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Clinicians Can Learn From Alternative Practitioners

Many physicians could learn from their colleagues who practice complementary and alternative medicine. Some doctors frown on the use of CAM, but many patients find value in seeing what some call unconventional practitioners, such as those who practice acupuncture, homeopathy, and naturopathy.

In fact, CAM is a \$40 billion industry, and Americans visit alternative practitioners at twice the rate of visits to conventional doctors. Nonetheless, traditional physicians and their patients rarely talk about CAM with each other, partly because patients who use it believe these physicians are critical of such use.

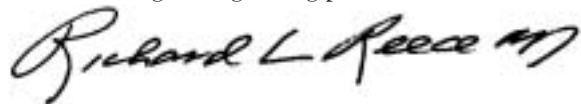
Patients may seek CAM providers for several reasons. They may crave the attention and compassion that they feel they get from alternative providers but not from traditional physicians in busy practices. They may fear the side effects from prescription medications and turn to herbal remedies instead. They may believe that conventional medicine cannot cure chronic or degenerative disease.

Noticing the growth of CAM, the National Institutes of Health founded the National Center for Complementary and Alternative Medicine in 1992. By the end of last year, 23 of 125 academic medical centers were participating in the Consortium of Academic Health Centers for Integrative Medicine. The American Academy of Family Physicians has published a primer on CAM for its 95,000 members and says CAM users tend to be well educated and well off and are willing to embrace the self-care, preventive care, and "natural" therapies that these practitioners offer.

Neil Baum, MD, author of *Take Charge of Your Practice* (Gaithersburg, Md.: Aspen, 1996), says clinicians should learn to work with CAM practitioners, in part to learn why so many patients believe conventional therapy doesn't relieve their symptoms, and why so many believe alternative therapies are more cost-effective and have fewer side effects. Using this knowledge, doctors can attract patients who might otherwise seek care from a nontraditional practitioner.

Physicians should also ask their patients in a friendly, nonthreatening way about their use of CAM. For safety reasons, physicians should consider revising patient questionnaires to include questions about alternative therapies, herbal medicine, and over-the-counter medications, especially since 15 million Americans take herbal medication that may interact with OTC or prescription drugs.

By developing relationships with qualified alternative practitioners, just as they would develop such relationships with other more traditional specialists, physicians may be able to refer patients to chiropractors, massage therapists, acupuncturists, and other CAM providers and get referrals back in return. From a patient safety and business-building perspective, it makes sense to learn more about this large and growing part of medicine.



Richard L. Reece, MD

Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

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Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

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

Neil Baum, MD

Urologist
New Orleans

Daniel Beckham

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

Thomas M. Gorey, JD

President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA

Executive Vice President
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD

Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman

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

Paul H. Keckley, PhD

Executive Director
Vanderbilt Center for
Evidence-based Medicine
Nashville, Tenn.

Peter R. Kongstvedt, MD

Partner
Cap Gemini Ernst & Young
Vienna, Va.

John W. McDaniel

President and CEO
Peak Performance Physicians, LLC
New Orleans

Lee Newcomer, MD

Executive Vice President
Vivius Inc.
St. Louis Park, Minn.

James G. Nuckolls, MD

Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD

Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

James M. Schibanoff, MD

Editor in chief
Milliman Care Guidelines
Milliman USA
San Diego

Jacque Sokolov, MD

Chairman
Sokolov, Sokolov, Burgess
Scottsdale, Ariz.

Flaws in Consumer Care Examined

Consumer-directed health care is defined by most experts today as high-deductible health plans accompanied by consumer contributions to tax-free health savings accounts. Recently, the concept has been receiving a lot of attention from the media, from health policy experts, and from physician organizations, mainly because advocates claim it will help control rising health care costs by shifting costs to consumers. Consumers will be frugal and careful when spending their money on health care, these experts say.

But not everyone sees the concept as a panacea for reducing health care inflation. In fact, some experts say the CDHC concept has flaws that could exacerbate health care inflation. Consumers, especially those suffering from chronic and costly conditions, are unprepared to make the treatment decisions necessary to make appropriate use of consumer-driven health plans, experts caution.

Promoting Quality

“What the CDHC concept is missing is any strategy to promote quality health care, and there’s plenty of evidence that improving the quality of care for the 10% of chronically ill people who account for more than two thirds of expenditures is the best way to control costs,” says Karen Davis, president of The Commonwealth Fund, a research organization in New York. “Also, these plans may be hard to under-

stand for many consumers, and their Internet-based tools may not be very easy to use.”

Kenneth Jacobsen, national health practice leader with The Segal Co., benefit consultants in Atlanta, agrees. “Consumers lack adequate information and experience to make informed decisions about choosing a health plan,” he says. “Who knows how to shop for and select quality, how to ask the right questions, and how much to pay? Very few people.”

What’s more, say Davis and other experts, is that the plans may not serve those people who need health insurance the most, such as the working uninsured poor who cannot afford the high deductibles and who won’t benefit from the tax breaks that come from investing in health savings accounts (HSAs). CDHC plans may draw healthy people away from traditional health plans, thus driving up premium costs in traditional plans. Another concern: CDHC plans may discourage consumers from seeking needed health care services, resulting in ultimately higher costs if they get sicker as a result.

“It is really cost-shifting,” says Alain Enthoven, PhD, a Stanford University economist. “That’s not necessarily bad. If employers are saying, ‘You’ll bear a greater part of the cost of your care,’ it can help get incentives right. But I don’t think it’s going to have a lasting effect on controlling costs.”

Reports about the popularity of

CDHC plans vary. On Sept. 9, *The Wall Street Journal* reported in “Health Savings Accounts Gain Momentum” that tens of thousands of HSAs had been opened in recent months. New rules designed to make HSAs more attractive to employers and consumers were introduced in the Medicare Prescription Drug Improvement and Modernization Act of 2003, which was enacted in December. About 20 financial institutions (including J.P. Morgan Chase & Co. and Mellon Financial Corp., both in New York) are marketing HSAs and about 50 insurers (including giants like Aetna and Cigna), as well as smaller companies (such as Destiny Health in Oak Brook, Ill.) are offering the high-deductible plans required for consumers to qualify under the MMA for HSA tax breaks.

