

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

February 2007

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Pay for Performance Raises Questions

A federal pay for performance demonstration project is helping to improve the quality of care in hospitals, says the federal Centers for Medicare & Medicaid Services. In a report last month, CMS says it made incentive payments totaling \$8.69 million to 115 top-performing hospitals (about \$75,569 per hospital). The participating hospitals reported improvements in process and outcome measures in their treatment of patients with acute myocardial infarction, heart failure, coronary artery bypass graft surgery, pneumonia, and hip and knee replacement.

Other reports are not quite so glowing. An article in the Feb. 1 *New England Journal of Medicine* concludes, "Hospitals engaged in both public reporting and pay for performance (P4P) achieved greater improvements in quality than did hospitals engaged only in public reporting. Additional research is required to determine whether different incentives would stimulate more improvement and whether the benefits outweigh the costs." In the same issue of the journal, Arnold Epstein, MD, of the Harvard School of Public Health, says, "Pay for performance is fundamentally a social experiment likely to have only modest incremental value."

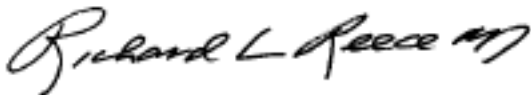
More than half of commercial HMOs use P4P in provider contracts. Of 126 health plans that have P4P programs, nearly 90% pay incentives to physicians and 38% pay incentives to hospitals. In general, the Northeast, Midwest, and West have the most P4P programs. Such incentives are notably absent in the South.

In Minnesota, eight P4P programs are in place and pay bonuses on 43 quality criteria. Barry Bershaw, MD, medical director and head of information systems at Fairview Health Services in Minneapolis, said, "Payments offered by health plans provide little incentive for doctors and nurses to go the extra mile. The reward can also be delayed gratification in the extreme, coming as long as two years after meeting the performance goal." Doctors and nurses may be offended at being asked to do something they already do.

Research shows that a bonus of 10% to 25% is needed to change behavior. That's much higher than the typical 3% that health plans offer under P4P, said Robert Wachter, MD, an expert on health care quality improvement.

There are other P4P problems and questions as well. Bonuses in physician practices may not cover the investment required to buy the information systems needed to track measures for such clinical indicators as care for patients with diabetes, mammography, asthma medication, cholesterol levels, management of antidepressant medication, and blood pressure control.

P4P is still largely unproven as a tool for improving care in physicians' offices. Improving care by aligning payment and quality measures is an irresistible idea, but the concept needs to be tested, validated, and approved by participating physicians.



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

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Databank Yields Unexpected Findings

Since 1976, the Arthritis, Rheumatism, and Aging Medical Information System (ARAMIS) databank has had far-reaching implications for patient health. Funded by the National Institute of Arthritis and Musculoskeletal and Skin Diseases of the National Institutes of Health in Bethesda, Md., and managed by researchers at Stanford University in Palo Alto, Calif., ARAMIS is a national chronic disease databank system consisting of parallel and longitudinal clinical data sets gathered from 11 locations, including university clinics, private practices, and communities in the United States and Canada.

“ARAMIS introduced the chronic disease databank model, a widely used and extremely valuable method of investigation,” says James F. Fries, MD, a rheumatologist, professor of medicine at Stanford University School of Medicine, and principal investigator of ARAMIS (<http://aramis.stanford.edu>). “ARAMIS has allowed researchers to tackle many important questions related to the care of patients with rheumatic diseases. As a result, the databank has been responsible for generating information related to safety and outcomes, influencing how physicians provide care, and ultimately improving patient health.”

Implications for Specialists

For physicians in other specialties, ARAMIS-based research efforts have important implications for patients with a variety of conditions. One such finding involves the epidemic of nonsteroidal anti-inflammatory drug (NSAID) gastropathy. “In the late 1980s, ARAMIS data revealed that thousands of people were dying and 100,000 or more were hospitalized each year due to gastrointestinal

Over the past 30 years, the ARAMIS databank has formed the basis of more than 940 original, peer-reviewed studies that have had a major influence on the care rheumatologists offer.

bleeds resulting from chronic NSAID use,” Fries says. NSAIDs are used not only to treat rheumatic diseases but also metastatic bone pain, headache and migraine, menstrual pain, postoperative pain, mild to moderate pain due to inflammation and tissue injury, and renal colic.

The original ARAMIS observations spawned a number of investigations into safer ways to deliver or use NSAIDs. “These included the development of misoprostol; the widespread use of H₂ antagonists and proton pump inhibitors to decrease the frequency of gastrointestinal events; the development of safer NSAIDs such as the coxibs, which have their own sets of side effects but are less toxic on the gastrointestinal tract; and the exploitation of existing NSAIDs that were safer but had been used less frequently,” Fries explains. “All of these activities resulted in the more selective use of NSAIDs and the use of lower doses, ultimately prompting a decline in NSAID gastropathy.”

Other recent findings relate to long-term disability outcomes in the normal aging population. “For example, one long-term longitudinal study examined the effects of long-distance running and found that over a 20-year period, both disability and total joint replacement were substantially lower in the group of runners compared to the control group of non-runners,” Fries notes. “A second longitudinal study followed individuals into their 80s and found that those who exercised, maintained a lean

body weight, and didn’t smoke had much better quality of life and much less disability than did subjects with poorer health habits.”

These two studies address musculoskeletal aging in the broadest sense, and highlight the major role of exercise and other lifestyle factors in improving outcomes. “Musculoskeletal disability becomes the greatest threat to quality of life after age 65,” Fries comments. “The implication for physicians is clear: recommending exercise (ideally prior to disease onset) will help people enhance their health and quality of life as they age.”

Overall, the ARAMIS staff has an outcomes-oriented view of quality, rather than a process-oriented view, Fries explains. “We don’t care, in terms of quality, how many checklists are met if the patients do not get better,” he says. “We are not interested in guiding physician processes of care. Rather, we want to provide important, evidence-based research that will actually lead to improvements in outcomes.”

