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October 2007

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What Do Doctors Want From Health Reform?

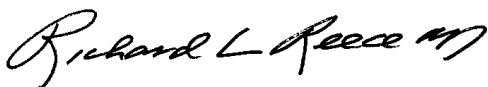
Doctors' attitudes toward health reform will help to make or break any reform proposal. Seeking to define trends among physicians, Sermo.com, a company in Cambridge, Mass., has established a Web site under a contract with the American Medical Association. Wall Street firms seeking health care trend data pay for part of the cost. Only licensed physicians can visit the site and post comments, and Sermo encourages them to join in the discussion forums. Reading the responses to a variety of posts, it's possible to get an idea about what physicians are thinking.

In general, the physicians who write for and post comments on the site distrust large integrated systems that reduce them to protocol-following functionaries. They also question the value of retail clinics and disease management systems in which they do not participate directly. It should come as no surprise that physicians remain wary and even hostile toward managed care, regarding its managers as intrusive, ill-informed, and obsessed with cost, not quality. They also seem to think that information technology is overrated.

In an editorial on Sept. 23, "The Battle over Health Care," *The New York Times* said it favors an approach espoused by some Democrats to use federal funds to expand health insurance programs and to impose more regulations on all parties. The newspaper also dismissed Republican market-driven and tax-credit strategies. It failed to mention tort reform, even though defensive medicine costs \$30 billion to \$50 billion each year and doctors are greatly concerned about medical liability issues.

Last month, the Mayo Clinic Health Policy Center announced 19 recommendations to improve health care, including moving from employer-based insurance to portable, individual-based coverage. This recommendation comes from suggestions from more than 400 providers, academics, medical industry leaders, business people, insurers, political leaders, and patient advocates in a series of forums, Mayo said. The four tenets of the proposal are: universal insurance coverage, regardless of ability to pay; more coordination of care; increased focus on quality and patient satisfaction and a decrease in medical errors, costs, and waste; and payment reform to improve health and minimize waste.

M.G. Bloche, MD, JD, a law professor at Georgetown and adjunct professor at the Johns Hopkins School of Public Health, has proposed one of the most thoughtful approaches to health reform. In an article, "Health Care for All," in the *New England Journal of Medicine* on Sept. 20, Bloche wrote, "No plausible presidential candidate is urging a European-style program of generous public insurance for all. Most plans call for all of us to take greater personal care for our bodies and buying insurance."



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

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Payers Call for More Focus on Quality

By Michael Bihari, MD

During the past few years, health care organizations have begun to define quality of care and to establish quality measurement tools to assess the processes and outcomes of care. Some of these initiatives have focused on data collection and measurement and have resulted in the identification of significant variations in how care is delivered.

These efforts are affecting physicians in every specialty including oncologists, rheumatologists, pulmonologists, and allergists. A number of these efforts are aimed at improving care for patients with chronic conditions in part because such care is costly and there is a rising number of patients needing such care. But other specialists have been affected as well. The American College of Rheumatology, in Atlanta, says the focus on quality will affect how physicians treat patients and how physicians are reimbursed for services.

Chronic Conditions

In the coming years, demand for specialists' services is expected to increase significantly, driven by the aging of the population, the age-sensitive nature of chronic conditions, and a projected relative decrease in physicians in some specialties. Such an increase in demand will heighten the need for all physicians to take a leadership position in defining quality care and developing appropriate measurements and indicators.

Current projects that health plans, the Centers for Medicare & Medicaid Services (CMS), and other organizations have developed are partially a

response to reports that show a gap between ideal care and the care that many patients receive. One report, *Ensuring the Quality of Cancer Care* published by the National Cancer Policy Board (NCPB) of the Institute of Medicine concluded, "that for many Americans with cancer, there is a wide gulf between what could be construed as the ideal and the reality of their experience with cancer care."

To address these issues, the NCPB and other leading oncology-related organizations have several recommendations including the systematic use of evidence-based guidelines for cancer prevention, diagnosis, treatment, and palliative care; the development of a core set of measures to monitor the quality of care; and, the establishment of a cancer data system to provide quality benchmarks.

Increased Scrutiny

Other specialty organizations are taking similar steps and the result of these efforts is that physicians are likely to face increased scrutiny from health plans and Medicare. Not only will physicians need to review their clinical practices and office systems, but also they will need to develop ways to become more involved in helping to define the parameters used to evaluate the care they provide.