However, a study released in July by the Center for Studying Health System Change in Washington, D.C., found that although employers are aware of consumer-driven plans, many are reluctant to implement them because of the costs and hassles of educating employees and because of unanswered questions about the programs, such as the effect of these plans on costs over time. The HSC study, *Rhetoric vs. Reality: Employer Views on Consumer-Driven Health Care*, was based on biannual interviews with employers, health benefit providers, and insurance brokers in 12 metropolitan areas. It concluded that despite providers’ and brokers’ strong promotion of consumer-driven

(Continued on page 4)

“So-called consumer-driven health care will lead to people not getting care and discriminates against low-wage workers. It could lead us back to bare-bones coverage and high deductibles.”

—Karen Davis, The Commonwealth Fund

(Continued from page 3)

plans, employers will not all move to the new plans “like lemmings into the sea.” The study argued for a wide range of health benefit plans to fit the needs of diverse businesses and work forces.

Market Appeal

Even so, the CDHC concept is appealing to some employers because market conditions are right, says Alexander Domaszewicz, senior consultant with Mercer Human Resource Consulting in Newport Beach, Calif. “Rising costs and dissatisfaction with traditional managed care techniques mean employers are looking for ways to manage health quality and cost,” he says.

However, like Davis, Domaszewicz warns that the CDHC concept has its dangers. “Asking employees to take on greater responsibility and accountability for health care decisions and not giving them the information, tools, and support to be effective is a recipe for disaster,” says Domaszewicz.

Davis and other health policy experts contributed to a supplement in the August issue of *Health Services Research*, a journal published by the Health Research and Educational Trust, a research organization in Chicago. Several articles in the supplement resulted from a conference, “Consumer-Driven Health Care: Evidence From the Field,” that examined the market potential of CDHC (available at www.academy-health.org/publications/hsr.pdf).

The September 2003 conference was held in Washington, D.C., and

sponsored by The Commonwealth Fund and The Robert Wood Johnson Foundation’s Changes in Health Care Financing and Organization Initiative, a research organization in Washington, D.C.

In her article in the HSR supplement, “Consumer-Driven Health Care: Will It Improve Health System Performance?” Davis opines that such plans are not likely to improve performance. In fact, CDHC plans could worsen health outcomes by reducing patients’ receipt of needed preventive care and care for chronic conditions, she argues.

Cost-shifting is not an effective way to control costs, says Davis. Studies have found that increased cost-sharing for prescription drugs has led to a reduction in filling prescriptions that are effective in controlling chronic conditions, she notes. Such studies and others have concluded that when people do not use available health insurance, their health status may suffer as a result, she adds.

Moreover, two studies published in the HSR supplement (“Employee Choice of Consumer-Driven Health Insurance in a Multiplan, Multi-product Setting” and “Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization”) suggest that the cost-savings employers experience do not lead to overall savings, Davis says.

Researchers for these two articles analyzed the CDHC experience of one large employer over three years. Initially, CDHC had helped

to reduce spending by reducing the number of prescription drugs used and the number of physician visits, factors that may have been related to nurse-line coaching services or comparative information that was available on pharmaceutical prices. Over three years, however, hospital admissions for CDHC enrollees doubled, eliminating any cost advantage. Although the rise in hospitalization might have been caused by the underuse of physician services to control conditions at an early stage, the researchers suggested that the rise in hospitalization may be because only one major medical center participated in the CDHC and it was available only to HMO and PPO enrollees with substantial out-of-pocket, out-of-network cost sharing.

Underuse of Care

Another problem, Davis says, is that some studies show that few CDHC plans advise patients who are underusing services. “Some plans exclude preventive services from the deductible, but financial incentives to avoid seeking care even in the face of serious symptoms could contribute to underutilization of essential services, as other cost-sharing studies have found,” Davis says. “Nor is anything known about the financial burden on lower wage employees with greater out-of-pocket costs not covered by health reimbursement accounts. The studies do suggest that CDHC plans have high information requirements in order for enrollees to understand the plans and use them

“What the CDHC concept is missing is any strategy to promote quality health care, and there’s plenty of evidence that improving the quality of care for the 10% of chronically people who account for more than two thirds of expenditures is the best way to control costs,” says Davis.

The Goal of Health System Improvement Should Be to Promote Quality, Expert Advises

The goal of health system improvement efforts should be to promote the spread of high-performing health systems, hospitals, and physicians, says Karen Davis, president of The Commonwealth Fund, a research organization in New York (at www.cmwf.org). In an article in the August issue of *Health Services Research*, a journal published by the Health Research and Educational Trust, Davis outlined several steps health systems should pursue as alternatives to consumer-driven health care.

To achieve a truly high-performance health system, Davis recommends that health systems address the root causes of poor performance, rather than using what she calls the blunt instrument of consumer financial incentives. "They should speed the adoption of modern information technology, and provide powerful financial incentives to hospitals, physicians, and integrated health care delivery systems to improve quality, safety, and efficiency performance," she says.

To do so, health systems and health policy planners should promote the public reporting of cost and quality data on physicians, hospitals, nursing homes, other health care providers, and health plans. "The Centers for Medicare & Medicaid Services has been a leader in posting nursing home quality data on its Web site, but this is just a modest beginning," Davis says. "If we are serious about doing better, we need to know where we stand, routinely collecting comprehensive quality measures across a broad range of providers."

Also, health systems and the federal government

should invest in health information technology. "Other countries are quickly surpassing the United States in the adoption of electronic medical records and electronic prescribing," she says. "They are doing so because the government has been willing to invest in the infrastructure and establish the standards required to make this potential a reality."

Health systems also should develop and promulgate clinical guidelines and quality standards, Davis suggests. "It is long past time to simply pay for services rendered without establishing a scientific basis for effectiveness, not just for new drugs, but for consultations, procedures, and tests," she says.