Three Decades of Data

ARAMIS data describe the course of disease and treatment of more than 10,000 patients with rheumatic diseases followed for as long as 30 years. Unlike clinical studies based on medical records, ARAMIS data are collected using standard, defined data collection instruments, including the Health Assessment Questionnaire (HAQ), an instrument that

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helps researchers measure disability, discomfort, drug side effects, mortality, and the costs of care.

“The focus of ARAMIS is on long-term outcome assessment,” explains Fries. “ARAMIS data allows rheumatologists and other physicians who have patients with rheumatic diseases to discern the treatment options and sequences that lead to the best possible quality of care. The goal of ARAMIS has been to continually improve the approach to the management of patients with rheumatoid arthritis, so that physicians can help them arrive at better outcomes and have fewer problems with their disease.”

ARAMIS has between 50 and 100 ongoing projects at any one time. Common themes include post-marketing surveillance of rheumatoid arthritis treatments, long-term outcomes of rheumatic diseases, and declining disability in rheumatoid arthritis. But while ARAMIS is focused on rheumatology, many findings have a broader relevance to patient populations beyond those with rheumatoid arthritis, including research related to NSAID gastropathy and the effects of lifestyle-oriented risk factors on health in older age.

The chronic disease databank model consists of enrolling patients with specified criteria as they appear at a particular center and following them for the remainder of their lives, Fries explains. “It represents an attempt to put in chronological order all of the illness-related occurrences of a given individual over his or her lifetime, from the time of onset of the illness until death,” he says. “A chronic disease databank is designed to have the features of consecutive patient entry and lifetime follow-up.”

More than 1,000 variables are incorporated into the databank. “Categories of data items collected include demographics, comorbidities, the economic effect of disease, laboratory test results, treatments, treatment side effects, and long term outcomes,” Fries says. About 20 investigators on the ARAMIS staff manage the databank and its research studies.

Practitioners at the 11 sites collect data and then send it to Stanford at six-month intervals. “The ARAMIS staff check the data for quality and then incorporate it into the databank,” Fries says.

Improving Care

Such data can inform the long-term view physicians need when managing patients with chronic diseases such as rheumatoid arthritis. “Physicians are challenged to improve patients’ health status throughout their illness,” Fries explains. “They may offer treatment that is directed at short-term resolution of symptoms, which ends up doing harm down the road.” The studies based on ARAMIS data can help physicians learn to manage patients optimally over the entire course of their disease.

In the past 30 years, the ARAMIS databank has formed the basis of more than 940 original, peer-reviewed studies that have had a major influence on the care rheumatologists offer.

One of the major accomplishments of the databank is that studies using ARAMIS data have contributed to inverting the therapeutic pyramid in rheumatoid arthritis care. Until recently, this pyramid depicted the accepted model of care, which involved a base of NSAIDs and the

sequential addition of slow-acting disease modifying antirheumatic drugs (DMARDs) in higher tiers. Studies using ARAMIS data, however, showed that a superior treatment model involved using DMARDs earlier. DMARDs slow the progression of the disease.

“Now, the currently accepted standard is early, persistent, and consistent use of DMARDs starting at rheumatoid arthritis onset while using NSAIDs only as adjunctive therapy,” Fries explains. “Based on ARAMIS data, researchers developed a theoretical model for what we thought should happen if we changed the base of treatment from NSAIDs to DMARDs. We then measured the results of this change and encouraged others to do the same. Ultimately, researchers found that the toxicity of the older NSAIDs was equivalent to that of the DMARDs, which had always been considered more dangerous. Gradually, the change was universally adopted, leading to better patient outcomes and a decline in rheumatoid arthritis disability nationally.”

This result prompted the search for better DMARDs, which in turn led to the development of the biologic compounds (TNF-blockers) and their widespread use for the treatment of rheumatoid arthritis, Fries explains.

Fundamental Changes

Another large-scale change that came from ARAMIS-based studies involves the care of patients with osteoarthritis. “The care of patients with osteoarthritis, like that of patients with rheumatoid arthritis,

“We are not interested in guiding physician processes of care. Rather, we want to provide important, evidence-based research that will actually lead to improvements in outcomes.”

—James F. Fries, MD, Stanford University School of Medicine

has been revolutionized,” Fries comments. “Formerly, physicians managed osteoarthritis without regard to the effect of lifestyle on the disease. As a result of ARAMIS data and other studies, we now recognize that lifestyle and behavior are probably more important than any drug in achieving good long-term outcomes. As a result, physicians have moved away from excessive medication use in patients with osteoarthritis and toward exercise and weight control. This is a fundamental change in the management of the disease.”

Overall, the effect of ARAMIS on rheumatology quality of care has been enormous. “For example, ARAMIS data was used to identify the many different subsets of systemic lupus,” Fries says. Other examples abound, he notes. ARAMIS was responsible for the creation of the criteria sets in the rheumatic diseases such as rheumatoid arthritis, scleroderma, lupus, vasculitis, fibromyalgia, and juvenile rheumatoid arthritis. It formed the basis of a pioneering set of outcomes studies in osteoarthritis, which found that lack of exercise is a risk factor for the disease rather than a management solution. It identified that the side effects of all NSAIDs are not the same, which previously were assumed to be identical, and it quantified the differences in toxicity among NSAIDs. Recently, it identified that hydroxychloroquine use reduces the incidence of type 2 diabetes in patients with rheumatoid arthritis. In a series of studies dealing with long-term outcomes, ARAMIS data established the premature mortality rates of patients with rheumatoid arthritis.

The data also has had an effect on studies involving the cost of care as well. “ARAMIS has permitted the estimation of the direct and indirect economic costs of rheumatoid arthritis, as well as the study of work loss and other productivity issues,” Fries explains.

Seeking to take ARAMIS in a new direction, researchers have

developed an innovative project related to data measurement called the Patient-Reported Outcomes Measurement Information System (PROMIS). Funded by the National Institutes of Health (www.nihpromis.org), PROMIS establishes a collaborative relationship between NIH and six research centers. The goal of the collaboration is to develop and test a large databank of items measuring patient-reported outcomes and create a computerized adaptive testing system that allows for the efficient, psychometrically robust assessment of patient-reported outcomes in a wide range of chronic diseases.

