCT says. Physicians appear to be particularly reluctant to advise patients who are chronically ill and at high risk for alcohol misuse to

(Continued on page 12)

(Continued from page 11)

monitor their drinking habits. Only 11% were advised to do so, according to FACCT.

One way to improve care for patients with chronic conditions is through the increased use of practice guidelines that emphasize the importance of self-care education, FACCT says. “Guidelines recognize that infrequent and brief visits to the physician cannot substitute for active monitoring of key indicators, such as peak flow, blood pressure, and blood glucose,” FACCT states. “And many patients need to use and manage their medication programs carefully to avoid complications.”

Comorbid Conditions

Physicians also need to address the issue of comorbidities among patients with chronic illness, says Allen R. Nissenson, MD, a nephrologist at the University of California, Los Angeles, and co-chair of the National Anemia Action Council in Milwaukee (at www.anemia.org), a consortium of physicians who specialize in identifying and treating anemia. Anemia, for example, is present in a substantial number of patients with a variety of chronic diseases, he says, and is frequently undetected because it is masked by symptoms of the diseases with which it is associated, including chronic kidney disease, cancer, diabetes, cardiovascular disease, HIV/AIDS, rheumatoid arthritis, and inflammatory bowel disease.

As a result, patients with chronic illness should be tested for anemia as early as possible, Nissenson says. “If anemia is recognized early, its treatment significantly reduces the likelihood of cardiovascular complications,” he says, which, he notes, could improve outcomes.

Frustration Cited

There are several ways health systems can improve outcomes for patients with chronic conditions including addressing the issue of reimbursement, providing more support for clinical staff, and conducting more physician training, according to *Chronic Conditions: Making The Case for Ongoing Care,* a report published in December 2002 by the Partnership for Solutions.

Physicians find that treating patients with chronic conditions is frustrating, in part because they believe they have been inadequately trained, the partnership report shows. Although 54% of physicians report a high level of satisfaction with the care they provide to patients in the general population, only 36% of physicians responding to a telephone survey reported the same level of satisfaction in treating chronically ill patients. In surveys conducted in 2000 and 2001, partnership researchers interviewed 1,236 physicians.

When treating patients with chronic conditions, physicians believe their training did not adequately prepare them to coordinate in-home and community services (66%), educate patients with chronic conditions (66%), manage the psychological and social aspects of chronic care (64%), provide effective nutritional guidance (63%), or manage chronic pain (63%).

The partnership report outlines the prevalence and cost of major chronic health conditions, reporting that almost half (60 million) of the 127 million Americans with chronic conditions have multiple conditions and account for more than half of all health care spending.

A chronic condition, according to the report, is a medical condition that lasts a year or longer, limits a patient’s activities, and may require ongoing medical care. Having multiple chronic conditions increases the risk that activity can be limited still further.

Common Illnesses

The most common chronic conditions in adults are hypertension (affecting 26% of Americans who are not institutionalized but who have a chronic disease), mental illness (22%), respiratory disease (18%), arthritis (13%), heart disease (12%), eye disorders (10%), asthma (10%), cholesterol disorders (9%), and diabetes (9%). Many patients have more than one condition. In children, the most common chronic conditions are respiratory diseases (33%) and asthma (28%).

Chronic conditions have the most detrimental effect on the elderly, the report says. Almost all Medicare resources and the majority of Medicaid resources are used on behalf of beneficiaries with one or more chronic conditions. What’s more, two thirds of Medicare spending is on behalf of people with five or more chronic conditions, the report adds.

Ultimately, the U.S. health care system is a good news-bad news story. “Americans with chronic illness tell a positive story, but one with many gaps that remain to be filled,” the FACCT report concludes. “People are functioning, learning, and managing. They are using our health system, seeing their doctors, getting many of the right tests and treatments, and managing to live their lives with only modest limitations. But our system is falling short.”

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice strategies is on our Web site (see page 16).

“Americans with chronic illness are no more or less likely than others to choose healthy behaviors and lifestyles.” *—FACCT*

Battles Brewing as Physicians Build Specialty Centers, Consultant Says

***Daniel Beckham** is president of The Beckham Company, a health care consulting firm in Bluffton, S.C. Most of his engagements involve strategic planning for hospitals, health systems, and multispecialty group practices, and his clients include the Mayo Clinic and the Cleveland Clinic. Beckham discussed with Editor in chief Richard L. Reece, MD, the changing relationships between physicians and hospitals.*

Q: *Since hospitals are still the power and money centers in most communities, are they the only organizations that can make a difference in health care in many markets?*

A: Yes. Unfortunately, the physician community is so divided. The downside of physicians' independence is that doctors have no collective voice. The hospital, at least arguably, has that.

