

Visit [www.MDOptions.com](http://www.MDOptions.com)

# PHYSICIAN PRACTICE OPTIONS™

---

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

---

*July 2007*

## EDITORIAL

Is There a Viable Alternative to Fee for Service? 2

---

## STRATEGY

Tactics for Improving Operations 3

---

## CAREER OPTIONS

Make Choices That Match Your Goals 6

---

## TECHNOLOGY

Consider the Value of Decision Support 9

---

## CAPITAL IDEAS

Investment Opportunities to Review 11

---

## INTERVIEW

Physician Demand Drives Buy-Ins 14

## Is There a Viable Alternative to Fee for Service?

**H**ealth policy experts, academics, and many physicians themselves believe fee for service payment is a leading cause of rising costs, inconsistent quality, duplicative service, lack of care coordination, and fraud.

Medicare and other patients bounce among doctors, most of whom are unaffiliated with one another and as a result, few patients have a single doctor central to the care they receive, says Peter Bach, MD, a physician at Memorial Sloan-Kettering who recently served as senior advisor to the federal Centers for Medicare & Medicaid Services (CMS). The problem is fee for service payment, Bach added. In fact, fee for service offers an incentive to physicians to provide more services and more expensive services, he said in a recent article in *The Wall Street Journal*.

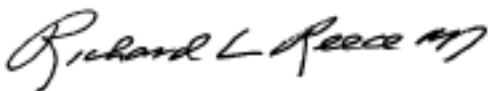
While fee for service may be flawed, it is not easy to identify a workable alternative. Some experts believe we could organize doctors into larger groups, pay them salaries, and reimburse these groups on a risk-adjusted basis for the full spectrum of care for each patient. Experts also say we should establish medical homes for patients by putting them under the guidance of one doctor or one group and reimburse for episodes of care rather than for individual services. At the same time, the system should be organized so that physician and hospital services are integrated for patients with chronic diseases, among other improvements.

Given the autonomous nature of physicians and the fact that 75% of doctors practice in groups of five or fewer, these changes are not likely to occur soon on a large scale.

Many different models of payment have been tried in limited situations. We have seen prepaid care, gatekeeper physicians, and large integrated systems. Each of these has had varying degrees of success and none has successfully controlled the rising cost of care over more than a few years. Just last month, Hewitt Health Resource, a consulting firm in Lincolnshire, Ill., said that initial 2008 HMO rate increases are averaging 14.1%, the highest rate increase in four years.

It is doubtful that fees for individual services can be seriously curtailed. These fees may be bundled, integrated into packages for a range of services for a given disease or procedure, and in certain regions of the country, prepaid care may prevail. But fee for service is likely to continue to be a significant part of health care payment. It is simply not possible to pay doctors in any other way.

Congress may reduce fees and it may compare resource use among doctors so that it can penalize those who overuse services, but it is unlikely to change the way most doctors are paid.



Richard L. Reece, MD  
Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: [Rreece@premierhealthcare.com](mailto:Rreece@premierhealthcare.com)

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

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

### Publisher

Premier Healthcare Resource, Inc.  
150 Washington St.  
Morristown, NJ 07960  
973/682-9003; Fax: 973/682-9077  
[publisher@premierhealthcare.com](mailto:publisher@premierhealthcare.com)

### Editor

Joseph Burns  
508/495-0246  
[editor@premierhealthcare.com](mailto: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, PA  
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

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, MHA

Senior Vice President, Oncology  
UnitedHealthcare  
Minneapolis

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.

# Tactics for Improving Operations

By John W. McDaniel

**H**ighly efficient physicians are continually exploring ways to improve the operational efficiencies of their practices. While many medical practices focus on expense reduction, highly productive physicians focus on ways to gain economies of scale through various consolidation or centralization opportunities. These practices also explore other initiatives such as group purchasing contracts and changing the mix of personnel in an attempt to do more with less.

Typically, the most efficient physicians have more support staff than physicians in average practices have. Having more staff means these practices view personnel as an investment, much the way large corporations do.

## Cost-Benefit Analysis

Also, before implementing operational or technological improvements, these successful practices explore various return on investment strategies through cost-benefit analyses. The most efficient practices want to know the true cost of providing a particular service and so are likely to do a cost-benefit analysis on any services being considered as well as on existing services to know which ones should be modified or eliminated.

The best-run practices also use cost allocation methods to determine the true cost of providing direct and indirect patient care services. These practices are reviewing fixed versus variable costs, direct versus indirect costs, and clinical versus non-clinical costs. Practices use various cost-allo-

**To get the most from their personnel and increased physician productivity, practices often use mid-level providers in lieu of recruiting additional physicians. These groups recognize that the key to success in any medical group is the ability to maximize provider production.**

cation methods depending on need. For example, some practices allocate costs according to patient visits and others use work relative value units (WRVUs).

In its publication, *Performance and Practices of Successful Medical Groups*, The Medical Group Management Association in Englewood, Colo., has said highly productive medical groups provide programs for their employees to optimize staff productivity by focusing on formal training programs, cross training, exit interviews to detect potential problems, timely and meaningful performance evaluations, and employee recognition or awards and bonus opportunities based on group profitability. Better performing groups also tend to have higher ratios of staff to physicians than other groups, and these groups have higher levels of productivity and enhanced ancillary services as well.

## Mid-Level Practitioners

To get the most from their personnel, the best practices often consider using mid-level providers in lieu of recruiting additional physicians to optimize existing physician productivity. These groups recognize that the key to success in any medical group is the ability to maximize provider production. Other ways to increase production involve improving patient scheduling and patient flow within the physical office layout.

Some of the most significant operational improvements result from revising physician compensation plans. Most practices tend to develop their own compensation plans, and better performing practices link compensation to each physician's personal production. Production can be based on patient visits or encounters, which are acceptable metrics. Perhaps the most efficient method of linking production and compensation, however, involves tying compensation to a formula based on percentage of collections. Another method involves using WRVUs, a method that has become popular recently because it focuses only on physician productivity and not on collections or operating expenses.