“PROMIS is involved in enhancements to outcome assessment using two new survey research theories: item response theory and computerized adaptive testing,” Fries explains. “These techniques will allow us to create new instruments that will surpass the HAQ, which has been the traditional ARAMIS instrument and the most popular outcome assessment instrument in rheumatology and in reporting patient-reported values as outcomes in clinical trials.”

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

Tools Define Health Status

ARAMIS relies on formal measurement tools to provide data on patient reported outcomes. One such tool is the Health Assessment Questionnaire (HAQ) that ARAMIS uses to collect patient data every six months. HAQ is a comprehensive questionnaire used to determine a patient's functional status. ARAMIS data are gathered using a version of HAQ designed for patients with a wide variety of rheumatic diseases, including rheumatoid arthritis, osteoarthritis, juvenile rheumatoid arthritis, lupus, scleroderma, ankylosing spondylitis, fibromyalgia, and psoriatic arthritis.

“The focus of HAQ is on self-reported patient-oriented outcome measures, rather than process measures such as access to care or laboratory test results,” says James F. Fries, MD, who developed a health assessment questionnaire with colleagues at Stanford University in 1978.

The HAQ Fries and colleagues use examines long-term patient outcomes involving four dimensions: disability, discomfort and pain, drug side effects, and dollar costs; the fifth dimension, mortality, is recorded using the National Death Index.

“These five dimensions represent the elements that people think about when they define quality of care,” Fries says. “If individuals consider medicine to be a service profession, they expect it will keep them alive as long as possible, they will be functioning fully, they will be free of pain and other discomfort, they will not suffer any ill effects from their treatments, and they will remain solvent through it all.”

Disability is determined by measures in eight categories: arising, dressing, eating, walking, hygiene, reach, grip, and common activities. Discomfort is assessed by the presence and severity of pain. Drug-associated side effects are classified according to their severity and whether the medication was stopped. Dollar costs are divided into direct costs, such as physician visits, hospitalization, surgery, nursing home care, medications, diagnostic tests, and assistance with personal care; and indirect costs, including productive days lost from work or other activities.

—DJN

Beyond HIPAA: Preventing ID Theft

Patient medical records contain all the information a thief needs to steal someone's identity. "Medical records and patient charts may include Social Security numbers, driver's license numbers, phone numbers, addresses, even checking account and credit card information," says Rhonda Picou, RN, MSN, vice president of physician compliance for Peak Performance Physicians, LLC, in New Orleans. Yet providers are generally more concerned about protecting clinical information than they are about protecting their patients' identity information.

"If someone breaks into a physician's computer system, you can be sure they care less about a patient's clinical information and more about the information that could be used to steal identities," Picou comments. "Clinical data have layers of protection, such as computer passwords and other security features, to prevent leaks, but providers just don't think about protecting identity information. It's not a natural thought process for them."

A Growing Threat

Medical identity theft is a disturbing and growing trend, however, and practices that fail to protect their patients' financial information risk their reputations, possible huge legal damages, and the expense of victim credit monitoring and counseling. Fines under the Health Insurance Portability and Accountability Act

(HIPAA) for unlawfully disclosing patient data can be as high as \$250,000 and, if convicted, a person could face 10 years in prison. A number of states have even tougher laws regarding security and identity theft.

As a result of some high-profile cases, providers are becoming more aware of the dangers of medical identity theft, says John C. Parmigiani, president of John C. Parmigiani & Associates, LLC, in Ellicott City, Md. When patient's information is stolen, the cost to fix the problem can be high. After patient data was stolen from the Veterans Administration, the VA spent \$7 million just to inform everyone affected that their medical and personal data were at risk, he notes. "In another case, a well-known company that provides identification and credentialing services for business and government had to pay \$15 million in legal fees and lost \$720 million in business following a security breach," he says.

Typically, physicians and other providers must notify each person whose identity information was lost or stolen, set up a call center for victims, pay legal fees of about \$1,000 per victim, and pay fines and penalties for each incidence. "Then they have to perform credit monitoring for the victims," adds Parmigiani.

Low Compliance Rates

"The problem is huge; much larger than people realize," according to Wayne F. Mackert, owner of iTM Healthcare, a health care consulting

firm in Bellevue, Wash. The Federal Trade Commission defines medical identity theft as the use of a person's name or insurance information without permission to obtain medical care or file false claims for medical care. The FTC reported almost 18,000 such cases in 2005.

This trend affects medical practices of every size, Mackert notes, saying physicians aren't doing enough to prevent HIPAA violations. "Physicians' HIPAA compliance rates are pretty abysmal, at only 38% for security," he says. The security segment of HIPAA went into effect in 2004, but compliance rates for security measures are declining, he adds.

Sealing Leaks

A surprisingly large number of potential leaks exist in medical practices, including paper files, laptop and desktop computers, personal digital assistants, cell phones, printers and fax machines, servers, and of course, the Internet. "I have read of cases in which computers were stolen and the clinical information could not be accessed because the information was not housed on the computer hard drive," says Picou. "The business software, however, was on the hard drive and there was plenty of financial information easily obtainable on the computers." Thieves usually steal computers to resell, she adds, but more savvy crooks use the financial information.

Even health care providers who follow HIPAA regulations are at

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risk. "Everyone focuses on having patients sign the standard HIPAA consent forms," Mackert says. "They think this gives them an out, but it won't stand up in a court of law."

Making Improvements

For William R. Fellows, MD, an internal medicine specialist in Biloxi, Miss., security is a high priority, says Gini Fellows, the office manager for her husband's practice. "We use safeguards such as individual computer passwords for employees and separate individual passwords for the billing system," she says. Credit card receipts are kept in a locked file and when the office is closed, security guards patrol the hospital campus where the office is located. The guards ask all outsiders, including maintenance workers and technicians, to sign agreements to protect patient information, she adds.

"And because we're in hurricane land, our disaster plans include provisions to protect all patient information," Fellows says. After Katrina, patient records from many practices were found lying all over the beach, and medical charts were seen scattered on the roads. "Many doctors lost their records in that hurricane," she adds.