One of the most significant steps health systems can take involves paying for performance, Davis comments. Efforts to pay financial incentives for treatment quality should be expanded and best practices should be documented and disseminated, she says. Also, the federal government should have the Medicare program become a leader in the pay-for-performance movement, she adds. "To date, very few private insurers have instituted value-based purchasing strategies," she says.

And, finally, health systems should invest in research, Davis advises. "We urgently need to gather evidence on what works to improve care, eliminate waste and ineffective care, and promote greater efficiency, including use of modern information technology, teamwork, and improved care processes," she says. "Any industry that fails to invest in research to improve quality and efficiency is going to be a backward industry." —MS

effectively."

In fact, education and patient training are critical to the success of any CDHC plan, says Greg Scandlen, director of the Center for Consumer-Driven Health Care at the Galen Institute, a research organization in Alexandria, Va. "Good customer service is critical to making these plans work," Scandlen says.

Overall enrollment in CDHC plans is relatively low. Only about 10% of people who are offered such plans among other plans offered by their employers have chosen a CDHC plan, and only about 270,000

HSA were opened as of 2003, out of the 160 million people in employer-sponsored health plans, Davis says. Although reenrollment in CDHC plans is relatively high (90%), only 30% of enrollees say they would recommend such a plan to others, she adds. "This may suggest that they perceive their own situation to be relatively unique, and may not make the plan the best choice for others," she notes.

A more effective and equitable alternative to increased cost-sharing for patients would be care management for high-cost patients, says

Davis. "Longer term solutions aimed directly at the root causes of higher costs are needed to improve health system performance and to achieve better quality, safety, and efficiency of care provision," she comments. "So-called consumer-driven health care will lead to people not getting care and discriminates against low-wage workers. It could lead us back to barebones coverage and high deductibles."

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

Study Shows Effect of Rising Rates

Physicians, politicians, and patients are concerned about the escalating cost of medical malpractice insurance and whether the high rates are adversely affecting the quality of care. “We believe that increasing rates are affecting the quality of health care by driving doctors out of practice, and our research shows that nearly three fourths of all physicians agree with that,” says Donald J. Palmisano, MD, immediate past president of the AMA and a surgeon in private practice in New Orleans.

The National Bureau of Economic Research, an independent research organization in Cambridge, Mass., commissioned two Dartmouth College economists to study the issue. They published their findings in August in *The Effect of Malpractice Liability on the Delivery of Health Care*. In the report, the researchers concluded that

- Increases in malpractice payments made on behalf of physicians do not seem to be the driving force behind increases in premiums.
- Increases in malpractice costs do not seem to affect the overall size of the physician workforce.
- There is little evidence that physicians have increased the use of treatments in response to malpractice liability concerns, although there may be some increase in screening procedures, such as mammography.

To be sure, the researchers added, malpractice costs may affect individual physician’s decisions to enter medicine as a profession or when to retire, although they described that influence as weak. Malpractice costs seem to slightly reduce the rural physician workforce.

The conclusions of the NBER

researchers differ from those of the AMA. According to AMA data, between 1994 and 2001 average liability awards increased 176%, and in 2002, the last year the AMA published research data, the average malpractice jury award was \$3.9 million. President George W. Bush has said large liability settlements are driving up malpractice rates, and he has called for state and federal legislation mandating liability caps for noneconomic damages at \$250,000. Sen. John Kerry (D-Mass.), Bush’s opponent in the November election, opposes such limits, as do several consumer groups, including Public Citizen in Washington, D.C.

Data Sources

In discussing the NBER report, Katherine Baicker, assistant professor of economics at Dartmouth, in Hanover, N.H., and lead researcher on the NBER-sponsored project, notes that “we used data from a wide variety of sources to reach our conclusions. We saw hardly any evidence that a lot of doctors are leaving medicine because of rising state malpractice premiums or that the use of so-called defensive medicine has significantly increased.”

“The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings,” the NBER report concludes. Baicker’s research places the more dire predictions of malpractice alarmists in doubt, she says.

The NBER-commissioned study used annual state-level data on premiums, payments, physicians, and treatments to examine the long-term

effects of physician malpractice liability. To measure premium growth, the researchers gathered and analyzed data from the *Medical Liability Monitor*, an independent newsletter in Chicago that since 1991 has published a nationwide survey of annual physician malpractice insurance premiums. The newsletter’s survey provides premium data for internal medicine, general surgery, and obstetrics-gynecology by state.

To measure data on malpractice payments to plaintiffs, the researchers used the National Practitioner Data Bank (NPDB), which is maintained by the federal Department of Health and Human Services and collects data on all malpractice payments that physicians make to plaintiffs. The researchers analyzed payments at the state level, overall, and by specialty, averaged for 1992 to 1994 and for 2000 to 2002 and converted the totals in 2000 dollars.

Effect of Payments

Physician workforce information by specialty and age came from the 2003 Area Resource File (ARF), published by the National Center for Health Workforce Analysis, a database of the U.S. Department of Health and Human Services. The ARF gathers information from the AMA’s Physician Master File and the American Hospital Association’s County Hospital File. Finally, treatment rates were averaged by state for 1992 to 1994, 1999, and 2002 from data gathered from the National Center for Health Care Statistics and Medicare data.

The researchers used detailed eco-

Arguments that state tort reforms will avert local physician shortages are not supported by the findings.

conomic equations to determine the effect of changes in malpractice payments through judgments and settlements on changes in malpractice premiums. "Economic theory and previous empirical studies suggest that there are four primary factors that may explain the rise in malpractice premiums: declines in insurers' investment income (including the presence of an underwriting cycle), a less competitive insurance market, climbing reinsurance rates, and insurer losses from a growing number of malpractice claims and accompanying awards to plaintiffs," the researchers say.

Primarily, the researchers examined the last of those four factors, and found that with regard to the issue of awards payments, there seems to be a fairly weak relationship between malpractice payments for judgments and settlements and premiums, both overall and by specialty. "Past and present malpractice payments do not seem to be the driving force behind increases in premiums," the report says. "Premium growth may be affected by many factors beyond increases in payments, such as industry competition and the insurance underwriting cycle." The report did not address those two issues, a fact the authors described as a limitation of the study.