Since so many physicians affiliated with peak performance practices are concerned with collections, they often base compensation plans on WRVUs that are tied to collection rates. This approach tends to be more acceptable among physicians than compensation plans that are based on allocating various expenses unless all physicians can reach agreement, which is often difficult, if not impossible, particularly in a multi-specialty practice. Physicians usually can agree on direct physician-specific or personal expenses such as for continued medical education, equal share expenses such as rent and util-

(Continued on page 4)

*John W. McDaniel is the president and CEO of Peak Performance Physicians Inc. ([www.peakphys.com](http://www.peakphys.com)), a consulting firm in New Orleans. Readers may contact McDaniel by phone at 800-279-0614 or by e-mail at [info@peakphys.com](mailto:info@peakphys.com). This article is the second of two parts.*

(Continued from page 3)

ities, and expenses allocated on a production basis such as a percentage of medical supplies used.

After making improvements to practice operations, highly productive physicians next explore ways to grow their practices. When they do, they find they can increase patient volume by boosting physician productivity through improved patient access and improving continuity of patient care. They also find that raising patient satisfaction scores helps a practice retain current patients and attract new ones as well.

Indeed, the number one factor that contributes to high patient satisfaction is giving patients access to the provider of their choice at a time and manner that is convenient for patients. Access is also the key factor in retaining current patients and attracting new ones to the practice. Access not only involves the traditional face to face visits, but also includes giving patients access to information, medical and lab test results, medical records, medication records, and educational material. Recognizing the value of allowing patients to access information online, a number of practices are installing Web portals to allow patients access to test results and to schedule appointments, among other functions.

### Fostering Growth

The most efficient practices find that access should be linked with continuity of care. Optimal continuity is the ability of the practice to create a process allowing a patient to see his or her provider of choice almost all of the time. A practice that focuses on improving access and continuity of care can almost guarantee that it will have a solid and growing patient base for years to come.

For the average primary care practice, providing excellent patient care and recalling patients periodically will ensure future practice growth. Specialty physicians should

## Practices Find Value in EMRs, PDAs

Seeking to improve operations, some of the most efficient practices are continually evaluating information technology. The most sophisticated practices, for example, are using electronic medical record (EMR) technology, either as a stand-alone system or in conjunction with a practice management system. Physicians also are using personal digital assistants (PDAs) for many purposes including:

- Charge capture
- Prescription information or electronic prescribing
- Coding and documentation
- Reference materials
- Clinical decision making
- Continuing medical education
- E-mail and Web searches.

Indeed, as new computer-savvy physicians enter the workforce, integrating technology into practices is no longer a luxury. It is essential to keeping and attracting new staff. —JWM

## Surveys Help Physicians Fine-Tune Operations

Few medical practices survey patients routinely. For that matter, few practices survey physicians or employees regularly and surveying all three groups will provide particularly useful information for physicians seeking to improve results over time. In a report, *Performance and Practices of Successful Medical Groups*, the Medical Group Management Association (MGMA) in Englewood, Colo., reported that well-run practices survey patients on their satisfaction level 71% of the time while other practices survey patients only 57% of the time.

Interestingly, only 31% of high performing physicians routinely engage in employee satisfaction surveys while 27% of other medical practices survey their employees regularly. Efficient practices survey referral physicians only 13% of the time and internal physician satisfaction only 9% of the time. —JWM

recognize that their primary customer is the referring physician and should continually analyze physician referral patterns to identify strengths and weaknesses. Also, specialists should make every effort to cultivate referring physicians through contact with this most important customer. All practices should track physician referrals to determine both the number and types of referrals from physicians.

Another way to foster growth is to

conduct a patient origin analysis. This process involves determining the number and types of patients by primary Zip code to identify the demographic and socioeconomic mix of patients in the practice and analyze areas for growth. For example, an ob-gyn practice may want to serve areas where 18 to 35 year old females live in households with income in excess of \$30,000 per year. Such target marketing would allow the practice to identify whether to have

# Technology Helps Boost Growth

Many medical practices are discovering they need a presence on the Internet. Practices are finding such sites allow them to attract patients who are accustomed to getting information and making transactions via the Web. Other practices find that having a Web site helps them avoid technological obsolescence while also increasing the level of sophistication in the practice that can help improve efficiency and productivity.

High performance medical practices use Web sites to:

- Register and schedule patients
- Verify online eligibility, make referrals, and submit claims
- Access online coding tools
- Do electronic inventory management and order supplies
- Write electronic prescriptions
- Make e-connections with hospitals, other physicians and labs, imaging centers, and other ancillary providers
- Get information for practice management benchmarking
- Provide online patient education
- Get information for government and regulatory agencies
- Access medical and business information.

Among practices that have adopted full service e-health portals for their patients, many find that these systems allow a practice to connect with patients 24 hours a day and seven days a week, attract new patients, increase overall patient satisfaction, and save money by streamlining office systems. Allowing patients to communicate electronically reduces the daily volume of phone calls. Most physicians find that once they communicate with patients via such portals, the time they spend online may be much less than the time they spend on the phone.

Patients prefer such systems because they can make appointments, get lab results and prescription refills, and collect information from electronic patient records at their convenience. The office can use the system to share medical records through a referral management process, manage the flow of information from health insurers about benefits and formulary changes, bill and receive patient payments online, provide automated health alerts, and most important, conduct a virtual office visit, when appropriate. All of these processes save time and money.

—JWM

its primary office location in this geographic area or consider a satellite office for future growth.

A similar method of target marketing involves identifying patients by payer type and then offering them preventive care services. Depending on specialty, this strategy can be useful for patients who are enrolled in plans that cover preventive care, such as in wellness or weight-loss programs. Physicians should ensure that they see these patients according to

the patients' benefits program. If a patient's plan covers an annual physical, for example, then each patient in the plan should have a physical each year. Working to fulfill the plan requirements not only promotes appropriate patient care but ensures continued growth for the practice's preventive medicine services.

In addition to target marketing, many practices have found that they can increase patient volume by adding ancillary services. Given the

continued decline of reimbursement for the average medical practice, physicians that add these services find they can increase patient convenience and attract new patients too.

## Assessing Strengths

One of the most important steps highly efficient practices can take regarding growth strategies involves developing and implementing a strategic business plan. Virtually every successful business undertakes this process to some degree. One of the most essential components of any strategic plan is a SWOT analysis. In a SWOT analysis, a practice would review its strengths, weaknesses, opportunities, and threats in its market so that it can make the requisite adjustments to be positioned for growth.