Fellows believes her staff is tough when it comes to security. "They're up on HIPAA and we let them know what we expect and need from them," she says. "And, we always check references, which we believe is really important."

The Highest Risk

In her husband's first year of practice, Fellows hired a receptionist. "I didn't check her references because we were so busy that first year," she explains. The employee spent a lot of time on the Internet, which violated the practice's security policies. "She would turn it off when she heard me approaching," she says. "Then we began receiving telephone calls asking for a person with her first name, but different last names. She had

ID Thefts Reported Widely

It is not unusual to find stories about medical identify theft in most major newspapers and trade journals. Often, medical office staff are involved in the theft and are found to have used the information for credit card shopping and submission of phony Medicare and Medicaid claims. Here are two examples.

In one case, a phlebotomist in the Seattle Cancer Care Alliance used a bone marrow transplant patient's medical record to obtain the patient's name, Social Security number, and date of birth. With this information, the worker got credit cards in the patient's name and made purchases totaling almost \$10,000. This employee was the first to be prosecuted under the HIPAA criminal privacy violation statute. After a trial, he was sentenced to 16 months in prison.

In another case, a front office worker from the Cleveland Clinic in Florida stole names, birth dates, Social Security numbers, Medicare numbers, and addresses from more than 1,000 patients in the clinic's database. The worker used the information to make fraudulent Medicare claims worth more than \$2.8 million. He also sold the information to others who filed false Medicare claims as well. —DE

VA Has Had Several Incidents

The Department of Veterans Affairs reported last May that a laptop and disks containing personal information on 26.5 million veterans were stolen from an employee's home. The FBI later recovered the computer and found no signs that personal data had been compromised.

But, in August, a desktop computer containing insurance claims data on about 20,000 veterans treated at the Pittsburgh and Philadelphia VA medical centers was stolen.

Last month, a portable hard drive that may contain the personal information of as many as 48,000 veterans may have been stolen, the federal Department of Veterans Affairs said. An employee at the VA medical center in Birmingham, Ala., reported the external hard drive missing on Jan. 22.

As a result of those incidents, VA Secretary Jim Nicholson established the VA information security program, setting standards for accessing information systems and requiring officials to report compliance failures or policy violations immediately. He also ordered annual cyber security and privacy awareness training for all VA employees.

been using aliases for some reason and then one day, someone came to our office to repossess her car. I let her go after that."

The weakest link, experts agree, is office staff. "Personnel with the most

access to financial information are generally the lowest paid employees in a practice," Picou says. Every time a patient pays with a check or credit card, an employee has access to that

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information. "It's crucial to ensure your employees are of good character," she adds. "It may seem like overkill, but every employee should have to pass criminal and credit background checks."

Parmigiani agrees, saying a lack of such safeguards would not help a provider in a lawsuit. Formal staff training and informal refreshers are necessary. "Use meetings, posters, and memos to keep security a priority," he advises. "Educate staff that charts should not be left on copy or fax machines and that patient information should be discussed in a low voice.

Improving Accountability

"In addition to training and refreshing staff on policies and procedures, be certain to assign responsibility for privacy and security to one person," notes Parmigiani. That's a HIPAA requirement, but also provides accountability. Providers must also record their actions, to show that security policies and procedures are enforced.

People are most often the problem, but policies, procedures, and technology also are concerns. "Be certain that policies are designed to fit your

practice," says Parmigiani. "Good security is done in layers. The goal is to make access difficult enough to deter thieves, but not so difficult that personnel must take shortcuts around security safeguards."

Physicians also should know what safeguards are required and effective. "Some physicians' offices insist that patients sign the HIPAA privacy notice at every visit, but they only have to do that once," Parmigiani says. "To ensure privacy, a pharmacy I know placed expensive baffles in the store to absorb sound, but the sound-proofing did such a good job that they had to take it out. People with hearing problems, including many elderly patients, could not hear and had to scream to be heard."

Notification and Security

Aside from HIPAA, other laws affect the security of patient financial information. The Fair and Accurate Credit Transaction Act (FACTA) of 2003 requires credit bureaus and other credit-reporting agencies to investigate victims' claims of inaccurate information and make necessary changes. "This law directly affects doctors' practices," Picou says.

Identify theft protection provided in this law and HIPAA may be used as a standard of due care in the event of a security breach.

In addition, California state law requires the government, private companies, and nonprofit corporations with computer databases containing personal information to report all privacy and security breaches to all affected individuals. "If there is a breach and the database is not encrypted, providers must contact everyone in that database," claims Parmigiani. More than 30 states have passed similar notification laws.

Regardless of the level of enforcement, safeguarding patients' identity and financial information should be a top priority and a continual process. "Security policies and efforts tend to break down over time," Mackert says. "For the 10 people who work in the office now, there are more than 100 people who may have access to the system. Security is a journey, not a destination."

—Reported and written by Deborah Epstein, in West Milford, N.J. More information on physician practice strategies is available on our Web site (see page 16).

Steps to Take to Improve Practice Security

Many of the steps used to protect patient personal and financial information are common sense. Here are some tips for preventing medical identity theft in your practice:

- Lock all medical records in a fire-proof environment, as required under HIPAA.
- Be certain that everyone who enters the office, including patients, family members, and vendors, signs in and signs out at all entrances.
- Maintain alarms, secure windows and doors, and install a security system that the police or a security company monitor.
- Use privacy screens and automatic log-offs for all computer monitors. Never leave unattended computers turned on.
- Recognize that almost every case of identity theft involves staff members.
- Limit personnel access to patient financial data as much as possible.
- Make sure that vendors for electronic medical records systems, practice management systems, and imaging systems are HIPAA compliant.
- Be certain to collect all access tools, such as keys and passwords, when an employee leaves the practice. Change locks if keys are not returned.
- Develop policies regarding Internet access, including e-mail usage.
- Have all non-employees who have access to the office sign confidentiality agreements to protect patient information.
- Keep patient records separate from the patient waiting area with a physical barrier.
- Notify recipients when faxing referrals, treatment plans, or any information that includes patient information, and ask the recipient to call back when the fax is received.