"We wanted to evaluate whether, by specialty and region, large jury awards were directly affecting premiums," says Baicker. "We could not find evidence that that was the case."

Effect on Workforce

The authors next examined whether states with larger increases in malpractice premiums saw greater declines in the per-capita number of physicians. With regard to the effect of malpractice liability on the physician workforce, the Dartmouth

researchers concluded that the effect apparently has been minimal.

The issue at the core of the relationship between workforce and malpractice premiums is whether "increases in malpractice premiums raise the costs of doing business for physicians and hospitals," Baicker says. If the increase in malpractice premiums is unique to certain areas or states, some physicians might respond to the increased costs and lower compensation by retiring early, or by moving to another state where premiums are lower, she says. If, however, demand for health services is inelastic in a region (meaning if there is a larger demand for health services than there is a supply of physicians to meet demand adequately), then net physician compensation would be unchanged regardless of malpractice insurance rates, and consumers of health care would bear the cost of increased malpractice rates through increases in prices and health insurance premiums.

Again using a detailed economic equation, the researchers concluded that increases in malpractice premiums will not necessarily result in physicians relocating. "There is thus reason to believe that there could be very few physician relocations in response to increases in premiums," the report says.

The researchers did find, however, that some groups of physicians are more sensitive to changes in malpractice liability costs: physicians under age 35, who are most likely to be choosing where to establish their practices; physicians over age 55, who are most likely to be choosing whether or when to retire from practice; and physicians practicing in rural areas, who may be particularly sensitive to increases in liability.

The authors also looked at the

effect of malpractice costs on the treatments patients receive. They analyzed several percutaneous coronary interventions, angiography, coronary artery bypass grafts, mammograms, Cesarean sections, transurethral prostatectomies for benign prostatic hyperplasia, and radical prostatectomies, as well as overall Medicare expenditures.

Effect on Treatment

There was little evidence of change in treatment patterns in response to increases in premiums, the report says. Except, the use of mammography seemed somewhat more sensitive to malpractice costs than the other procedures tested, according to the report.

With regard to treatment patterns, the authors did note, however, that their analysis reflected comparative regional service utilization, based on Medicare and other data. As a result, the researchers could not infer from the results that there was no defensive medicine, rather only that local differences in malpractice costs did not produce local differences in the physician workforce or the use of treatments, the report says.

The researchers concluded that the research does not support the argument that state tort reforms will avert local physician shortages or lead to greater efficiencies in care. This conclusion differs sharply from that of the AMA, says Palmisano, adding that he is not familiar with the NBER report's findings. "Our opinion is based on a wide variety of studies that demonstrate that malpractice liability costs are adversely affecting the practice of medicine," he says. "We believe the evidence of that is very strong."

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Some physicians, such as those under age 35, are more sensitive to changes in malpractice liability costs, the researchers found.

Primary Care Changes Needed to Improve Delivery of DM Services

By Richard L. Reece, MD, editor in chief

Disease management activities are growing within the managed care industry, fostered primarily by large employers and more recently by government purchasers dissatisfied with health plans' track records of controlling health care costs and managing chronic diseases, says David Epstein, MD, senior medical director of the Greater Rochester Independent Practices Association in Rochester, N.Y.

Unfortunately, while disease management programs are an important tool for improving patient care, they are not the silver bullet that many have touted, Epstein says. Programs are often delivered by "carve out" vendors, a process that may further fragment health care services provided to managed care members. Additional challenges include the ability to enroll and retain participants, and to focus adequate resources on eligible patients in programs long enough to show positive health and financial outcomes. Finally, physician support for and participation in DM programs are essential to improving patient outcomes and to ensure success of these programs. DM has not universally achieved sufficient involvement from physicians in order to "defragment" the delivery of health care services and improve patient involvement and clinical outcomes. Epstein offers a number of suggestions for improving the delivery of DM in primary care settings.

As a physician executive for 17 years, Epstein has served as medical director for national and regional managed care companies. He also has worked as a senior health care consultant for an international health

care and employee benefits firm and as a medical director for a national disease management company. He is a graduate of the Chicago Medical School, and is board certified in emergency medicine. He also has an MBA from Emory University.

Flaws Exposed

Disease management is an important strategy for improving care and controlling costs, Epstein believes. "Managed care is suffering today because it has failed to deliver on its initial promise during the late 1980s

care, most health systems expect primary care physicians to shoulder the clinical management burden for their patients' enrolled in DM activities. "Physicians typically are not reimbursed for DM activities, which take significant time and attention to manage properly," he says. "Time is money for PCPs, and expectations that they will participate in DM activities because it is the right thing to do is simply short-sighted and unfair."

The second problem is that PCPs tend not be organized in large groups or into managed care organizations.

"It makes some sense intuitively to manage patients with chronic disease proactively so that you can reduce costs."

—David Epstein, MD

to prevent runaway health care costs by keeping people healthier," he comments. "Part of that promise was disease management. Clearly, disease management is not the only solution to rising costs, but it's certainly part of the solution. It makes sense intuitively to manage patients with chronic disease proactively so that you can reduce health care costs. And employers are receptive because DM it is not viewed as a take-away from employees."

While disease management is growing, there remain a number of areas in which disease management programs are challenged, says Epstein.

One of the areas involves how physicians are paid, or actually not paid, for participation in DM activities, Epstein says. Under managed

As a result, there's inadequate technology and patient support infrastructure for these physicians. "They don't have the people or the technology to optimize real-time patient management across the continuum of care," Epstein explains. "So, we're asking physicians to do all of these things in disease management but they're not being paid for it, and they don't have the infrastructure to support what they do."

A New Care Model

PCPs who participate in DM programs need assistance first in identifying the high risk and potentially high cost patients who may benefit from DM interventions. Predictive modeling systems that managed care organizations use are too costly for

individual PCP groups to own. "Even if MCOs provide that information, there are still too many complex issues for PCPs to manage while also managing the care of these folks," Epstein says. "These issues require coordination between different physician specialists and with other resources such as ambulatory care settings, home care providers, pharmacies and infusion companies, social services, and mental health care providers, for example."