A similarly important step in positioning a practice for growth involves implementing a productivity improvement program that is centered on patient scheduling and physician or provider productivity. Most well run practices have begun measuring physician productivity with WRVUs which accurately reflect the intensiveness and resource utilization needed to produce patient care based on the acuity of services provided. Furthermore, the use of various information technology solutions leads to overall productivity improvement such as computerized scheduling, electronic medical records, increased use of personal digital assistants and voice recognition.

In summary, efficient physicians invest in areas with the greatest return on investment such as reimbursement systems, billing and collection processes, accounts receivable management, operations improvement (which includes promotion of ancillary services and an analysis of human resource investments) and development of strategies for practice growth.

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

# Make Choices That Match Your Goals

Once they finish their first full-time position in medicine, most younger physicians face a wide range of choices about career direction. The challenge they face involves selecting the alternative that lays the foundation for a stable, growing, and satisfying professional career.

For these physicians, the most popular options include working in an established private practice, forming a group practice, starting a solo practice, buying into an existing group, or working in a private or public setting. Since each of these options has advantages and disadvantages, experts offer guidance on how to choose among them.

## Private Practice

Doctors who prefer working full-time as clinicians should consider joining an existing group, forming a new group, starting a solo practice, or buying into a medical group.

**Joining an existing group.** In a typical group, the members will want to have a new associate join the group so that the established members can work fewer hours or so that they can expand the group's patient volume. It is likely that one or more of these doctors is considering retirement. They want a younger doctor who can contribute new knowledge and energy and take over some patient hours.

Initially, the new physician won't be expected to bring in patients or income, but may receive a share of group profits. A hospital where the group has admitting privileges may help subsidize compensation for their incoming physician.

A large group that has many different specialists will have a big advantage over other groups in that it can generate in-house referrals. If an internist in the medical suite finds that a patient should see a

rheumatologist, the physician can recommend one in the same group, for example.

It's important to explore any medical group thoroughly. "The partners must show you their books, and everything that they do," says Robert Mestas, MD, medical director of Physicians' Career Practice, LLC, in Denver. "If they keep that from you, you'll simply have to believe what they tell you, and you will have no recourse in case of a serious problem. Pay attention to how the business is run. Ask questions and show interest. Since you may have to make critical decisions with a small amount of information, you will have to think like a businessperson, which can be hard."

**Forming a group partnership.** Several younger doctors with a few

years of experience in an existing group might decide to combine their skills and form a new practice. If each physician has developed name recognition individually or has developed an adequate patient base, this option can be viable. However, it's fairly unusual for most younger physicians to have the name recognition after only a few years of practice and so likely will not yet have enough patients to launch a new group, says Mestas.

**Starting a solo practice.** This option involves running an entire practice according to your own principles without the need to gain consensus from colleagues. The physicians in this setting define the range of their practices, select their own staff, and set all hours and procedures. They do not share revenue

## Where to Get Career Help

Making a significant career choice is a complex decision. Therefore, it's often worth seeking an impartial perspective. An adviser at medical school, or staff member in a professional specialty association might be able to help a physician sort through the various options.

A specialized firm such as Physicians' Career Practice, LLC, in Denver (at [www.pcpllc.org](http://www.pcpllc.org)), also can provide assistance. Such firms specialize in guiding physicians into a career or into a new job.

Trained career counselors familiar with health and science careers can address a physician's concerns and help one set priorities. Some career counselors are listed by the National Board of Certified Counselors (at [www.nbcc.org](http://www.nbcc.org)).

If the physician has a general idea of what direction he or she would like to pursue, an executive recruiter or headhunter in the medical field can offer a range of potential positions and make suggestions for targeting the physician's resume.

The best way to find the right position is by networking: simply talking to as many people as possible. At local medical association meetings, conferences, continuing medical education classes and other professional gatherings, physicians seeking new positions should ask other physicians if they know of any openings at hospitals, medical schools, public agencies, or group practices. One's medical school alumni association can offer information about other graduates who are working in the types of jobs, or locations, one is seeking. —CM

among partners. For physicians who want independence and autonomy, this situation is ideal.

Such freedom comes at a price, however; doing all your own marketing can be difficult and time-consuming. Covering every expense, including rent, equipment, salaries, benefits, and malpractice insurance is an ongoing financial responsibility. The solo physician is the only doctor on call for emergencies, and setting office hours to allow more family time usually means seeing fewer patients. Despite the challenges, many physicians still find a way to make solo practice work.

**Buying into a medical group.** Some group practices allow a physician to buy in, becoming vested over a specified period, such as five years. (See “Physician Demand Drives Buy-Ins,” page 14). “This is fine as long as everyone knows up front what the plan is,” comments Mestas. He cites one young doctor who accepted a salary, 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.” Mestas doesn’t recommend buying in because it tends to build, rather than reduce, debts incurred during medical training.

Mestas was fortunate in that before he worked as a career consultant, he had a long and satisfying career in a group practice in part because he was lucky to choose the right group situation. In 1980, he became the sixth physician in a large, established ob-gyn practice. “They wanted me to work with them and I wanted to work with them,” he recalls. “They showed me their books, and how much each doctor had produced over the previous five years.”

Mestas earned a set salary for the first year, then 50% of a partner’s

## Keys to Evaluating a Practice

Here are some steps to take when considering joining an established medical practice.

1. Seek transparency. Will partners share all books and records for the physician’s careful review?
2. Discuss expectations thoroughly. Is the new physician required to see a certain number of patients each week or be on call for a designated number of nights or weekends?
3. Scrutinize financial arrangements. Will the new physician receive a salary, a percentage of profits, or some combination? How long will it take to become a full partner?
4. Study every contract provision. Ask a lawyer to review the contract and check if a non-compete clause is included.
5. When was the practice established? Are founding partners still involved? How many new physicians have been hired or remain since it was founded?
6. What percentage of cases are referred by physicians or patients? What is the practice’s reputation in the medical community?
7. Where do practice members have admitting privileges? What is the nature of 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?