Dawn Holcombe, executive director of the Connecticut Oncology Association, in South Windsor, says all physicians are facing a challenging future and have a steep learning curve. In the coming years, more physicians will be involved in payment for quality programs as health

plans seek increased value for what they spend on care. "Of course, all physicians provide quality care, but they must now define the value of their services both internally and externally," Holcombe explains.

Defining Value

Practices seeking to meet quality of care initiatives will need to do a self-assessment to identify their quality goals and to question and evaluate their services to define their value continually, Holcombe says. "Performance measurements are being defined by organizations, and physicians might not know where they stand," she adds. More transparency is needed and physicians must be willing to be part of the process, she explains.

To define value, physicians must recognize, catalogue, and measure services that third-party payers do not necessarily cover and therefore do not measure. "These activities not only prove value both internally and externally, but also practices can use them to identify marketing activities," Holcombe says. Among a long list of parameters to measure, Holcombe suggests the following:

- Patient mix by type of patient
- In-office use of guidelines
- Documentation of symptom management, coaching, counseling, and patient education
- Reason for and resolution of incoming and outgoing phone calls
- Avoided emergency room visits and hospitalizations
- Hospital admissions and readmissions

(Continued on page 4)

"Part of the solution is better standardization of care within a practice. When a patient comes into the office, all physicians in the practice should be using a standard set of orders."

—Lee N. Newcomer, MD, UnitedHealth Group

(Continued from page 3)

- sions counted, reason identified, and follow-up care documented
- Documentation of conversations about end of life, hospice, and palliative care
- Patient satisfaction and compliance with regimens and treatment
- Tracking compliance with oral prescriptions.

In addition, Holcombe suggests looking for variation in care within the practice, understanding why there is variance, and finding ways to reduce it.

Health Plan Initiatives

Lee N. Newcomer, MD, senior vice president, oncology, at UnitedHealth Group, the country's largest health insurer, agrees that it is important for all physicians to consider implementing quality improvement initiatives. He warns, however, that doing so requires significant effort and not all practices have the resources.

"At a minimum, oncologists should begin to standardize the care they offer in their practices especially for the treatment of breast, colon, and lung cancer," Newcomer says. He is concerned that variation within a practice may lead to increased error rates.

"Promoting quality of care is integral to UnitedHealth's mission," Newcomer says. Recently, UnitedHealth Group implemented several quality initiatives using published, evidence-based measures for breast cancer, colorectal cancer, and appropriate use of medications. UnitedHealth has documented a clear change in utilization based on several of these initiatives, he adds.

In the breast cancer study, UnitedHealth performed a chart audit to find out how many women with breast cancer who were being treated with trastuzumab had documentation of HER2 expression. According to the study, 4% of the charts had no record of HER2 expression testing and 8% had low expression recorded. Based on these find-

Improvement Strategies Gain Momentum

The quality movement has been gaining momentum over the last few years as health plans and the federal Centers for Medicare & Medicaid Services (CMS) promote pay for performance, outcomes measurement, and similar concepts, according to the American College of Rheumatology (ACR), in Atlanta. The focus on quality will affect how physicians treat patients and how they are reimbursed for services.

The ACR is defining best practices for treating rheumatic diseases, saying that health plans and purchasers should ensure that experts are involved in pursuing quality improvement. If experts are not involved in developing quality programs, the result could be, "A one-size-fits-all system based on an oversimplification of appropriate rheumatologic treatment and short-term cost-savings," the ACR says. "Perverse incentive programs that adhere blindly to specific medical practices could punish physicians for providing appropriate care to some patients—an untenable conflict that would damage patients' trust."

Seeking to improve the care that rheumatologists deliver, the ACR has formed the Quality Measures Committee and the Quality Leadership Council to coordinate the quality-related efforts across the college and communicate to members about these initiatives. Also, ACR is developing tools and processes to help rheumatologists implement quality measures in their practices and to measure their own results.

In addition, the ACR Rheumatology Fellowship Core Curriculum Outline addresses quality of care in a way that no previous curriculum outline has done, the ACR says, adding that it aims to prepare rheumatology fellows for work in an environment where evaluating and reporting on quality of medical care is an integral part of all physicians' practices.

ACR's Government Affairs Committee is working with both Congress and CMS during the development and implementation of quality performance indicators. The committee also engages with other organizations that have a vested interest in the quality movement to monitor and respond to quality-related legislation.