—DE

Make Choices Match Career Goals

Once accustomed to being a full-time physician, many younger doctors face a range of choices about career direction. The challenge for these physicians is selecting an alternative that lays the foundation for a stable, growing, and satisfying professional career. For any physician in practice, there are a wide variety of possible career pathways, but each one has advantages and disadvantages that relate to professional development and lifestyle decision. For physicians who opt to be full-time clinicians, the variety of settings to consider includes joining an existing group, forming a new group, starting a solo practice, or buying into a medical group. A physician seeking to work in other settings can consider taking a position in a hospital or in another country, or working in the public or private sectors.

Joining a Group

In a typical situation, members of a long-running successful group practice may want to work fewer hours than they have worked in the past while also expanding the practice's patient population. One or more of the physicians in the group may be looking toward retirement, for example. In this situation, the group may decide to add a younger doctor who can contribute new knowledge and energy, while taking over some patient hours. Initially, the new physician may not be expected to bring in new patients or income, but would receive a share of group profits. Sometimes a hospital where the group has admitting privileges may help subsidize compensation for the incoming physician.

Before making a decision to join such a group, the younger physician should understand the practice thoroughly. "The partners must show you

Some physicians have an interest in the business or financial side of health care, where first-hand medical knowledge and an understanding of the health care system are valued assets.

their books, and everything they do. If they keep anything from you, you'll simply have to believe what they tell you, and will have no recourse if there is a serious problem," cautions Robert Mestas, MD, medical director of Physicians' Career Practice LLC in Denver. "Pay attention to how the business is run. Ask questions and show interest. You will have to make critical decisions with a small amount of information, and also be a businessperson, which can be difficult."

In these situations, there are several potential problems to consider. First, an entering physician who expects to see a set number of new patients may be given fewer of them if partners aren't ready to lessen their own incomes. It takes a while for younger doctors to build patient volume through word of mouth and to generate referrals. Second, senior physicians may opt out of night calls, but still work full days. A younger doctor, told to anticipate night calls, actually might be taking most of them. Third, sometimes, the group will ask entering physicians to sign a noncompete contract, requiring them to affiliate with a different hospital after leaving the group practice or relocating.

One of the most difficult problems to address involves productivity. Some physicians are highly productive, while others see fewer patients and generate less income. In other words, some physicians will work the same

number of days and receive the same income, but see far more patients than others. Resolving problems involving productivity can be challenging for any group.

Starting a Practice

To avoid any issues involving productivity and other concerns, some physicians simply decide to start their own solo practice, allowing them to run the operation according to their own principles, without needing the consensus of colleagues. These physicians define the range of practice, select staff, and set hours and procedures. For physicians who want independence and autonomy, this option is attractive. But doing all the marketing and administrative work can be difficult and time-consuming. Covering every expense (including rent, equipment, salaries, benefits, and malpractice insurance) is a steady financial responsibility. If you choose such an arrangement, you would be the only doctor on call for emergencies and creating office hours to allow more family time usually means seeing fewer patients.

After several years of experience in a solo practice or a larger group, some younger physicians might decide to combine their skills with other doctors and form a new group. If each physician has developed name recognition or an adequate patient base, forming a new group can be a viable option. Doing so, however, is fairly unusual, says

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Mestas. Most physicians with relatively few years of practice don't yet have enough patients to launch a new group, he says.

Buying Into a Group

Some group practices allow a physician to buy in and become an owner over a specified period, such as five years. "This is fine as long as everyone knows up front what the plan is," Mestas says. One young doctor Mestas knows accepted a salary and then returned a set percentage of each paycheck as payment toward his buy-in. "This is an alternative to simply borrowing \$500,000 to buy into the practice, but you won't get full benefits until you become a partner," he says. Mestas doesn't recommend buying in because physicians who do so tend to add to the debt they already have from medical school.

Mestas' experience illustrates an alternative method of joining a group. In 1980, he became the sixth physician in a large, established ob-gyn practice. "They wanted me to work with them and showed me their books and how much each doctor had produced over the past five years," he says. He was paid a starting salary for the first year, then 50% of a partner's salary during his second year, and 75% during the third year. By the fourth year, he was a full partner.

"It was fair and simple, with everything known up-front," Mestas explains. "They told me I could leave after the first year if I was unhappy. I was not asked to sign a noncompete agreement. I stayed 21 years until I retired. I knew what I was getting into, and all subsequent hires got the same treatment."

Other Settings

Apart from group or solo practice, thousands of physicians work fulltime in hospitals and academic institutions. When choosing a hospital position,

8 Ways to Evaluate a Practice

For physicians considering taking a position at an existing practice, there are many ways to evaluate the operation. Here are eight steps experts recommend.

1. Seek transparency. Will partners share all books and records with you so that you can review them?
2. Discuss expectations thoroughly. Are you required to see a certain number of patients each week, or be on call for a designated number of nights and weekends?
3. Scrutinize the financial arrangements. Will you receive a salary, percentage of profits, or some combination? How long will it take to become a full partner?
4. Study every contract provision and have your lawyer review it as well. Is a noncompete clause included?
5. When was the practice established? Are founding partners still involved? How many new physicians have been hired and how many remain with the practice?
6. What is the practice's reputation among medical professionals and consumers in the community?
7. Where do practice members have admitting privileges? Are you familiar, and comfortable, with these hospitals?
8. Sit inconspicuously in the waiting room once or twice. Are front desk staff cordial and efficient? Are phones answered quickly and professionally? Is the environment clean and orderly? Do patients seem comfortable? Is the typical waiting time acceptable to you?

a physician needs to make several decisions. Should the physician choose a hospital that is a private or public organization, large or small, urban or rural setting, or a specialty center or general hospital? Each setting has pluses and minuses, so physicians need to take an honest look at their temperament and preferences. A big academic medical center usually offers the latest equipment, technology and treatments, and may be a site for important clinical trials. These centers may afford an opportunity to collaborate on complex cases with colleagues in many disciplines. However, some physicians find they dislike the impersonal, departmentalized feeling of a huge institution. A smaller hospital can be a less hierarchical workplace and afford closer contact between staff and administration. A specialty hospital provides a chance for physicians to

develop expertise in a particular procedure or condition and work with experts who share their focus.