—CM

salary during his second year and 75% during the third. In the fourth year, Mestas became a full partner. “It was fair and simple because I knew everything up-front,” he explains. “They told me I could leave after the first year if I was unhappy. I was not asked to sign a non-compete agreement. I stayed 21 years until I retired. I knew exactly what I was getting into, and all subsequent hires got the same treatment. We addressed problems and talked about them. It was the fairest way to treat people.”

### Other Medical Settings

Apart from group or solo practice, thousands of doctors work full-time in hospitals and academic institutions. Choosing a hospital position opens an array of considerations: private or nonprofit? Large or small? Specialty center or general hospital? Each setting has advantages and dis-

advantages, meaning physicians should look at each situation thoroughly and decide how one’s temperament and preferences fit with the situation.

A big academic medical center usually offers the latest equipment, technology and treatments, and may be a site for important clinical trials, for example. They afford an opportunity to collaborate on complex cases with colleagues in many disciplines. Some physicians find they dislike the impersonal, departmentalized feeling of a huge institution.

A smaller hospital can be less hierarchical as a workplace and may afford closer contact among staff and administration. A specialty hospital gives a physician a chance to develop his or her expertise in a particular procedure or condition while also working with other experts who share the same focus. Someday, a desire to work with a broader range

(Continued on page 8)

(Continued from page 7)

of health issues may surface.

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 in these settings have a set weekly schedule of classes and office hours and academic vacations and time for conferences. Teaching positions bring an office and support staff, removing large expenses that self-employed physicians incur. One disadvantage is that tenured teaching positions require an often substantial amount of research and publication in peer-reviewed journals. A set salary may mean earning less than some doctors in private practice.

International careers offer distinctive gratification and experiences for doctors drawn to helping treat patients in unusual settings or solve major health problems in developing countries. Rachel Bronzan, MD, MPH, had traveled in Kenya and was impressed by the enormous effect family physicians can 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 was working with pediatric patients.

### **The Public Sector**

For physicians seeking jobs in the public sector, there are positions at every level of government from federal offices to county health departments. What makes these jobs attractive is the chance to affect the well being of vast numbers of people. Especially at city or county levels, doctors can improve public health. With federal and state governments, physicians get involved

## Pitfalls to Avoid When Joining a Practice

There are a number of potential problems that young physicians are likely to encounter when joining an established practice. Here are some of the most common.

First, a new physician who expects to see a set number of new patients may be given fewer patients if partners aren't ready to reduce their own incomes. Therefore, it may take time for a new doctor to build word-of-mouth referrals.

Second, senior physicians may opt out of night calls, but work full days. A new physician, told to anticipate night calls, might actually be asked to take most of these calls. These situations can quickly generate resentment between new younger doctors who are on call at the most difficult times and the older doctors who are enjoying a more relaxed lifestyle.

Third, new physicians are sometimes asked to sign a non-compete contract, requiring them to affiliate with a different hospital or in a different area after leaving the group practice.

—CM

in developing and setting health policies. And the opportunities are richly varied.

Other lures of government health jobs include predictable hours, a known salary ladder and benefits, and an opportunity to educate the public. A classic bureaucratic setting can be difficult for someone who enjoys autonomy, however. Some commissioners or department heads encourage innovation, but large bureaucracies tend to have well defined roles and procedures.

### **The Business Side**

Some physicians realize an interest in the business or financial side of health care and find that first-hand medical knowledge is a valued asset. One new employee at a medical venture capital firm in New York completed an MD degree in 2001, and then earned an MBA in 2006. But an advanced degree isn't always necessary. With a MD degree, a young physician landed a position as an investment banking associate at Merrill Lynch.

The health insurance and legal professions rely on medical knowledge for a variety of vital roles, such as claims examiner. Large, well established pharmaceutical companies hire physicians in research, administration, marketing, and other departments.

While corporate salaries and benefits are appealing at highly profitable companies, some younger physicians are drawn to the fast pace, excitement, and unpredictability of smaller start-ups. Or, physicians may be interested in an entrepreneurial company. In 1999, Tod Cooperman, MD, founded Consumer Lab. The New York-based firm has built a solid reputation as a company that tests and certifies vitamins, nutrients, and supplements. Test results are posted on the Web and are available to consumers and others for a fee.

—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).

# Consider the Value of Decision Support

By Joseph Britto, MD

**A**dvances in science and technology have led to remarkable changes in health care and in the delivery of patient care. New diagnostic tests, medical devices, and treatments enable clinicians to treat patients more quickly and more effectively than they could in the past. Despite these extraordinary advancements, a fundamental problem continues to hinder the quality of patient care.

As an increasing amount of medical knowledge becomes available, physicians and other providers are expected to recall and synthesize a staggering amount of information surrounding clinical features, differential diagnoses, investigations, treatments, and complications for thousands of disease entities. For any given set of clinical features, it is difficult to construct, on every occasion, a complete and safe differential diagnosis, no matter how well trained, well read, or well practiced a physician may be. This failure can lead to delays in diagnosis and misdiagnosis.

## Identifying Errors

A poll the National Patient Safety Foundation commissioned found that one in six persons has personally experienced a medical diagnosis error. Furthermore, according to a 2005 meta analysis, funded by the federal Agency for Healthcare Research and Quality and published in *Advances in Patient Safety*, diagnosis errors represent 10% to 30% of all cases of medical error.

Unlike most medical errors, which

*Joseph Britto, MD, is the CEO and cofounder of Isabel Healthcare Inc. (at [www.isabelhealthcare.com](http://www.isabelhealthcare.com)), a company in Reston, Va., that provides physicians and other providers with decision support systems to reduce diagnosis errors.*

**Diagnosis reminder systems decrease diagnosis errors by providing physicians with a list of likely diagnoses for a given set of signs and symptoms and the most up-to-date and relevant clinical information about the potential diagnoses.**

are usually errors of commission, diagnosis errors are usually errors of omission and therefore are difficult to identify and measure. A 2005 study published in the *Archives of Internal Medicine* found that the cognitive error of premature closure is the single most common cause of diagnosis errors. Premature closure occurs when a clinician arrives at an initial diagnosis that seems to fit the facts but then does not consider other reasonable possibilities.

Diagnosis decision support systems (DDSS) offer physicians an easy to use, effective means of ensuring that all possible diagnoses are considered and diagnosis delays are reduced.