From the PCP's perspective, such coordination takes a significant amount of time, Epstein explains. At the same time, there's no unifying technology infrastructure to pull all of this information together in one place. "So, not only are you taking time to do these things but you're taking time to do these things in a complicated way because the left hand often doesn't know what the right hand is doing," he comments.

Recognizing that more and varied resources are needed to coordinate care more effectively, Epstein proposes a more robust model to reorganize primary care. "As historically structured, the current primary care practice model is inadequate to meet the needs that are arising," he explains. Some experts have suggested using more nurses in primary care and fewer physicians, but Epstein believes it may be best to supplement the work of PCPs with physician assistants, patient educators, and additional nursing support. "Rather than replace physicians with nurses, I would augment primary care practices and instead of having physicians deliver one-on-one care for everything, I'd move PCPs into a role of a 'medical director' responsible for their panel of

patients," he says. "PCPs should not be expected to deliver everything to every patient on a one-on-one basis. There are other health care professionals better suited to deliver education, nutritional support, mental health services, and lifestyle management issues than are physicians. We have graduated from the Marcus Welby model of care delivery. I'd deploy complementary resources in primary care practices that might include mental health, advanced practice nursing, health and disease education, and nutrition, among other disciplines."

Under Epstein's plan, PCPs would work more collaboratively rather than independently, as many do now. "We're trained to be very independent and what we say, goes," he explains. "In other words, we're good at doing, we're good at lecturing, but we're not particularly good at being part of a team. So this model would require a significant shift in physician perspective and it would require a huge shift in reimbursement methodology for primary care, which probably won't happen in my lifetime but it makes sense."

Paying for Care

Indeed, the issue of reimbursement is likely to be one of the most difficult to solve. But again, Epstein has an idea. "In a utopian world, I would pay the medical director a salary plus offer a financial incentive based on quality indicators, including service attributes, because service in this business is just awful," he says. But also, the technology infrastructure support of the health system would need to be improved so that PCPs, and all relevant treating professionals, would have the information they need at

hand to deliver care effectively without duplicating tests and services and needlessly sending patients for consultations, he adds.

Reimbursement methodology should shift toward episode-based, comprehensive physician and non-physician global fees rather than the current piecemeal, episodic nature of physician reimbursement.

In his book, *From Chaos To Care, The Promise of Team-Based Medicine*, David Lawrence, MD, has a similar theory: that PCPs ought to be an essential part of a care team. Lawrence is a member of the National Academy of Sciences and was the CEO and chairman of Kaiser Permanente for 10 years.

Establishing such a system, however, would require significant changes in how the health system is organized and in how much money is paid to PCPs and other specialists, comments Epstein. The current disparities between the income of PCPs and specialists is irrational, he says. "Some of the dollars that are going to specialty and high-technology services should be redirected," he adds. "I have trouble with valuing procedures and technology so much more highly than we value the time and cognitive skills of PCPs. Often, PCPs spend much more time than specialists in managing complex patient care issues, yet they may earn only 10% as much as some specialty physicians making \$1 million a year or more. It doesn't make sense to me."

For physicians, developing the best systems to deliver care may mean fostering change in the health care system, Epstein suggests. "Physicians always have to advocate clinically for what is the right thing to do," he says.

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Physicians need to be vocal in terms of demanding reimbursement for their time and perhaps even thinking of creative ways for that to happen, Epstein says.

(Continued from page 9)

“So my advice to them is this: In the short term, it’s going to be tough but they can’t back away from the responsibility inherent in being a major part of a team that manages people’s care. They need to be vocal in terms of demanding reimbursement for their time and perhaps even sitting down and thinking of some creative ways for that to happen.”

As always, health plans and insurers will be looking for new ways to manage care and to contain costs and when they do, they may realize that disease management is one of the best ways to do both, Epstein explains. “So, maybe the time is ripe for more innovative reimbursement trials and methodologies that would compensate physicians better for taking the time to establish these systems of care,” he says. “I would strongly advocate for physicians not to resist change because the call for change from health plans, insurers, and employers is not going to go away. Instead, physicians ought to participate and to lead the changes that are coming. They ought to say, ‘We need change, but we need to be paid for it, and here are some solutions.’”

In other words, physicians need to become involved as members of committees with insurers and health plans in setting policy, Epstein suggests. “There is ample opportunity for physicians to become involved,” he says. “And, in most communities, they will get paid for their involvement on committees. And that’s the only way they’re going to be able to ‘get inside the system’ and begin to make their lot better. It won’t do, in my opinion, to sit back and hope that the AMA or some state organizations will lobby the federal government or other government agencies on their behalf.”

There are examples of improving insurer-physician collaboration. A number of insurers have begun to invest in putting computer systems in physician practices and are giving financial rewards for better quality

outcomes and the adoption of patient management technology such as electronic medical records. Some are paying more to physicians for each office visit if the physician uses an EMR (at the rate of \$38 for EMR use and \$33 if no EMR is used, for example). Also, some health plans are paying physicians to answer patients’ questions via e-mail. Such incremental increases in reimbursement represent steps in the right direction, Epstein adds. “These are piecemeal solutions but they could create enough of a critical mass to effect change,” Epstein says of the incentives being offered for quality and technology use.

The next step is to alter current reimbursement methodologies and reward physicians to manage the care of patients in a team-based approach. However, few experts have commented on this issue yet. “While \$38 versus \$33 for a physician visit is a good

It may be time for health systems to pay physicians to manage the care of patients in a team-based approach.

step, I would say, physicians who need to spend more time with patients perhaps should be paid \$50 or more for each half hour,” Epstein comments. “The system needs to be changed in a dramatic way, but in the interim what’s being done in some places makes some sense.”

Fundamentally, Epstein is calling for a revised reimbursement structure and new, more efficient organizations as well. For years, George Halverson, CEO of Kaiser Permanente, has argued that physicians should be working in large integrated, and highly structured organizations, which are not at all like the settings in which most PCPs work.