Academic positions at medical schools are a popular career choice. The positives include the stimulation and gratification of working with students, and the salary and benefits of a faculty job. Physicians will have a set weekly schedule of classes and office hours, along with academic vacations and time for conferences. Teaching positions include office and support staff, removing large expenses that self-employed physicians incur. Among the disadvantages of an academic position is the pressure of a tenure track, which often requires a substantial amount of research and a requirement to publish articles in peer-reviewed journals. A set salary may mean earning less than some doctors in private practice make.

International careers offer distinctive gratification and experiences for doctors drawn to helping treat or solve major health problems in developing countries. Rachel Bronzan, MD, MPH, had traveled in Kenya and appreciated the enormous success family physicians could have with simple interventions. She joined an international epidemiology training program that sent her to Mali, Kazakhstan, and South Africa to work on infectious diseases. After two years, Bronzan accepted a hospital position in Malawi, caring for seriously ill children and conducting malaria research. Her biggest reward involved working with pediatric patients.

The Public Sector

Physicians have jobs at many levels of government. They often serve city, county, and state health departments as immunization specialists and as communicable disease experts. Physicians also work as directors at some of the largest federal agencies, including the federal Centers for Disease Control and Prevention. Such positions are attractive because they afford the chance to affect the well being of large numbers of people. Especially at city or county levels, a doctor can directly improve public health. And, within the federal and state governments, physicians get involved in developing and implementing significant health policies. Employment opportunities are as varied as the national and state health-related agencies, such as the National Cancer Institute, Department of Veterans Affairs, and the Food & Drug Administration.

Additional lures of government health jobs include predictable hours, a known career ladder, good salary and benefits, and an opportunity to educate the public and promote health. Bureaucratic settings can be difficult, however, for someone who enjoys autonomy. Some commissioners or department

One of the best ways to find the right position is by networking, meaning simply talking to as many people as possible.

heads encourage innovation, but large bureaucracies tend to have well defined roles and procedures. In addition, some senior positions are political appointments.

Private Industry

Some physicians have an interest in the business or financial side of health care, where first-hand medical knowledge and an understanding of the health care system are valued assets. Some physicians who have earned a graduate business degree (MBA) after medical school may be particularly attractive candidates for jobs in managed care and for health care purchasers, such as large businesses. Several programs combine medical and business training, leading to a combined MD-MBA degree. But an advanced degree isn't always necessary. Physicians with some experience may be able to land positions in health care groups of large investment companies such as Merrill Lynch or in large firms that consult on health care.

Almost all managed care companies and health insurance plans hire physicians, many at senior level positions, such as medical directors. Large, well established pharmaceutical companies hire physicians in research, administration, marketing, and other departments. While corporate salaries and benefits can be appealing at highly profitable companies, some younger physicians are drawn to the fast pace, excitement, and unpredictability of small start-up companies, such as biomedical and information technology firms.

Getting Help

A major career choice is a complex decision, so it may be worth seeking

an impartial perspective. An adviser at your medical school or staff member at your professional specialty association might be able to help you sort through various factors. A specialized firm such as Physicians' Career Practice provides thorough, intensive, individual assistance. Trained career counselors familiar with health and science careers can address concerns and help set priorities. Some career counselors are listed on the Web site of the National Board of Certified Counselors (www.nbcc.org). Once you have a general idea of a direction you'd like to pursue, an executive recruiter can provide a range of potential positions and make suggestions for targeting your resume.

One of the best ways to find the right position is by networking, meaning simply talking to as many people as possible. At local medical association meetings, conferences, continuing medical education classes and other professional gatherings, ask physicians if they know of any openings at hospitals, medical schools, public agencies, or group practices. Contact your medical school alumni association to get in touch with graduates working in the types of jobs or locations you've identified. Attend as many alumni association meetings as you can.

Medical training provides an array of skills and knowledge that are welcome in diversified settings. Taking the time to weigh your own circumstances thoughtfully against different work possibilities will increase your odds of landing the right position.

—Reported and written by Carol Milano, in Brooklyn, N.Y. More information on physician practice strategies is available on our Web site (see page 16).

ACPE Fosters Professional Development

Susan Quinn is the director of educational design and development for the American College of Physician Executives (ACPE), in Tampa. ACPE is dedicated to developing physician leaders through medical management education and professional programs. The college aims to build a critical mass of physician leaders who can guide the direction of health care. ACPE is the nation's only professional and educational association of and for physicians in health care management. Quinn reviewed the development of physician leaders with Editor-in-Chief Richard L. Reece, MD.

Q: Let's begin by discussing some of the reasons physicians are motivated to pursue business degrees.

A: Like members of any group, their motivations vary. Physicians in private practice typically want to learn more about the business side of practice. For others, it's become sort of a baseline career requirement to have an advanced degree, especially in business or medical management. Obviously, earning an additional degree or certification doesn't guarantee that a physician will automatically advance within an organization or that the degree will be the deciding factor between two candidates for a position. But, from what we're hearing from recruiters, an advanced degree is becoming a prerequisite in many organizations.

Q: In addition to advancement or additional opportunities, are there other reasons physicians pursue advanced degrees?

A: We've found that many doctors are frustrated by the limitations of medical practice. They want to have a more significant effect organizationally on the health care system and realize that they need medical or business management skills and education to do so.

“From what we're hearing from recruiters, an advanced degree is becoming a prerequisite in many organizations.”

—Susan Quinn, ACPE

Q: Can you describe the physicians who typically participate in the programs the ACPE offers?

A: Many of our participants have just completed their residencies, while others are looking for a second career in management. Some are doctors who have become medical directors in hospitals and they've found that they have an aptitude and enjoy the administrative side of medicine.

On the other hand, a vast majority of our members are still practicing clinically in some capacity. They want to stay closely involved in clinical practice, but also continue to move toward medical management positions. Our membership is open to licensed allopathic (MD) and osteopathic (DO) physicians, and licensed dentists with a DDS or DMD degree.