ACR has more information including a library of materials on quality of care for rheumatologists (at www.rheumatology.org). —MB

ings, UnitedHealth now requires oncologists to document HER2 testing before approving treatment with trastuzumab. As part of its quality initiatives, the American Society of Clinical Oncology includes a set of measures related to trastuzumab administration for Her2Neu positive patients with breast cancer.

Last year, the FDA issued an advisory outlining new safety information about erythropoiesis-stimulating agents (ESA), including a new black box warning advising physicians to

monitor hemoglobin levels and adjust doses of ESA to maintain the lowest hemoglobin level needed to avoid blood transfusions, not to exceed 12 g/dL. After studying patient records, UnitedHealth found that approximately 30% of its members using ESA exceeded the recommended hemoglobin level and the plan now requires appropriate documentation before approving payment for ESA, Newcomer says.

In an article, "Lymph Node Evaluation and Survival after

Organizations Evaluate Approaches to Quality

Several organizations are evaluating approaches to measuring quality. Mostly, these groups have focused on adherence to generally accepted practice guidelines.

National Quality Forum. With funding from the National Cancer Institute and other federal agencies, the National Quality Forum, a non-profit organization in Washington, D.C., is in the second phase of a quality initiative: Standardizing Quality Measures for Cancer Care. The scope of this project includes endorsing evidence-based standards for quality improvement in three areas: breast cancer treatment and diagnosis, colorectal cancer treatment and diagnosis, and symptom management and end-of-life care.

AQA. Formally known as the Ambulatory Care Quality Alliance, AQA was created in 2004 as a collaborative effort of the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the federal Agency for Healthcare Research and Quality, to determine ways to improve physician performance measurement, data collection, and reporting.

Medicare. The federal Centers for Medicare & Medicaid Services initiated a voluntary demonstration project in 2006 to determine how and whether oncology practices follow well established evidence-based practice guidelines. Office-based oncologists and hematologists received an additional payment of \$23 in conjunction with certain office visits for patients with one of 13 specified cancer diagnoses.

Cancer Quality Alliance. Founded in 2005 by the National Coalition of Cancer Survivorship (NCCS) and the American Society of Clinical Oncology, the alliance includes representatives from cancer care providers, patient advocacy groups, accreditation organizations, public and private payers, federal agencies, foundations, and other national organizations. The alliance is developing a blueprint to define optimal cancer care (including prevention, detection, diagnosis, treatment, post treatment, recurrence, and end-of-life care); establish mechanisms to collect, review, and catalog cancer quality measures; and, foster the dissemination and use of cancer-related quality measures and tools.

—MB

Curative Resection of Colon Cancer: Systematic Review" in the *Journal of the National Cancer Institute*, George Chang of the Department of Surgical Oncology at The University of Texas M. D. Anderson Cancer Center, in Houston, and colleagues (JNCI 2007 99(6):433-441), wrote, "Adequate lymph node evaluation for cancer involvement is important for prognosis and treatment of patients with

colon cancer. The number of lymph nodes evaluated may be a measure of quality in colon cancer care and appears to be inadequate in most patients treated for colon cancer."

Relevant to this finding, and based on the recommendations of several cancer experts, Newcomer says UnitedHealth asked more than 1,500 surgeons in four urban areas to document five cases in which at least 12 lymph nodes were included in the

surgical specimen. Those surgeons who demonstrate adherence to this standard will be designated as providers of high-quality care within the UnitedHealth network, he adds.

Newcomer believes better standardization of care is needed within each practice. A review of UnitedHealth's claims data for pancreatic cancer found high rates of variation, Newcomer says. "Although there are only two drugs commonly used to treat the condition, our data revealed 188 different regimens," he explains. "So many variations increase error rates. When a patient comes into the oncology office, all physicians in the practice should be using a standard set of orders."

Early QOPI Results

Interestingly, an analysis of a first round of quality data identified variability not only between practices but between physicians in the same practice. In an article, "Physicians Guided by First-Round Data from QOPI," Richard Levine, MD, an oncologist with Space Coast Medical Associates in Titusville, Fla., reported that he found that the six physicians in his practice didn't ask about pain as often as might be clinically beneficial. As a result, the group instituted measures to remind physicians to ask all patients about pain at each visit, Levine reported.

Published in the *Journal of Oncology Practice* last year, the article also reported on an analysis of end-of-life care. The article reported that the documentation of level of pain at either of the last two visits for terminally ill patients ranged from never to always. These early findings demonstrate that by providing feedback, quality of care in physician practices can be measured and actions can be taken to improve care.