“Well, we’re not team players, as I said earlier,” Epstein comments. “Most of us are not used to working in such organizations.”

More women are working in primary care today than worked as PCPs in the past, Epstein adds. “In primary care today, over half of the practitioners are women. I’m not trying to be sexist about this, but women have a different view of the world than men do. Perhaps they are more willing to work collaboratively. Perhaps they are a bit less competitive and maybe a little bit more nurturing. So maybe their presence in primary care might catalyze a shift in the core values of primary care.”

Solutions Needed

In conclusion, Epstein notes that more patients will need chronic care as the population ages and as technology helps to extend life expectancy. Despite the coming increase in chronic care needs, health system planners do not seem focused on developing comprehensive solutions

to the problem, he says. “The fragmentation of the health care system and the fragmentation of the proposed solutions to the health care crisis in this country are not driving us toward a viable long-term solution to reforming our health care system,” he comments. “We had a fragmented system to start with and now we’ve overlaid even more fragmented solutions on top of it without any corresponding central strategy that ties all of these various initiatives together.”

To be sure, some initiatives that have been proposed are promising, but few incorporate the necessary changes to disease management that will be needed to care for an aging population, Epstein adds.

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

Physician Supply Shortage Explained

By Richard L. Reece, MD, editor in chief

If the law of supply and demand applies to physicians, then America's doctors should see their income rise in the coming years. Yet many physicians may be asking themselves whether any increase in their income will be enough to offset the difficulties of practicing medicine today.

In fact, the stress of practicing medicine is causing the number of doctors delivering health care to decline. In *Will the Last Physician in America Please Turn Off the Lights? A Look at America's Looming Doctor Shortage* (Independence, MO: Practice Support Resources, 2004), James Merritt, Joseph Hawkins, and Phillip Miller explain and document the coming shortage of physicians. The three authors are principals at Merritt Hawkins & Associates, a physician recruiting firm, in Irving, Texas. Their firm recruits doctors for physician groups, community hospitals, large health systems, and other positions in health care.

No Longer Practicing

As recruiters, the authors have found that there are not enough doctors to fill the positions currently available. Many physicians have left the practice of medicine because they are frustrated with managed care, reimbursement has been reduced, malpractice rates have risen, and they feel overworked.

What's more, as more doctors are leaving medicine, fewer are entering,

and the gap is being filled only partially by international medical graduates. Physician population will reach negative growth in about 15 years, the authors say.

The high turnover among allied health professionals is another factor contributing to decline in the number of physicians: Many physicians are frustrated by having to work with new hospital staff and have trouble finding good staff for their own offices (see table).

Also, not surprisingly, many young physicians want more personal time for themselves and to spend with their families. Among younger physicians, a rising number are women and these younger physicians want time outside of medicine to spend with family, to pursue personal interests, and to lead a balanced life, the authors say.

Waiting for Care

Many patients have had trouble finding physicians, but those who are elderly, live in rural areas or in inner cities, or participate in Medicare and Medicaid are experiencing severe problems in gaining access to care, the authors say. The problem is seen clearly when the authors report on the time it takes for a new Medicare or Medicaid patient to see an ob-gyn physician in certain cities.

In Boston, for example, such patients would wait 45 days, and find that only 56% of these physicians accept these patients. In Detroit, the

wait is 39 days, and only 40% of these physicians accept such patients. In San Diego, 31 days, 80%; in Philadelphia, 28 days and 24%; and in Atlanta, 24 days, 25%, according to research by Merritt, Hawkins & Associates.

Similar problems exist in other specialties as well. In emergency rooms, the lack of specialty coverage is a growing national problem, the authors report. There are three significant reasons for the shortage of specialists in emergency departments. According to research by The Schumacher Group cited in this 120-page book, 26% of specialists who had been working in the ER were discouraged by malpractice concerns from continuing to practice, 33% were discouraged by a lack of payment for ER services, and 31% of specialists were recruited away by competition. The Schumacher Group, a physician staffing organization in Lafayette, La. (at www.tsged.com), focuses on finding physicians for hospital staff positions.

Replacements Needed

In psychiatry, the supply of specialists is severely limited among the poor due to lack of government funding and shortage of psychiatrists, the authors say.

One of the most significant reasons for the doctor shortage is what the authors call maldistribution in thinly populated rural states. In the five states with the most physicians per capita, there are 375 physicians or more per 100,000 residents, accord-

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More doctors are leaving medicine, fewer are entering, and the gap is being filled only partially by international medical graduates. Physician population will reach negative growth in about 15 years, the authors say.

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ing to the AMA: Vermont (375), Connecticut (385), Maryland (406), New York (409), and Massachusetts (448). The District of Columbia has 718 physicians per 100,000 residents. Conversely, in the bottom five states, there are fewer than 200 physicians per 100,000 residents: Idaho (178), Mississippi (181), Oklahoma (184), Alaska (194), and Nevada (196).

In rural areas, the shortage of physicians is particularly acute, the authors say. Although they found a number of highly skilled and dedicated country doctors and listed them in

opportunities per specialist, the authors say. In radiology, there are 2.94 opportunities per physician; in cardiology 2.43 opportunities; and in emergency medicine, 2.07 opportunities, the authors say.

One consequence of rising demand is rising salaries, and in a separate press release on a survey it did of hospitals and medical groups, the Merritt, Hawkins & Associates' 2004 Review of Physician Recruiting Incentives, Merritt Hawkins says income has risen for many physicians. In general, specialists are in

ticular, many small to mid-sized communities are seeking to build centers of excellence in orthopedic surgery to keep these surgeons from relocating, the firm says. The income offered to recruit orthopedic surgeons increased from \$287,000 in 2000-01 to \$330,000 this year, according to Merritt Hawkins.

Interestingly, the Merritt Hawkins survey also showed an increase in demand for family practitioners in the recent past. Although this trend is not expected to continue, there will be demand for family practice physicians in rural areas and inner cities, the firm says.