Q: Is it true that finance and business courses go beyond what physicians learn in medical school?

A: Yes. That's one of the reasons we offer an entry level course called the Physician in Management. This program is a week-long seminar that introduces all components of management. There's a day spent on finance, a day on marketing, a day on influence, a half day on management, a half day on communication, and a full day on negotiations. Another option is to take individual modules in any order. Physicians can do so using ACPE's InterAct Express, which is an educational program on the Web.

The Physician in Management course is popular because it gives par-

ticipants a taste of health care management. Many participants then take more intensive courses, which expand on each of these basic management skills. Physicians are eager for more advanced programs, in part because the modules provide them with a good foundation for adding to their knowledge and confidence.

We also publish several books on medical management, which are often of interest to physicians who might be thinking about taking courses, but want to learn more before doing so.

Q: You mentioned online courses. Is there much interest among physicians for learning via the Web?

A: We offer many options because we believe our programs should be flexible so that physicians can choose the methods that work best. We offer four live classroom programs a year. These are our institutes in the winter, spring, summer, and fall. These same courses are available throughout the year via InterAct, our online distance learning system, and are typically three to six weeks long. We call it InterAct because the online courses involve interaction with other participants and faculty. Participants also receive lectures and other resources such as digital video, which they can view at their convenience.

Many of our members complete all of their 125 ACPE hours via InterAct. Because physicians can participate any time of the day or night, they find it much more convenient than attend-

ing a live program. In fact, we've found that a significant percentage of physicians log in after 11 pm and do the majority of their coursework between 11 pm and 3 am. Such flexibility allows them to reach their goals and complete the program. In contrast, most executive MBA programs require that you conform to a fairly restrictive schedule, such as attending live courses one weekend every month.

Q: *After the Physician in Management program, what types of advanced courses do you offer?*

A: We have several, of course. For example: One program is a four-day course on financial decision making. Participants learn to assess their organization's current financial health and use that knowledge to make informed decisions. It's an advanced course that includes tools for better budgeting, improving cash flow, and generating higher rates of return. They learn to read financial statements (both the numbers and beyond the numbers) to determine what the numbers really say about an organization. And they study financial statements and case studies extracted from actual organizations that illustrate the concepts they're learning.

Another area of interest is informatics. In this area, we offer five InterAct Express courses: computerized physician order entry, e-health strategies, IT change management, practical fundamentals of information technology, and using technology for knowledge management.

But, of course, as the premier organization for medical management education, we offer a full spectrum of programs from basic management courses to master's level programs. We also offer a certification program to members, who must be licensed physicians, which allows them to earn the designation of Certified Physician Executive.

Another feature of our programs is that all ACPE courses carry

Category I continuing medical education credits, which is important to many physicians and not usually available through universities. In addition, we offer our master's level programs at leading universities. Our partner universities include Tulane University, Carnegie Mellon, the University of Southern California, and the University of Massachusetts at Amherst. Tulane, Carnegie Mellon, and USC offer a master of medical management (MMM) degree, and UMass offers a master of business administration (MBA) program.

After physicians complete a certain number of course hours with ACPE (currently 125), which we call Section I, they can continue with one of our partner universities to earn an MMM or an MBA.

The Section I curriculum can be completed in six months even though participants can take seven years to complete the program at their own pace. On average, physicians complete the MMM degree coursework in 12 months and complete the MBA program in 2.5 years.

Q: *Do you know how many ACPE participants work for hospitals, health plans, and group practices?*

A: We haven't segmented the population this way, but hospitals likely employ the vast majority of our participants.

—Edited by Laura Herbst, in Mashpee, Mass.
More information on the ACPE courses is available on the Web (at www.acpe.org) or by phone (at 800-562-8088). More physician practice strategies are available on our Web site (see page 16).

MBA vs. MMM: What's the Difference?

The ACPE cites four main differences between the MMM and the MBA in Medical Management offered at UMass. In addition to the typical MBA courses of accounting, information management, finance, marketing, and human resources management, the UMass program includes courses in behavioral science, economics, and quantitative analytical methods. In contrast, the Master of Medical Management (MMM) program includes some MBA coursework with additional content unique to the issues and concerns of medical management.

The ACPE says the four main differences are as follows:

- **Content.** The MMM integrates health care research with business to teach relevant management and leadership competencies in a doctors-only classroom. By contrast, the UMass program teaches management and leadership competencies from a broad, comprehensive business school approach using examples from all industries, and there are non-physician professionals among the participants.
- **Format.** The MMM format includes short on-campus sessions blended with independent study and distance learning. The UMass MBA involves all distance learning and includes independent study and online learning.
- **Duration.** After completing Section I, the MMM takes one year to 18 months to complete. The UMass MBA can be completed in two to four years.
- **Credential.** The MMM is quickly gaining recognition. More than 500 graduates are working in leadership positions across the country. The MBA is widely recognized even among business leaders who have little health care background.

Data Needed When Marketing

By Richard L. Reece, MD

Physicians seeking to build their practices need to ensure that they retain the patients they have and add new patients whenever possible. John McDaniel, president and CEO of Peak Performance Physicians, in New Orleans, offers a number of ways physicians can build volume by marketing to the right patients.

"It's not unusual for physicians to ask me how they can develop a marketing plan for their practice," McDaniel says. "And the answer is, it is relatively simple.

Tools to Use

"The tools physicians would use include physician referral reports or patient origin information," McDaniel says. "Also, physicians could use Zip Code analysis data. These are the primary tools a practice would use. But, in addition, it would be best to be aware of the general demographic and socioeconomic information within a marketplace to determine whether it's growing, how it's growing, and where and how the group is positioned to take advantage of growth.

"Fortunately, most information systems in group practices can generate data on the number of patients by Zip Code and the number of referring physicians for a certain area," he explains. "In some cases, these systems will report diagnosis frequencies

by ICD-9 code. In that way, the physicians in the group would have extensive data on the types of patients they're treating.

"Collecting the right data is simply a matter of knowing what tools are available and then using them appropriately," McDaniel says. "Any group can use these tools, but, of course, everything a physician does depends on the specialty involved. Primary care physicians have completely different needs than specialists. And specialists, such as oncologists, allergists, pulmonologists, and rheumatologists, for example, have their own needs.