—Michael Bihari, MD, is a health care writer and editor in Falmouth, Mass. More information on physician practice strategies is available on our Web site (see page 16).

Groups Develop New Models of Care

Compensating for the loss of revenue resulting from declining reimbursement, many physician practices are offering new services to patients. Practices are opening pharmacies to serve their patients and patients' families, developing partnerships with other physicians, and providing psychological counseling. Among the physician specialists who have perhaps been hit hardest by declining reimbursement are oncologists and so the strategies they are developing may be most useful to other physicians seeking new strategies in a challenging environment.

"Revenue must come from somewhere," says Teri Guidi, president of the Oncology Management Consulting Group in Pipersville, Pa. "Whether it's joint ventures with radiologists, acquiring their own imaging equipment, or new service lines, virtually everyone has to look at new revenue streams."

Diversification Strategy

Some large oncology practices, such as Tennessee Oncology in Nashville, have been adding services for many years. Founded in 1976, the practice employs 41 medical oncologists and 450 employees in 30 locations in Tennessee. "We began diversification earlier than many other practices, and that has helped us cope with decreasing chemotherapy margins," says Charles McKay, MD, the founder and CEO of Tennessee Oncology.

Tennessee Oncology's diversification strategy began in 2000 when it acquired a PET CT scanner. It now owns two scanners and is considering adding a third, says McKay. It also owns a radiation facility, a laboratory, has recently opened a bone marrow transplant department, and is buying a computerized tomogra-

"Revenue must come from somewhere. Whether it's joint ventures with radiologists, acquiring their own imaging equipment, or new service lines, virtually everyone has to look at new revenue streams," says Teri Guidi, president of the Oncology Management Consulting Group in Pipersville, Pa.

phy facility. Recently, the practice sold a research facility as an independent business.

Chronic Care

Recognizing the value of managing patients with chronic conditions, the practice also plans to develop a disease management company specializing in cancer treatment. Toward that goal, it is investing in its information system and standardizing its therapy procedures.

Adding such services may not be feasible for all practices in part because the cost of buying radiation and scanning equipment can total hundreds of thousands of dollars, and leasing such equipment can cost tens of thousands of dollars a year. But also practices considering such services frequently run into certificate of need issues, advises Martin Shenk, owner of Vista Group Consulting, oncology practice consultants in Danville, Calif. Many states have regulations requiring clinics, hospitals, and other health care organizations to demonstrate that sufficient need for a specific service (such as scans and radiation treatment for cancer) exists in a community before a new facility can open.

Hospitals that already offer radiation therapy and diagnostic scanning are likely to resist allowing

medical oncologists to offer what the hospitals say are duplicate services, says Dawn Holcombe, executive director of the Connecticut Oncology Association in South Windsor. "For many physicians, considering anything along this line, at any size, can result in significant resistance and state regulatory problems," she says.

Regulatory Resistance

In addition, such arrangements and in-office treatments can violate the Stark law. "For oncologists, a primary issue under the Stark law is the question of whether they can furnish the designated health services, such as laboratory and radiology services, to their patients in their own offices," says Terry Coleman, a partner with Ropes & Gray, a law firm in Washington, D.C. "Over the years, CMS has issued a series of regulations establishing a complex set of interpretations of the law. It can be confusing and usually requires legal advice."

Realizing the complicated nature of expanding into radiation services, several oncology practices have sought additional income from so-called closed-door pharmacies. These pharmacies provide medication only to patients and patients' family members. "More practices are

turning to this strategy, but then they realize that such pharmacies can run into their own set of problems," says Shenk.

Oncology practices considering a closed-door pharmacy may face regulatory hurdles. "Pharmacy associations fight them because they take business away from open-door phar-

macies, and some hospitals fight them because they take business away from their pharmacies," Holcombe says. "That resistance can lead to stiff regulatory controls. And in several states, they are simply illegal."

Even when closed-door pharmacies are permitted, the costs associat-

ed with them may be high. Such costs include regulatory compliance, medication stock, dispensing fees, and at least one salary (for a pharmacist). "Many oncologists are discovering that such operations are simply not worth the problems and cost," says Shenk.

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Agencies Focus on Quality Care

While many patients may value the addition of counseling services and classes in yoga and nutrition, simply adding such services does not address the deeper financial problems practices face, cautions Dawn Holcombe. Executive director of the Connecticut Oncology Association in South Windsor, Holcombe also is a member of the board of directors of the Community Oncology Alliance, a lobbying and research organization in Washington, D.C.