Armed with this information, the issue facing physicians and health system managers is how to ensure that the United States will have the physicians it needs. Perhaps expanding the current medical schools and building new ones, eliminating current regulatory burdens to keep the doctors we have, and reforming the system so that all health care consumers can afford the care they receive are steps that can begin to address the physician shortage.

But for physicians and those contemplating whether to enter the profession, the issue is this: Is becoming a physician worthwhile today?

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

A survey shows that one specialty that has been in demand is radiology.

the book, each one is over age 70 and no physicians are waiting to take their place. For example, the authors cite John Harlan Haynes, MD, the country doctor of the year in 1992, who practices in Vivian, La., a town of 4,156 residents; Clair Louise Candill, MD, the country doctor of the year in 1993, who practices in Morehead, Ky., a town of 8,357 residents; and William Hill, MD, the country doctor of the year in 1994, who practices in Carrolton, Ala., a town of 1,170. For these physicians and seven others listed in this book, no replacement has been identified. What's more, only 6% of medical residents say they want to practice in small towns.

Seeing Opportunities

Given the shortages of physicians in many specialties and in many markets, physicians who are willing to work in temporary positions may find plenty of opportunities, the authors say. *Locum tenens* physicians provide an important service for physician-short communities and a way for older physicians to see fewer patients while earning a decent living. In child psychiatry, for example, there are more than seven *locum tenens*

demand, the search firm says, including gastroenterologists, urologists, neurologists, and pulmonologists, who are leading a wave in demand that is still cresting.

One specialty that has been in demand is radiology. The average income offers used to recruit radiologists, for example, rose from \$317,000 in 2002-03 to \$336,000 this year, Merritt Hawkins says. Another specialty in demand is orthopedic surgery. That demand is driven by the active elderly and aging baby boomers who require orthopedic surgery to maintain their active lifestyles, the search firm says. In par-

Annual Turnover Rates in Allied Health

Nurses	15.5%
Occupational therapists	14.9%
Respiratory therapists	14.2%
Speech/language therapists	14.0%
Physical therapists	13.5%
Radiologic therapists	12.1%
Pharmacists	12.0%
Laboratory technicians	10.7%

Source: The Bernard Hodes Group, New York (at www.hodes.com)

Health Plans, Other Groups Seek to Make IT Affordable for Physicians



Mark Leavitt, PhD, is the medical director and director of ambulatory care for the Health Information Management Systems Society in Chicago. He has practiced

internal medicine full-time for 10 years in Portland, Ore., and led a project to launch the implementation of systemwide electronic records at Providence Health System in Oregon. In 1985 he founded MedicaLogic, a pioneering developer of ambulatory electronic health records, then served as its CEO and later worked as vice president of clinical initiatives for GE Medical Systems. He joined HIMSS earlier this year. In addition to holding a fellowship at HIMSS, Leavitt is a clinical assistant professorship in the Department of Medical Informatics at the Oregon Health and Science University. He spoke with Editor in Chief Richard L. Reece, MD, about the value of information technology for practicing physicians.

Q: To begin, please tell us about your mission at HIMSS.

A: My mission is basically to bring what HIMSS has done for health care information technology to physicians in ambulatory care settings. This mission parallels what's been happening in IT in health care. Historically, most of the investments in IT have occurred in hospitals and in large enterprises, and physician offices have been last in line to adopt or receive the bene-

fits of IT. My job is to help change that situation.

Q: Do you find that physicians are interested in IT?

A: Among practicing physicians, the interest level is skyrocketing. The projects I'm working on at HIMSS involve responding to this interest, and one of those projects involves electronic health records.

Q: There is a lot of confusion about which EHR physicians should choose and which vendor to use. Are physicians interested in investing in EHRs?

A: Yes. Let me put it this way: There's a wave of interest accompanied by enthusiasm mixed with fear. Some payers and purchasers of health care are offering incentives to foster the adoption of IT, which generates even more interest. One health plan is Wellpoint, and several other health plans have invested \$5 million, \$10 million, and sometimes as much as \$50 million in incentive projects to encourage physicians to adopt IT. If the biggest health care buyer, Medicare, would invest in such systems, it would be significant. And, while Medicare has not made a decision on such an investment, there are some conversations going on.

Q: Is there a growing sense that using IT will be necessary for physicians to have a viable practice?

A: Yes. The feeling is widespread now that IT is inevitable in

physician practices. We're well past the stage where doctors can say, "I don't think a computer will work for me." Now, their questions are: "How can I afford this?" "How can I transform my practice without suffering during the change over?" The handwriting is on the wall.

Q: A report from the Institute of Medicine in 2001 predicted that by 2010 physician handwriting would be obsolete. Is that prediction somewhat optimistic?

A: Yes; 2010 is a little soon. But it's possible that by 2010 we'll be at the halfway point, meaning half of all physician practices will be using electronic records. Maybe these physicians will not be completely electronic, but they'll be mostly electronic. If you move the date up to 2015, I can see that prediction happening. Handwriting might not be obsolete by then, but it would be considered a very risky procedure and one that's on its way out.

Q: Recently, two U.S. senators—Bill Frist, MD (R-Tenn.), and Hillary R. Clinton (D-N.Y.)—said IT is one way to improve our inefficient health system. Is there bipartisan agreement on this issue?

A: I think so. But I see a somewhat different spin on it from what they are saying. They both agree that IT is needed and can help reduce costs as we face this demographic crunch and cost crunch in

(Continued on page 14)

Among physicians, there's a wave of interest for electronic health records, and this interest is accompanied by enthusiasm mixed with fear, says Mark Leavitt, MD, PhD, of HIMSS.

Conference Aims to Improve IT ROI for Physicians

A conference run by the Health Information Management Systems Society in Chicago aims to help physicians get the most out of their investment in information technology and electronic health records (EHRs). Called Physicians Adopting Computer Technology, the conference will be held in various cities nationwide.

The PACT conference is designed to help physicians learn how to maximize practice efficiency, return on investment, and patient satisfaction with IT. The conference will offer two tracks: one for physicians exploring technology and one for those who have implemented an EHR and want to get the highest return on their investment.