While the use of emerging DDSS is growing, some health care providers remain wary because early DDSS did not live up to their advance promise. If anything, they slowed the diagnosis decision-making process. Obviously, this drawback made DDSS unsuitable at the point of care and in the clinical workflow.

Traditional DDSS often operated on a rules-based design and did not use natural language processing. In studies, rules-based systems took 20 to 40 minutes to use, making them impractical at the point of care. Traditional DDSS were also designed as expert systems that had a didactic and prescriptive approach. These systems told physicians what to do rather than treating providers as learned intermediaries

and reminding them of diagnoses they might want to consider. Emerging DDSS treat health care professionals as the experts and are designed to provide decision support, leaving the final decision to the professional.

## Point of Care Information

Also consider that traditional DDSS do not easily allow physicians to use these systems during patient encounters. If providers cannot employ a DDSS during a patient encounter without adding time to the visit, then they are not likely to use these systems. Health care professionals at the point of care are not going to guess at the diagnosis and do the research later to check the diagnosis. Changing a diagnosis after the patient encounter would not engender the kind of patient confidence providers seek and enjoy.

Diagnosis reminder systems provide an effective option to prevent diagnosis errors by arming physicians with the most up-to-date and relevant clinical information. Diagnosis reminder systems decrease diagnosis errors by providing physicians with a list of likely diagnoses for a given set of signs and symptoms and the most up-to-date and relevant clinical information about the potential diagnoses.

Better quality care is also good for business, and there are several ways that using a diagnosis reminder

*(Continued on page 10)*

(Continued from page 9)

system can improve a practice's results. These systems help to reduce clinical risk and malpractice premiums while increasing patient satisfaction. Also, some DDSS allow physicians to get continuing medical education credit while seeing patients.

**Reducing clinical risk.** Being able to produce a comprehensive check of diagnoses within seconds will reduce the chance of missing something important, which will help reduce the potential for a malpractice claim. The fact that there would also be a record of the diagnosis considered to support a case would provide an important audit trail and a good first line of defense.

Contrary to what some critics say, having a DDSS does not increase a physician's liability if the system is used and the diagnosis is missed. Courts have treated clinical decision support systems as textbooks, assuming that clinicians consult such systems and in this way, they supplement the physician's knowledge but do not supplant the provider's judgment.

**Reduction in malpractice premiums.** Since misdiagnosis accounts for over 40% of malpractice claims, it is likely that a physician's malpractice insurer would consider a reduction in premiums for using a properly validated DDSS.

**Increased patient satisfaction.** When working in partnership with patients, physicians often find that patients respond well when physicians review a comprehensive list of possible diagnoses. Patients find such thoroughness is reassuring and shows that the physician is delivering the best care. A satisfied patient is the best way to attract new patients as these patients are likely to report such care to friends and family.

**CME.** With some DDSS, physicians can earn CME credits while seeing patients, thereby giving a direct link between quality of care, patient satisfaction, and increased efficiency.

When seeking a practical system that physicians can use at the point of

## AMIA Releases CDS Roadmap

Last year, the American Medical Informatics Association (AMIA) released a report explaining how health systems could adopt clinical decision support systems. The report, *A Roadmap for National Action on Clinical Decision Support*, outlines a variety of approaches for providing clinicians, staff, patients, or other individuals with timely, relevant information that can improve decision making and prevent errors.

The report also makes recommendations on ways to advance the development, adoption, and value of clinical decision support in improving health and the quality and safety of health care delivery.

The roadmap identifies three pillars that are needed to support widespread and optimal use of clinical decision support (CDS):

1. Make the best knowledge readily available when it is needed.

Actions include building highly practical formats and services for representing, collecting, organizing, and distributing clinical knowledge and CDS interventions.

2. Foster increased adoption and effective use. Actions include organizing and publishing strategies for improving CDS system design, usability, and implementation, as well as strategies for addressing legal and financial barriers.

3. Continuously improve CDS interventions and health-related knowledge. Actions include developing systematic methods for sharing CDS experience and for leveraging electronic health records to enhance clinical knowledge.

care, practices should consider that some of the best DDSS are Web-based, meaning physicians can get quality diagnosis decision making information at the point of care if using a desktop, laptop, personal digital assistant (PDA), or other Web-connected device. The best programs in this class will provide an instant checklist of diagnoses for clinicians to consider. In a split second and at the point of care, these systems address the questions clinicians frequently ask: What diagnoses should be considered?

Typically, these systems are formatted for use on a PDA with wireless Internet connectivity. Having such access allows physicians to get information at the bedside and at any point in the continuum of care, meaning they can get the information while seeing patients in the physician's office, in a hospital, or even at home after hours if needed.

For hospitals, such systems cost about 50 cents per bed per day. The annual cost for hospitals starts at

\$180 per bed and goes down on a sliding scale based on size. Individual physicians and group practices can purchase such systems for about \$60 per clinician, per month. Physicians should not pay any additional set up or upgrade fees.

Clearly, the development of such systems means physicians and other providers should re-examine any resistance they have had to diagnosis decision support systems. While earlier iterations may not have been validated and may have exhibited limited accuracy, the latest generations of this technology have undergone clinical trials and are proving to be highly effective and user friendly. The systems reduce the risk of misdiagnosis related to malpractice claims, thereby saving time, money, and lives. What's more, they are helping physicians to do what they were trained to do: deliver high quality patient care.

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

# Investment Opportunities to Review

By Cameron Short

**M**any physicians and other professionals want to know more about the wide variety of investment opportunities that are available. These physicians and other professionals should know enough so that they can work intelligently with a professional investment adviser. To learn the basics about some of the various investment opportunities, these physicians should review a brief description of some of the most common investment vehicles.

It is best for physicians to leave portfolio monitoring to an investment professional and use this professional as an adviser. Physicians also should be aware of the factors that can affect the performance of an investment vehicle. (See "Managing an Investment Portfolio," *Practice Options*, June, for a description of the role of the investment adviser and a discussion about the factors that affect performance.)

## Investment Opportunities

One popular investment vehicle is convertibles. Convertible bonds are hybrid securities with the characteristics of both bonds and stocks. A convertible bond has a fixed coupon and a maturity date and can be exchanged for a predetermined number of shares of common stock. A convertible preferred stock has a

**The market timing strategy is generally considered a fool's game due to the statistical improbability that an investor can consistently time correctly when to be in or out of the market.**

fixed dividend, no maturity date, and can be converted into a predetermined number of shares of common stock.