"Most service-oriented solutions face a number of reimbursement and regulatory problems," Holcombe explains. "Adding counseling and other services is an important but limited step. These are Band-Aid solutions. As a profession we need to fix what's wrong beneath the Band-Aid. The only solutions that will work over time are changing the way oncologists are paid for their services."

Oncology consultant Martin Shenk of Vista Group Consulting in Danville, Calif., agrees. "Few supportive services offer any real income advantages," he comments. "The way things are now for payment of these services is probably not going to change very soon."

Change will come slowly, but several organizations are addressing how oncologists are paid. One is the federal Centers for Medicare & Medicaid Services, which started a demonstration project in which practices can get an additional payment for meeting certain goals related to care quality. Last year, CMS revised the project to gather more specific information on the quality of cancer care, including treatment, the spectrum of care patients receive, and whether care represents best practices.

CMS also is running the Medicare Physician Group Practice (PGP) Demonstration Project, which significantly improved the clinical management of patients with diabetes over the first year of the project. In this project, which began April 1, 2005, CMS rewards providers for managing costs and improving outcomes of fee-for-service Medicare patients with chronic conditions. There are 10 large medical groups participating. If it goes well,

CMS may increase the program to other practices.

Performance during the first project year was based on 10 measures developed from evidence-based guidelines for patients with diabetes, including HbA1c management; HbA1c control; blood pressure management; lipid measurement; LDL cholesterol level; urine protein testing; eye examination; foot examination; influenza vaccination; and pneumonia vaccination. Evidence-based measures addressing congestive heart failure and coronary artery disease were added in year two, and measures addressing hypertension and cancer screening were added in year three.

Physician groups participating in the project continue to be paid under the regular Medicare fee schedules, but also have the opportunity to share in savings generated as a result of making improvements in care management. Groups can earn as much as 80% of the savings they generate. Payment depends on both cost efficiency and performance on 32 quality measures.

Another organization, the National Quality Forum (NQF), is developing voluntary quality standards for CMS and private insurers. A private, nonprofit standards-setting organization in Washington, D.C., the NQF is preparing standards on the diagnosis and treatment of breast cancer and colorectal cancer, and on palliative care. NQF has convened panels in each area to review and recommend quality measures. Compliance with the measures could form the basis of new revenue streams, experts say.

The NQF panel addressing care for patients with breast cancer has approved five measures for quality improvement, including:

1. Axillary lymph node dissection and sentinel node biopsy in early stage breast cancer
2. Needle biopsy prior to surgery
3. Post-lumpectomy radiotherapy
4. Combination chemotherapy in estrogen receptor-negative patients
5. Percentage of breast cancer-conserving surgery.

—MS

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Adding Other Services

Another way to build patient volume is to add new service lines, such as individual and group counseling, massage therapy, nutrition workshops, and exercise programs. A practice associated with the North Shore University Hospital's Comprehensive Cancer Care Center in Manhasset, N.Y., improved practice revenue by adding such services. The center offers programs in yoga, Tai Chi, meditation, visualization and guided imagery, nutrition, exercise, and bone health.

One of the center's most popular services is a fee-for-service psychotherapy program provided by clinical social workers, says Rosemarie Ampela, the center's director of support services. The service includes individual counseling (such as interventions to help patients manage the fears and anxieties related to a difficult diagnosis) and family and crisis counseling. Some health insurers reimburse patients for such services, says Ampela. For those patients who do not have health insurance coverage for such services, the center sets a fee for each individual patient.

For other services, such as yoga classes, patients pay out of pocket. When patients cannot afford these services, the center provides the service for free, Ampela says. "The most important idea is to improve quality, not just improve revenue," she adds.

Coverage for Counseling

For several years, the American Society of Clinical Oncology, in Alexandria, Va., has been encouraging CMS and private insurers to cover counseling and illness prevention efforts. Illness prevention efforts to stop the spread of existing cancer is a critical component of quality care, says Robin Zon, MD, chair of the Reimbursement for Cancer Prevention Services Subcommittee of ASCO's Cancer Prevention Committee.

ASCs Offer Several Advantages

One strategy that appears to have been successful over the past three decades involves ambulatory surgery centers (ASCs). These health care facilities offer patients the opportunity to have selected surgical and procedural services performed outside the hospital setting, says the American Association of Ambulatory Surgery Centers in Johnson City, Tenn. "Since their inception more than three decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs. At a time when most developments in health care services and technology typically come with a higher price tag, ASCs stand out as an exception to the rule," AAASC says in a publication, *Ambulatory Surgery Centers, a Positive Trend in Health Care*.