Q: *Has the state of affairs between hospitals and primary care physicians changed over the last five years?*

A: Yes. About five years ago, there was a fair amount of primary care imperialism. Because of the gatekeeper model and managed care's emphasis on primary care, the notion was that primary care was going to control the flow of health care dollars to hospitals and specialists. That has not occurred; in fact, the power of primary care within health care has diminished significantly compared with what industry experts thought would be the case. That loss of power has clearly had some impact on the relationships PCPs have with hospitals.

What's more, hospitals have begun to question how primary care fits into their overall business strategy. In many instances, hospitals, because of financial pressures, have had to divest themselves of the primary care practices they once owned. Some institutions, such as the Detroit Medical Center, have jettisoned those groups.

However, the bigger story is that a surprisingly high percentage of hospitals have decided to weather the financial losses and continue to own primary care practices. Many hospitals recognize that no matter what is said on the financial reports, PCPs have a significant role in steering patients to specialists in the hospital, thereby generating revenue. Of course, this revenue does not show up on the financial reports as being traceable to the PCPs. Probably the majority of hospitals that owned significant numbers of primary physician practices five years ago continue to own them today.

Q: *How do hospitals in these relationships provide a financial return on their investment?*

A: The losses associated with physician group ownership are diminishing. One reason for that decline is that management systems have been put into place; productivity-based compensation systems, in particular, have reduced a lot of losses. As a result of such systems, there is significantly less pressure today to divest those groups. The hospital-owned physician group is going to be around for the long haul.

In addition, hospitals have learned more about how to work with physicians and how to function better as partners with physician groups. Furthermore, over time, physicians who have not been suited to the owned-practice model have left or have been asked to leave, making the hospital-medical group relationship more sustainable and potentially more financially justifiable.

Q: *What has happened to the primary care practices that have been divested?*

A: Most of the PCPs who have left these hospital relationships have gotten themselves back on their feet. In retrospect, they probably regard negatively the relationship with the hospital as an employer, in just the same way the hospital regarded the impact of PCPs on its bottom line in a negative light.

Over about five years, some hospitals and hospital systems spent $5 million a year on their physician practice ownership strategy; the result of the $25 million investment is that both parties were disaffected. I recall sitting in meetings in the early 1990s where hospital CEOs referred to physicians as their assets and gave every indication that they intended to treat these physicians as assets, not displaying much sensitivity. We

(Continued on page 14)

"The losses associated with physician group ownership are diminishing in part because of productivity-based compensation systems."

(Continued from page 13)

could see the handwriting on the wall in terms of the outcome of such ventures.

When the trend toward hospital ownership of practices was starting, we tried to encourage our hospital clients not to go to a straight employment model, but rather to adopt more of a partnership model. In such a model, physicians retain a significant equity position in their practices and potentially roll that equity position into an equity position in a bigger group as the hospital purchases more practices. This strategy also substantially reduces the hospital's financial exposure. Physicians who did not go to the full employment model have found it easier to bounce back after hospital divestment.

Q: *Are hospitals, many of which are marginally profitable, now turning to partnerships with specialists?*

A: Hospitals have definitely shifted their attention toward specialists, which is part of the broader trend toward a diminishment in primary care power. Hospitals are trying to figure out how to secure more sustainable relationships with specialists. Specialists have higher incomes than PCPs, and they have money to invest in joint ventures for the creation of specialty centers. In some instances, the relationship involves employment. When hospitals directly employ some specialists, the question becomes, what is the inevitable evolution of that model? It may begin to look like a multispecialty group practice over time because the hospitals already own primary care practices.

Q: *Given the financial resources of specialists, aren't many of them forgoing a formal partnership with a hospital and opening outpatient centers on their own?*

A: Yes. Specialists are developing more entrepreneurial modes of practice, such as single-specialty hospitals, outpatient surgery centers, diagnostic centers, or single-specialty practices. In that regard, they are positioned to make some significant inroads into health care.

In many areas of the country, this trend is causing strife between specialists and hospitals. Since physicians offer outpatient care, such centers logically are an extension of their practice model. Hospitals, on the other hand, regard outpatient centers as an extension of their past and current involvement in outpatient ancillary services, and therefore view the specialists as intruding on the hospitals' existing business.

I am amazed at the level of investment in additional capacity that is being incurred by physicians, whether it is diagnostic capacity or outpatient surgery capacity. Many physicians who are making those investments are securing them with their home mortgages. It is a big risk. So who will fight the hardest: the guy who's got his house on the line or the hospital administrator? This has the potential to be a bruising battle in many cities and towns nationwide.

My firm has conducted interviews and focus groups with many CEOs and chief medical officers in hospitals and health systems and asked them to define their most significant challenge over the next 10 years. Every one of them identifies the single-specialty hospitals and the physician-led for-profit entities as the trends they are most concerned about.