The unique risk and reward characteristics of convertibles make them excellent investment vehicles. They offer investors the limited downside risk of fixed income securities and the upside potential of common stocks.

Another popular vehicle is annuities. An annuity is a contract between an individual and an insurance company that allows the individual to accumulate tax-deferred earnings. When an individual purchases an annuity, he or she pays a fixed amount of money, which the insurer invests in a mutual fund, real estate portfolio, or fixed income account, according to the individual's financial objectives. On a specified date, the individual may withdraw part or all of the accumulated cash value or annuitize the annuity contract. If the individual annuitizes the contract, the insurance company distributes a specific amount each month for the life of the individual or perhaps for a spouse's lifetime. The individual chooses the time and method of payment most appropriate for one's income needs and tax situation. Annuities are generally designed as retirement vehicles.

Many professionals rely on life insurance as an investment strategy. Permanent life insurance, whether whole life, variable life, universal life, or variable universal life, provides an

investment feature called the cash value in addition to the death benefit. As the individual pays premiums, the policy's cash value accumulates on a tax-deferred basis. The individual may borrow against the cash value at relatively low interest rates, with possible tax-advantaged treatment although such treatment may reduce the policy's death benefit.

Of course, liquid and marketable securities also are popular mostly because high levels of liquidity and marketability are desirable characteristics in investments. Professionals should avoid investing in assets that are illiquid or unmarketable.

Liquidity refers to the ability to quickly convert assets to cash. A money market deposit account has instant liquidity, since the holder can write checks against the funds. Other liquid assets include savings accounts, checking accounts, money market mutual funds, and Treasury bills. Liquidity also refers to the ability to convert assets to cash without substantially affecting the price. A high level of liquidity indicates a good market for an investment.

Marketability refers to how quickly and easily you can access a market of potential buyers and sellers. An actively traded stock with a large number of outstanding shares is highly marketable. Shares in a small, closely held, or less well known company are less marketable

(Continued on page 12)

*Cameron Short is a senior vice president and certified investment management analyst at Ryan Beck & Co., in Pittsburgh. Founded in 1946, Ryan Beck & Co. (at [www.ryanbeck.com](http://www.ryanbeck.com)) provides financial advice to individuals, institutions, and corporate clients. Readers may contact Short by phone at 800-223-8162 or by e-mail at [cameron.short@RyanBeck.com](mailto:cameron.short@RyanBeck.com). This article is the second in a two-part series.*

(Continued from page 11)

because there are fewer potential buyers or sellers.

Physicians should be cautious, however; although liquidity and marketability are desirable characteristics, their presence does not indicate an asset that will necessarily provide a favorable return.

## Stock Strategies

When owning stocks, it is important, of course, to understand the various strategies one can use to get the most return from the stock market. These strategies include market timing, buy and hold, growth investing, value investing, contrarian investing, and indexing.

**Market timing** involves making decisions about when to buy or sell securities using economic factors, such as strength of the economy and direction of interest rates, or technical indications, such as the direction of stock prices and volume of trading. Investors may implement market-timing decisions by switching from stocks to bonds to cash and then back again, as the market outlook changes. The market timer is relying on his or her ability to determine when significant high and low points are achieved in a certain investment or category as the main factor when deciding to buy or sell.

Use caution when employing this strategy, however, because it is generally considered a fool's game due to the statistical improbability that an investor can consistently time correctly when to be in or out of the market.

**Buy and hold** is a well proven investment strategy in which an investor purchases assets and holds them over an extended period of time. If one adheres to the buy and hold strategy, the investor is trying to ride through the ups and downs of the market to achieve potentially higher returns than one could get if buying and selling securities.

Some advantages of the buy and hold strategy include no hassle

## Advice on Taking Income

An investor may take income from a portfolio that generates dividends and interest, and there are hundreds of books about the income tax consequences of doing so. Briefly, then, is a discussion on the topic.

Consider that stock and stock mutual funds may pay dividends. Qualifying dividends are currently taxed at the tax rates that apply to long-term capital gains. Only dividends that domestic corporations and qualified foreign corporations pay to individual shareholders qualify for this tax treatment. Certain dividends, such as those that credit unions and mutual insurance companies pay are taxed as ordinary income at ordinary tax rates.

For tax years beginning on or after Jan. 1, 2003, and before Jan. 1, 2011, qualifying dividends paid to individual shareholders from domestic corporations and qualified foreign corporations are taxed at capital gain rates. For tax years beginning before Jan. 1, 2003, however, dividends were taxed at ordinary income tax rates. This rate generally resulted in significantly more tax due. Without further legislative action, dividends will again be taxed as ordinary income beginning in 2011.

—CS

involved in timing the market, generally lower transaction costs and expenses, and long-term capital gains taxes may be favorable. Two of the disadvantages of the buy and hold strategy are that actual results may differ from those forecast, and it is psychologically difficult for some investors to have the requisite patience to make buy and hold worthwhile.

**Growth investing** is a strategy that involves selecting securities in growth companies, meaning those firms that have experienced significant gains and are expected to continue to do so. In other words, a growth company is a successful one, showing improvement each quarter and each year.

Growth investors believe that improvements will continue and result in rising stock prices. Growth stock is generally sold at a premium, but growth investors are willing to buy high to sell higher. The challenge of growth investing is knowing when a growth company has matured or is about to experience a permanent decline. This strategy is generally most successful during a bull market.

**Value investing** is picking stocks in companies that are undervalued and poised for a turnaround. In other

words, value investors look for a bargain so they can buy low and sell high. The key to value investing is in knowing what a particular stock is really worth.

Some of the advantages of value investing include:

- Value stocks are less vulnerable to market downturns
- Most value stocks offer high dividend yields
- Value investing is considered a relatively conservative style of investing, so even risk-averse investors may participate comfortably

There are disadvantages to value investing as well. A value investor must know, for example, whether stocks are bargains or just poor investments. Recognizing bargains takes research into company financial data, the ability to correctly interpret such data, and detailed knowledge of the company's business and market environment. Value investing is said to represent a contrarian style of investing because it focuses on the assets of a company more than its earnings or growth rate.