The federal Centers for Medicare & Medicaid Services has recently revised the rules for ASCs that may make them attractive for physicians in a variety of specialties. In addition, a recent analysis examined the effect of the aging population on the demand for surgical procedures and corresponding need for surgical subspecialists, AAASC says. The study concluded that the aging population would be a significant factor in fostering growth in the demand for surgical services. The forecasted growth in work by the year 2020 varied from 14% to 47%, depending on specialty.

Meeting this increased demand may require a number of solutions, including increasing the number of surgical residency positions, increasing the workloads of surgeons in the workforce, and improving the efficiency of surgeons, AAASC adds. Using settings that allow physicians to practice efficiently will help mitigate the effect of the aging population on the anticipated shortage in the surgery workforce and these settings include ASCs, the association comments.

ASCs offer physicians the ability to work more efficiently and are, therefore, uniquely positioned to play an important role in managing the increased need for surgical services as it arises in the years ahead. Physicians may find ASCs allow them to have more efficient scheduling than would be available when working in a hospital setting, AAASC says. Hospitals often have limited availability of operating rooms and limits on spending that make getting new equipment a challenge.

"The primary ways that oncologists deliver prevention are through counseling and educating the patient, and potentially other family members," says Zon, a medical oncologist at Michiana Hematology and Oncology in South Bend, Ind. "We make recommendations for screening or other testing, and then follow up on those recommendations."

In the past, oncologists were not concerned about the lack of reimbursement if they provided prevention counseling because other

sources of revenue covered them for these uncompensated costs, Zon explained. "Rather than deal with the headaches of diagnostic coding and billing and supporting documentation, they simply didn't worry about it," Zon says. "Now, however, with the changing reimbursement climate, all legitimate revenue is relevant."

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

Simple Changes Boost Productivity

By Richard L. Reece, MD

Simple changes in physician practices may pay off big in practice productivity, quality, and satisfaction. Many physician leaders regard large integrated multispecialty clinics as the most rational solution for solving small-practice woes; in other words, work together in large systems or die. Fitzhugh Mullan, MD, author of *Big Doctoring in America: Profiles of Primary Care* and a family doctor on the board of editors of *Health Affairs*, describes these physician leaders as “system doctors,” because they are medical directors of large health systems.

In his book *The Innovator’s Dilemma*, Clayton M. Christensen, a professor at the Harvard Business School, says that “disruptive solutions” can undermine even the best managed organizations, even large medical groups. A disruptive solution is a new technological invention, product, or service that eventually overturns the existing dominant technology or product in the market.

Disruptive Innovations

Simple, convenient, and powerful innovations aimed at the low end of the market disrupt large organizations. In health care, the market’s low end is primary care physician practices, and the high end is large multispecialty organizations. Like all large organizations, they may be mismanaged, develop bloated overheads, become overly bureaucratic, and may not appeal to physicians who seek more autonomy. In short, large organizations are complicated bureaucra-

This article was adapted from a book, Innovation-Driven Health Care: 34 Key Concepts for Transformation (Jones and Bartlett, Sudbury, Mass., 2007), by Richard L. Reece, MD, editor-in-chief, of Practice Options. Reprinted with permission.

The Instant Medical History is software that helps a patient document his or her own history electronically.

cies, and many, if not most, physicians do not feel comfortable in complicated working environments.

A good example of a disruptive innovation (also called disruptive technology) is EClinical Works, LLC, a software company in Westborough, Mass., that develops electronic health record (EHR) programs. In head-to-head competition with three larger EHR companies—GE Health, AllScripts, and NextGen—for small group practices in three Massachusetts communities, 170 of 180 physician practices picked EClinical Works as their vendor of choice.

The reason was quite clear. The three larger companies developed their products for larger groups. They perceived these to be more profitable while EClinical Works targeted the low end of the market, small-group practices. The EClinical Works system was cheaper and easier for physicians in small practices to learn, implement, and maintain than other systems. This ease was partly because its users were constantly ironing out its bugs in a Web site (www.ecwuser.com) where users could suggest how to continually improve the EHR.

Adding Functionality

The following are three disruptive add-on technologies that smaller practices can implement. An “add-on technology” is a piece of software that can be added to an existing electronic record. These technologies can also be used independently from an EHR.