Mark Leavitt, MD, PhD, the medical director and director of ambulatory care for HIMSS, says the organization recognizes that it's difficult for doctors in practice to close their offices and travel long distances to attend a national conference over several days. For that reason, HIMSS is sponsoring PACT conferences in cities around the country, near where physicians practice and on Saturdays, Leavitt says.

Two conferences are scheduled this fall, and HIMSS hopes to run at least two others in the spring. The conferences are designed to serve the needs of physicians, and most of the speakers will be physicians, Leavitt says. The HIMSS Web site (at www.himss.org) has more information.

—RLR

(Continued from page 13)

health care. They each take a little different spin on it but both of them see IT as a necessary step.

Most of the Republican advocates of IT in health care foresee the private sector taking the lead, and some of the Democrats call for more involvement from the government in terms of regulation and oversight. These issues remain to be sorted out, but having them both calling for more IT has helped push the issue forward.

Q: How much money are we talking about to pay for IT in the health care system?

A: If we're going to get IT out to all physicians, even those in rural communities where they may

not even have Internet activity yet, it may take some serious money. But we don't have to wait for massive federal funding. We can get going right now with what we have in terms of the payer incentives that are getting started. And, as I said before, even a modest incentive adopted by the nation's biggest health payer, Medicare, would have a terrific effect.

Q: Does it make a difference for a health plan to pay physicians who use an EHR \$38 for an office visit and \$33 to physicians who do not?

A: Yes. The results of a study showed that a financial incentive in the approximate range of \$3 to \$6 per patient visit or 50 cents to

\$1 per member per month might be a sufficient starting range. If you put that in terms of income per year per doctor, it gets into the \$10,000 to \$20,000 range and would have a significant effect on a physician's ability to invest in IT. The organization that did the study is the Connecting for Health Collaborative, in New York. Connecting for Health (at www.connectingforhealth.org) is a public-private initiative that seeks to engage those with diverse views of the health care system to work together to find solutions.

Q: In your meetings with chief information officers in hospitals and with physicians, do you find them open to your ideas?

A: Yes. The CIOs whom I have asked about IT have been very enthusiastic because even though some of the work we do focuses on physicians in offices, physicians also admit to and see patients in the hospital at one time or another. And physicians who are skilled at using EHRs are going to be more effective at using the hospital systems. One of the best things we can do to help hospitals roll out computerized prescriber order entry (CPOE) systems would be to have doctors adopting EHRs in their offices, because they'll be computer savvy and they'll recognize the benefits and be comfortable with them.

So the CIOs tend to be enthusiastic even though they might have to deal with different physicians who are using different IT systems and they want them to buy the one their hospital is using. But these CIOs also would prefer that the doctors become IT savvy than not be IT savvy. And remember, it solves a lot of problems for the hospital if it can send data,

To date, two of the most significant factors driving information technology in ambulatory settings have been revenue and efficiency as opposed to patient safety.

Group Recommends Financial Incentives

Financial incentives need to be realigned to promote improvements in quality care and to foster the adoption of more information systems, more connectivity among providers, and a greater exchange of information among all health care providers, says a report issued in July.

The report, *Connecting for Health Working Group on Financial, Organizational, and Legal Sustainability of Health Information—Summary of Financial Incentives Recommendations*, says physicians should be paid about \$3 to \$6 per patient visit or 50 cents to \$1 per member per month for using electronic health records. The payments should be made over at least three years to encourage and sustain the widespread adoption of basic electronic health record (EHR) technologies by small, ambulatory primary care practices, according to the report, which was published by the Connecting for Health Collaborative in New York (at www.connectingforhealth.org).

The estimate of \$3 to \$6 per patient visit would represent about \$7 billion to \$14 billion in increased health care spending per year for three years, or 1.2% to 2.4% of the total amount spent on ambulatory care in 2003, the report says.

Health care systems are experimenting with incentives to foster the greater use of EHRs in physician offices. Gradually, these health systems will use incentives to encourage more extensive use of EHR technologies for coordinating care and for advanced chronic disease management, according to the report.

Small and medium-sized physician practices have a great potential to benefit from information exchange, but will require significant attention and support from health systems and other organizations, the report points out.

—RLR

such as lab results and discharge information, electronically. Since doing so reduces hospital costs, everyone wins.

Q: *Is there more pressure on hospitals to use such information systems than there is on doctors because of the activities of the Leapfrog Group and other groups that are focusing on patient safety?*

A: Yes. Hospitals are under intense pressure from both a safety and a productivity standpoint. With the shortage of nursing personnel, hospitals are under enormous pressure to adopt IT as part of their focus on increasing productivity. Therefore, the forces that are driving hospitals to adopt IT are a bit different from the drivers in physician offices.

In hospitals, compliance and patient safety are two of the dominant factors driving them to adopt IT. In physician offices, increasing revenue or increasing quality of care comes first. For physicians, patient safety hasn't been highlighted quite as much as it has in hospitals.

Even so, the issue of patient safety is important in physician offices. An excellent paper by the Center for Information Technology Leadership addressed the need to reduce errors in ambulatory sectors. CITL (at www.citl.org), in Wellesley, Mass., is affiliated with Partners Healthcare, a large health system in Boston. Its goal is to guide IT investments by uncovering and communicating the financial and clinical value delivered by specific information technologies and strategies.

One way to reduce errors in ambulatory settings is to use EHRs, which are going to have a tremendous benefit in ambulatory settings. But to date, two of the most significant factors driving IT in ambulatory settings have been revenue and efficiency as opposed to patient safety.

At our upcoming physician conference—Physicians Adopting Computer Technology—we're not going to have a session about outpatient safety or CPOE systems. For physicians, these issues are not uppermost in their mind. They know they need electronic health records. The questions they want answered are: "How do I pick one?" "How do I afford it?" "What's the right price to pay?" "How do I implement it?" Their concern is very much about the nuts and bolts.

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

“With the shortage of nursing personnel, hospitals are under enormous pressure to adopt IT as part of their focus on increasing productivity. Therefore, the forces that are driving hospitals to adopt IT are a little bit different than the drivers in the physician office.”

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