**Contrarian investing** involves doing the opposite of what most investors are doing at a particular time.

# Strategies for Hedging and Options

As an aggressive investor, an individual can face a great risk from changes in the market's direction, including the loss of principal. Hedging is a strategy that allows individuals to offset this risk. The objective is to protect against loss from future price changes.

Options are a widely used hedging technique. An option gives the individual the right to buy or sell a specified number of shares for a set price within a predetermined time, usually several months. Options are traded as a put, which is a contract to sell shares, or as a call, which is a contract to buy shares. Options are traded on a number of exchanges. The Chicago Board of Options Exchange is the oldest and largest.

Hedging also can be accomplished through the use of warrants, stock index futures, and interest rate futures. For example, suppose one has \$65,000 invested in stocks during a bear market, and the individual doesn't want to sell the securities. One can consider selling stock index futures contracts to offset the potential loss on the shares. Doing so would allow the individual to keep one's portfolio intact and earn a profit on the futures if the market falls.

—CS

As the name implies, contrarians buy stock that is out of favor and sell stock that is popular. Here's their reasoning: If most people who say the market is going up are fully invested and have no additional purchasing power, then the market is at its peak. When most people predict decline, they have already sold out, so the market can only go up. Thus, contrarians buy securities that nobody else wants at the moment, betting that the current market trend is about to be reversed.

Indexing is a passive investing style that involves designing an investment portfolio to match a broad-based index, such as Standard & Poor's 500, so as to match its performance. Index investors believe that trying to beat the index is not worth the risk. In addition to the S&P 500, the other main categories to index are the Dow Jones 30 Industrials, the Russell 2000 Index, and the NASDAQ 100.

The advantages of index investing include no need to select stocks or time the market, increased diversification, and generally lower implementation costs. The disadvantages of

index investing are that getting good results requires an efficient market.

## Strategies for Bonds

Once a physician knows the strategies to use for stocks, he or she would be wise to learn the strategies for investing in bonds. These include laddering, rebalancing one's portfolio, and rebalancing versus redesigning.

**Laddering.** A ladder bond portfolio is one in which an investor staggers the maturity dates. Doing so diversifies the portfolio over time, reducing one's exposure to interest rate risk and increasing the likelihood that the investor will receive a higher than average interest rate. An investor can use a ladder portfolio for U.S. government, municipal, or corporate bonds.

**Rebalancing.** Some time after an investor has designed a portfolio and allocates assets accordingly, he or she will probably notice that the original allocations have changed. Investment gains and losses, and influxes or unexpected outlays of cash may alter the percentage holdings in each invest-

ment category. To maintain your asset class weightings, one may need to employ a rebalancing strategy.

**Rebalancing versus redesigning.** Rebalancing is not redesigning. Redesigning is a more drastic measure that involves dismantling one's old portfolio and starting fresh with a new portfolio that contains different investment categories. The investor may want to consider redesigning the portfolio when facing major life changes, such as retirement, or when investment goals or needs change.

Rebalancing simply involves restoring the original asset allocation by shifting funds among investment categories to regain the ratios one decided to use when designing the portfolio.

Many investment advisers recommend using shifts of 5% or more as a trigger for rebalancing. Others recommend rebalancing every year. Tax time or year-end are natural times to consider rebalancing.

Investors should be cautious, however, and consider the transaction costs or tax consequences that might result from rebalancing. Selling shares of a mutual fund, for example, might trigger redemption fees.

To rebalance a portfolio, one could sell investments, but this strategy should be considered only if it is advantageous to do so. One should sell only if the investment has performed poorly or well below expectations, or if the investment has performed well and exceeded expectations, and doing so is beneficial from a tax standpoint. In addition, the timing of a sale may depend on factors unique to a particular investment.

An investor may want to sell for a variety of other reasons, such as to generate cash flow, or to purchase a superior investment. But a wise investor will understand the importance of properly timing the sale of an investment and any capital gains tax consequences.

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

# Physician Demand Drives Buy-Ins

*Daniel M. Bernick, JD, MBA, is a principal with The Health Care Group and Health Care Law Associates in Plymouth Meeting, Pa. He advises physician groups on the financial and legal aspects of medical practice operations, buy-ins, buy-outs, sales, mergers, and other transactions. He has extensive experience in valuation of medical practices and he has lectured widely to such organizations as the MGMA, American College of Rheumatology, American Society of Ophthalmic Administrators, Medical Society of Delaware, and other groups. He discussed medical practice valuations with editor-in-chief Richard L. Reece, MD. This interview is the second of two-parts.*

**Q:** Recently about four urology practices in Baltimore consolidated into one large group of about 40 or 50 physicians. The reason was the need to adopt electronic health records and to address administrative complexities. Do you see mergers for this reason?

**A:** Mergers are taking place for various reasons. What you describe is certainly a valid reason in that these urologists were taking a long-range view so that they could afford some expensive resources. To share those costs, it makes sense to band together.

Other practices are merging or forming larger groups to centralize auxiliary services. As individual practices, they can't afford to acquire the necessary equipment or resources especially given the restrictions

under the Stark laws. Other physicians want increased leverage with payers, and assuming the merger passes muster for antitrust purposes, that is a desirable side effect of merging. I wouldn't say there's a huge trend toward mergers, but a healthy number of practices are merging.

**Q:** And one reason they're merging is to acquire expensive technology?

**A:** Yes. EMR systems can cost hundreds of thousands of dollars, as can imaging or other medical equipment, such as MRI, CT, nuclear cameras, or lasers. Oftentimes such expenses are beyond the financial resources of a solo or small practice.

**Q:** The traditional wisdom holds that doctors should form larger groups for the economies of scale. Is that something you see often?

**A:** It's difficult to quantify and I don't believe anyone is keeping statistics on how many groups are merging and for what reasons. But anecdotally, we see it happening. In addition, there's de-merging as well. It's not as if the sole impetus is toward forming larger groups. There are plenty of physicians who decide that greener fields lie outside of the borders of their current practice. When they do, they move on and start their own practice. This is going on at the same time that other groups are merging.