In a 2006 article in *Minnesota Medicine*, Rich Kirkpatrick, MD, a

general internist in a nine-person primary care group in Longview, Wash., suggested three ways for primary care physicians to improve their economic lot:

1. “Skim the cream” of the patient pool by eliminating Medicare and welfare patients and collecting \$40 to \$50 per visit. Kirkpatrick regards this strategy as unethical.
2. Go to work for a health care company and shift your allegiance from patients to business interests. Kirkpatrick finds this distasteful; in effect, selling out to the enemy.
3. Get into the ancillaries, such as X-rays, lab work, ultrasounds, and MRI and CT ownership. Kirkpatrick says this strategy is an acceptable alternative, though critics may condemn it as self-referral.

A fourth option might be called the “KISS Trifecta.” The KISS (keep it simple, stupid) method is a term that recognizes that users want things that are simple and easy to use and the use of simple services or products shortens time and reduces costs for consumers.

In horse racing, the trifecta is a system of betting. Bettors who pick the first three winners in the correct sequence win. It is possible the following KISS Trifecta will work for practitioners with too little time to see patients at too high a cost.

Seeking Simplicity

The first leg of the trifecta involves using software to improve efficiency. One program that aims to do so is The Instant Medical History, a program developed over the last 15

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years and available for demonstration purposes on the Web (at www.medicalhistory.com).

The software saves time and answers several fundamental questions. What eats up time when a physician sees a patient? The answer is taking and documenting the history with a review of the patient's systems. Moreover, third parties won't pay unless the physician extensively documents what took place. Why not let patients document why they are seeing the physician by entering their own histories and system reviews using simple software either from their home or in the reception room? Why not permit patients to tell their own story on their time, not yours? Why not place a laptop computer in your reception room to allow consumers to enter their own data by answering questions from a computer program that takes the history and records the review of systems?

All of this work can be done using a simple "yes" or "no" algorithm based on the patient's chief complaint, gender, and age. For the last decade, family physician Allen Wenner, MD, of Columbia, S.C., and John Bachman, MD, head of primary care at the Mayo Clinic in Rochester, Minn., have done so in a way that is satisfying for the physicians and patients. Once a physician knows the patient history he or she can enter findings with a few computer strokes based on the patient's complaint and story. Using this approach allows patients to leave the office with an electronic medical record with history, findings, and treatment plan in hand.

History Lessons

What is the cost of patient-generated histories for the physician? Probably around \$50 a month for software. The

gain? Four to eight minutes saved per patient and a documented electronic record. In addition, patient creation of this history and computer entry of your findings make most dictation unnecessary, and it serves for claims initiation and enhanced coding—even a referral letter. Furthermore, the patient immediately has a clear record of what has transpired, thereby eliminating confusion that may lead to a malpractice suit. Finally, because of the impressive documentation made possible through patient input, you can often move the code up one level, from a 99214 to a 99215, a gain of \$37.

The second leg of the trifecta involves having the physician do coding electronically. Most physicians are paid primarily for using one of five ICD-9 codes: 99211 through 99215. For example, Medicare would pay a physician using these payment codes in the Longview, Wash., area, \$21.20, \$38, \$51.90, \$81.41, and \$118.49, respectively. Medicare payments vary by Zip code and are changed frequently. Kirkpatrick and his colleagues are paid an average of \$53 per patient from Medicare. To cover overhead, Kirkpatrick says each physician must see 27 patients a day, something most cannot do comfortably.

Doctors can audit their current fees and make sure they do not exceed Medicare rates. Third party payers usually allow 125% to 150% of Medicare rates in most regions. Most practices haven't changed fees for years and may be below what Medicare currently pays.

For services they do not usually provide, such as consultations, physicians can use an electronic translator on the Web (at www.dpnx.com). Different specialists use different language for the same procedure or service and so some physicians unfamiliar with cer-

tain terminology may find it difficult to locate the precise code. The particular doctor's language, in other words, must be translated to find the right code. The translator function is enormously helpful because many physicians have a hard time locating the precise code for seldom coded visits or procedures.

Office Procedures

The third leg of the trifecta involves performing simple procedures in the office. In 1989, John Pfenninger, MD, a family physician, founded the National Procedures Institute in Midland, Mich. (at www.npinstitute.com). Since then, Pfenninger and his staff have taught procedure skills to thousands of physicians in Michigan and in regional conferences across the United States for continuing medical education (CME) credits. Pfenninger's reasoning for doing procedures is straightforward. Properly trained primary care physicians are capable of performing simple procedures such as skin biopsies, skin repairs, incision and drainage, joint injections, colposcopic biopsies, and colonoscopies, in their offices safely, effectively, conveniently, and for lower costs than can be done in specialists' offices.