"Primary care physicians have to do two things to grow their practices," he adds. "First, they have to take good care of their patients, and second, they have to recall patients. Primary care physicians probably are the worst at recalling patients.

"To be fair, internists and family physicians do a good job of recalling patients who have chronic illnesses," McDaniel adds. "If you have diabetes and it's time for new lab tests, they will call you. But primary care doctors should keep a profile on all patients about when they were last seen and then remind those patients to come in for visits each year. It's easy to collect such data simply by going into patient records and getting the last visit date. Any patient who hasn't been seen in

12 months should get a postcard reminder. Anyone on staff could do this task any day of the week.

Building Referrals

"The situation is different for specialists because the primary customer for most specialists is the referring physician," McDaniel continues. "There are some exceptions, of course. For example, allergists and ob-gyns get referrals from doctors and from other patients. Allergists and ob-gyns do a fairly good job of recalling patients, particularly those who have had allergy tests or Pap smears. But other specialists, such as oncologists, pulmonologists, and rheumatologists, get patient referrals from other doctors. Also, ear, nose and throat specialists get patients from self referrals as well as from physician referrals.

"Regardless of specialty, the data physicians need to review involves patient origin information or simple Zip Code studies," McDaniel says. "You want to know how many people are coming from the different Zip Codes in your primary service area. Are those particular areas attractive in terms of the demographics and socioeconomic mix of the population you want to reach? If so, then you're reaching the right patients. If not, then you probably have some work to do.

"You want to know how many people are coming from the different Zip Codes in your primary service area. Are those particular areas attractive in terms of the demographics and socioeconomic mix of the population you want to reach?"

—John McDaniel, Peak Performance Physicians

Analyzing Source Data

“Take an oncology group, for example,” McDaniel explains. “Maybe the group has an older practice downtown. Maybe one of the suburbs has a younger, more affluent population. In that case, the group may want to consider establishing a satellite office in the more affluent suburb. Eventually, the group may relocate to the suburb. In this way, Zip Code studies are useful in determining where your patients live.

“Another important tool for specialists is a physician referral analysis,” McDaniel comments. “You want to know which physicians are sending you patients. How many patients is each one sending you? What types of patients are these physicians sending in terms of diagnosis and payer mix? Also, determine if the number of referrals is increasing or decreasing. If there is an increase or a decrease, try to find out why. All of this information is extremely useful for specialists.

“If you’re an allergist, for example, and your referral profile data shows you’re getting a lot of referrals from primary care doctors, and the number of referrals from PCPs is increasing, then you should thank them for that business,” McDaniel says. “And maybe you should target other PCPs to get them to refer patients to you as well.

“But if the number of patients PCPs are referring to you is decreasing, consider meeting with several of them to ask them why,” McDaniel explains. “Take these PCPs to lunch or schedule a dinner with a few of them. You may find that the number of patients they’re seeing in their practices is declining. Or, maybe someone in your office has done something to offend someone in a referring physician’s office. Such information could be extremely useful.”

Serving Rural Areas

Another issue physicians should keep in mind when gathering market data

“In certain medically underserved areas, Medicare pays a 10% bonus to a doctor who practices in what it calls a health professional shortage area,” says John McDaniel of Peak Performance Physicians.

is how much payers pay for delivering care in certain areas. Reports show that physicians in some rural areas can earn more for the same procedure as physicians in urban areas. For example, a primary care physician treating Medicaid patients in a rural health clinic in Michigan would be paid more than \$70 for a routine visit, but a PCP in a city would be paid only \$35 due to a payment differential that Medicaid and Medicare build into payment rates, McDaniel says.

“In certain medically underserved areas, Medicare pays a 10% bonus to a doctor who practices in what it calls a health professional shortage area,” McDaniel says. “Medicaid can also pay different rates for areas in which there’s a shortage of physicians or for care delivered in rural areas.

“Physicians should be aware that in certain situations involving clinics serving patients in designated rural areas and in some specified community health centers, physicians may get a rate from Medicare or Medicaid that is higher than the normal rate,” he continues. “But the services have to be provided either in a rural area or in a medically underserved area. Keep in mind that these programs are designed to provide a financial incentive to physicians to practice in these areas and to see Medicare and Medicaid patients.

“Most states have different Medicare fee schedules for different areas, depending on the size of the state,” McDaniel explains. “Some small states have one fee schedule. Louisiana has two: one for the New

Orleans area and another for the rest of the state. New York City has a separate fee schedule from that of Buffalo or other places in New York State.”

Physicians should compare their fees against the Medicare fee schedule. “When we consult with a physician group, we compare the group’s fees as a percentage of the prevailing Medicare fees,” he says. “This exercise is important because many managed care plans generally base their fees on what Medicare pays. Setting fees that are much higher than what Medicare pays could be a red flag for insurers that the physician’s rates are too high.”

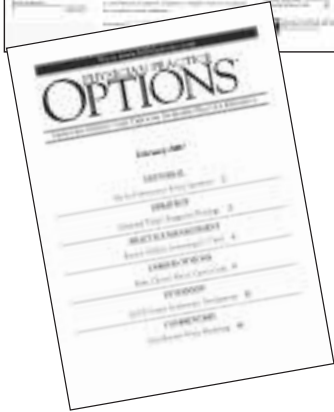
Target Marketing

In conclusion, McDaniel explains that once a group has gathered all of these data, the physicians can decide what type of practice they have and what kind of practice they would like to have.

“Some doctors want to have a higher percentage of commercial patients and so choose not to accept Medicaid or Medicare patients,” he says. “Others might say, ‘I’m going to see 20 patients a day and I’m limiting my practice to patients who are commercially insured or who pay cash.’ That is yet another way to tweak your practice as far as the types of patients you like to see.

“Many doctors develop their practices based on what patients come through the door each day,” McDaniel says. “Others do it simply based on intuition. Intuition is a wonderful thing but hard data is more accurate.” —More information on practice strategies is available on our Web site (see page 16).

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