Frankly, it's hard to control physicians. It's easy for them to get jobs in other places because there is such a

high demand for them. Hospitals are willing to set them up in practice. And physicians enjoy a number of options in terms of the size of the group they want to be in and whether they want to be independent or part of a larger group.

We also see some young doctors who try out different situations. They may start with the large group, for example. But if they find the large group to be constraining and that their voice is not being heard, or that they're not earning the income they want to earn because generally the larger incomes are available only in the smaller groups, then they may leave. When a physician joins a large group, oftentimes the numbers are not quite as good. So there's movement in both directions.

**Q:** What can you predict about what lies ahead for mergers and buy-ins?

**A:** In the mid 1990s, everyone thought the physician practice management companies would consolidate all of the physicians or that all physicians would end up working for integrated health systems that would contract for global payments and then parcel the payments out among the physicians. There was a belief that care would be tightly controlled under managed care. None of these predictions came true.

In fact, there's been an explosion of new technology, growing sophis-

**“It's easy for physicians to get jobs in other places because there is such a high demand for them. Hospitals are willing to set them up in practice. And physicians enjoy a number of options in terms of the size of the group they want to be in and whether they want to be independent or part of a larger group.”**

**—Daniel M. Bernick, JD, MBA, The Health Care Group**

tication among physician services, and new services have become available. At the same time, the demand for physician services continues to grow.

What we see is that the cost of technology inhibits solo physicians from starting practices in some specialties. As a result, there's impetus for larger groups among some specialists so that these physicians can afford new and costly technology. But also, other physicians are interested in working in small practices and that option remains available. Honestly, I don't see a strong trend in either direction. In other words, there's going to be a mix of options available.

**Q:** *How significant is the physician shortage? Physician recruiters say there's a terrific demand for doctors and the shortage is growing.*

**A:** In the mid-1990s, there was a lot of focus on how many physicians there were per 100,000 population and how many doctors would be needed to meet the demand for services. The estimates ranged widely. Some large physician groups claimed to have a very low physician-to-population ratio, based on gatekeeper and primary care controls. But the trend seems to be in the other direction now. Gatekeeper controls are unpopular with patients, and everyone wants access to the latest and greatest in technology, drugs, and specialty care. Plus, of course, you have the aging of the baby boomers. Certainly the escalation of salaries in different specialties, such as dermatology, orthopedics, radiology, and cardiology, attests to the fact that the demand is extremely strong and doctors are a hot commodity.

In many specialties, there are not many graduates coming out each year and at the same time, there are many physicians in their late 50s and 60s who are getting ready to retire.

**Q:** *Is it true that physicians want to join groups that have more sophisticated equipment, because nuclear*

**“Certainly the escalation of salaries in different specialties, such as dermatology, orthopedics, radiology, and cardiology, attests to the fact that the demand is extremely strong and doctors are a hot commodity,” says Bernick.**

*cameras, MRIs, CAT scans, and even electronic health record systems help to increase efficiency?*

**A:** I don't see technology as a major factor in recruiting physicians. Electronic health records are not yet widely adopted among physicians, and many groups that can afford them are hesitating because the bugs haven't been worked out and they're just not ready to take the plunge yet. If you were to insist on technology being a high priority item, then I don't think you'd have a wide selection of practices to choose from. Or, there might not be many practices that have the technology you want and the location you want.

Location, salary, and buy-in prices continue to be the major factors. And, of course, one other issue is call coverage. If you're an orthopedist, call coverage is going to be a real important item. Lifestyle, money issues, and geography continue to be the biggest issues in recruiting. Certainly if you're between two practices that offer most of what you want, and one seems to be on the cutting edge in terms of technology then that might swing a doctor from one practice to another. But I don't see it as an overriding issue.

**Q:** *In your work, do you operate mostly in the East and do you see differences among the different regions in terms of trends affecting buy-ins and mergers?*

**A:** We have a fair concentration of clients on the eastern seaboard. We do consult nationally so we certainly have clients all over the United States, but I would say we

have a healthy concentration on the eastern seaboard. And, yes, state laws on restrictive covenants certainly influence these trends.

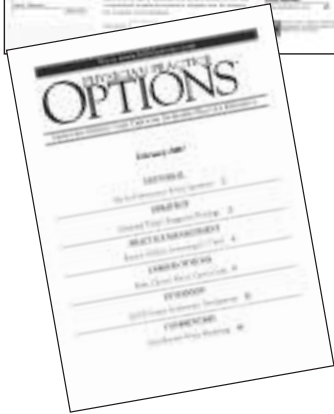
In Massachusetts and California, for instance, it's somewhat more difficult to have a substantial buy-in because the young doctor can start a practice next door. You cannot legally constrain a young doctor from doing so. But in most states, you can still get a non-compete restriction on a new doctor and most practices do in fact have such restrictions. And in these states, group practices have more leverage to demand more substantial buy-ins.

Out West, there are more megagroups where buy-ins are not so much of an issue. Those are groups of 100 to 150 physicians or more. There are not that many of these groups. So, nationally, they are not a significant factor for most doctors seeking jobs, in my experience.

We deal with physician buy-ins all across the country and many of them are driven by the economics of the particular practice. Practices that are more profitable tend to have bigger buy-ins. Generally, it works that way regardless of what state you're in. If there's more money to go around, then the ticket to become a shareholder tends to be larger. If the incomes are small or modest, then it's more difficult for senior group practice physicians to demand a big buy-in number, and as a result the values tend to be lower.

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

MD  
OPTIONS.com



**Our FREE online resource includes:**

- ▼ Strategies and tactics to build your practice
- ▼ A complete database searchable by keyword, subject, or issue
- ▼ Interaction with experts on all aspects of the Business of Medicine™
- ▼ Links to business resources, such as practice management, marketing, and CME
- ▼ E-mail updates on the latest developments in the Business of Medicine™

**E-MAIL UPDATES**

Let MDOptions.com come to you! MDOptions.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOptions.com or fill in your name and e-mail address below and fax it to us at **973-682-9077**.

**Name:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

# PHYSICIAN PRACTICE OPTIONS™



Premier Healthcare Resource  
150 Washington St.  
Morristown, NJ 07960

PRSR STD  
U.S. POSTAGE  
**PAID**  
Permit No. 30  
NEWARK, NJ