Q: *Is there an upside to this battle between physicians and hospitals?*

A: Some research has indicated that these single-specialty centers have outcomes that are as good as, if not better than, the outcomes at more traditional hospitals. From a quality perspective, then, this trend is healthy because it forces all players to get up on their game. The outpatient care delivered in most hospitals is not customer-centered, is not very responsive, and is not very cost-effective.

In contrast, the free-standing surgery centers are much better at responding to the needs of both patients and physicians. A big hospital without that kind of responsiveness or sensitivity built into its management system will find it tough to compete against them. But the major downside over the long run is that to some extent, the trend toward single-specialty centers reinforces the fragmentation that comes naturally with specialization.

Q: *Does such fragmentation contribute to the failure of the health care system?*

A: In the current arrangement, there is only so much we can expect from caregivers, particularly physicians, who are operating very much as individual pieces. Someone must put into place the systems that allow and promote truly integrated care. It seems that quality and cost problems almost always arise at the interface between specialties, between departments, and between functions. Whose job is it to monitor these interfaces? In health care, the unfortunate

"Hospitals are now trying to figure out how to secure more sustainable relationships with specialists who have higher incomes than PCPs and have the money to invest in joint ventures for the creation of specialty centers."

answer is: "It's no one's job."

Managing and monitoring these interfaces should be the responsibility of system leadership. In a system, the challenge of leadership and management is not the management of actions, it's the management of interactions. Health care managers need to focus on the interaction among the pieces, which won't be made easier when physicians are hunkered down in their specialty silos. But that is the trend, so we have to respond to it. Information systems are obviously important, but we also need some basic accountability for "systemness."

Q: *What is the potential of electronic medical records in promoting integration, enhancing safety, and increasing cost-effectiveness?*

A: The answer to the problem of integrating EMRs is to prepare physicians for the eventuality of these systems. We need to say, "This is what's going to happen: We are going to experience a 25% productivity reduction, and you will get frustrated. But we need you to stick with this and it will pay off in the future." Everyone should realize that they are part of creating a system that ultimately will make the delivery of care easier, more cost-effective, and safer.

Q: *Has the movement toward employing hospitalists changed the relationship between hospitals and the larger community, particularly the primary care community?*

A: Yes. The initial resistance of physicians is clearly an issue when hospitals and health systems first work to adopt hospitalist programs, but later physicians who may have resisted the idea often become more positive. They appreciate having the hospitalist fill the gap when they cannot or do not want to go to the hospital. We hear many positive stories from doctors after a year or two of experience with the hospitalist program.

Historically, after all, a floor nurse provided the backup when the physician couldn't be at the hospital. Now we have a physician on the floor who can provide that backup.

Q: *A critical care nurse, a hospitalist, and an outpatient physician working together can be a strong team. Can health care learn from other industries about the power of teamwork?*

A: Yes, although service quality is very different from the quality of a tangible product, and health care is very much a service industry. Teamwork, which is very important to service quality, is absolutely critical to effective management of both care quality and cost-effectiveness. In many hospitals and health care systems, there are both nurses and a hospitalist on the floor; there are employed PCPs in a group across the street; and there are a growing number of employed subspecialists. Eventually, someone realizes that the organization needs to integrate these otherwise independent players into a true team.

The Mayo Clinic, which has always been distinguished by its commitment to teamwork, has carefully created a collaborative culture. This is the challenge for the industry overall. If teamwork is essential to managing cost and quality of care, then we need to determine how to design a process that ensures a preselection of caregivers oriented to working as a team.

Teamwork often starts with an economic motivation. Physicians, who are now employing physician assistants and nurse practitioners in order to enhance practice productivity and profitability, must figure out a way to work more closely with nonphysician providers.

In fact, doctors are becoming sensitive to the need for teamwork. Furthermore, the growing number of female physicians may accelerate the institutionalization of teamwork if the stereotype that female physicians are more collaborative is, in fact, true.

Q: *What do you predict will be the future organization of health care systems?*

A: Whether it comes from a physician-oriented model like that of the Mayo Clinic or an HMO-model like Kaiser Permanente's, the solution to many of health care's most daunting challenges is still integration. Unfortunately, integration has become a loaded term. In many minds, integration means deal-making and making acquisitions and trying to force a physician practice to fit into an organization.

Rather, integration means managing the interfaces among the pieces of health care delivery so that better care is delivered faster and more affordably. This integration must occur in the context of the basics of delivering care: conferring dignity on and offering information to patients, pursuing teamwork, and applying information systems so that caregivers collaborate, yielding higher quality and more efficiency. That's where the power is, and physicians have as much power in that regard as ever before.

—Edited 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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