Towards these ends, he and his staff have organized courses for CME credits, developed a reimbursement manual for office procedures, and written a 2,080-page textbook, *Procedures for Primary Care*. The manual contains several reimbursement examples for procedures primary care physicians (PCPs) did routinely in the recent past. With the proper preparation and training, PCPs can do them again.

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

At the National Procedures Institute, physicians learn to perform skin biopsies, skin repairs, incision and drainage, joint injections, colposcopic biopsies, and colonoscopies.

Three Estate Planning Mistakes to Avoid

By David B. Mandell, JD, MBA, and Jason O'Dell

Like many successful professionals, physicians are often so busy dealing with their practices and attending to their personal lives that they often fail to take the time to address the important challenge of creating a tax-wise estate plan.

Not having an estate plan means it is likely that physicians are unaware of three of the most common estate-planning mistakes and how to avoid them. Fortunately, there are simple tools that physicians can use to elude the unnecessary costs that result from poor planning.

The three common mistakes are:

1. Losing half of life insurance proceeds to taxes
2. Leaving property to the IRS
3. Losing 70% or more of pensions, 401(k) plan proceeds, and individual retirement accounts (IRAs) to taxes unnecessarily.

Losing half of life insurance proceeds to taxes. Life insurance is highly recommended as a tool to pay the estate taxes due when a physician dies because the funds will be available immediately to your survivors, with-

One misconception about life insurance is that the proceeds are estate tax exempt. Such thinking is incorrect. The proceeds are income tax exempt but are subject to both federal and state estate taxes.

out any delays or expenses. Further, clients who establish policies before they retire will enjoy some leverage as a result of buying coverage with today's dollars. Nonetheless, many physicians fail to use a simple trust that, if established correctly, enables all of the insurance proceeds to be exempt from estate taxes.

The greatest misconception most clients have when it comes to life insurance is that the proceeds are estate tax exempt. The proceeds are income tax exempt but are subject to both federal and state estate taxes. In 2006, federal estate taxes are levied on estate assets beyond \$2 million. Amounts under \$2 million are exempt from taxes. The federal rate on those amounts above \$2 million is 46%, and many states have state estate tax rates of 16%. In other words, a physician who paid premiums diligently while holding the policy could lose much of the policy's proceeds.

The preventive medicine for this scenario is to use an irrevocable life insurance trust. An ILIT is simply an irrevocable trust that owns a life insurance policy. The ILIT will cost about \$2,000 to \$4,000 and will save estate taxes because it, rather than the holder personally, owns the life insurance policy. Because the policy is not owned in one's name, the policy proceeds will not be part of one's net estate upon death as long as the holder lives for three years from the date of the transfer to the trust. Thus,

the proceeds will not be subject to the estate tax, saving the physician's family a great deal of money.

Gaining Control

The ILIT gives the holder much more control over what happens to the policy proceeds than one would get from a bare insurance policy. With an insurance policy alone, one's only decision is to whom to leave the proceeds. The insurance company simply pays these beneficiaries when the policyholder dies.

With an ILIT, on the other hand, the physician controls who gets the proceeds and exactly what happens to the funds upon death. The owner of the trust can have the trustee pay the beneficiaries directly or pay them over a period of months or years. Also, the owner of the trust can incorporate spendthrift provisions and anti-alienation provisions to protect against a child's or a spouse's financial problems. In fact, an ILIT gives the trust owner all of the benefits of a trust arrangement while providing for one's family just as if using a bare insurance policy.

One of the significant drawbacks of an ILIT involves policies with cash value. Once the policy is transferred to the trust, the policyholder would no longer have access to the cash value.

If a physician already has a life insurance policy or is making payments on a policy, it is not too late to transfer a policy to an ILIT. There may

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be some gift-tax issues associated with this maneuver, but they are likely to be minor compared with the potential tax savings one's family would enjoy.

Leaving property to the IRS. While no physician leaves property to the IRS intentionally, quite often a physician's estate will do so if the physician has not implemented a gifting program. After the exemption amount, the government will likely take any property not given away "in title" during one's lifetime. To prevent this taking, clients can give property as gifts to family members. The cost of this strategy is about \$3,000 or more.

Initially, most physicians hesitate to begin a gifting program because they believe they will need to relinquish control of the underlying assets. But this result is not necessarily true. Instead, one can use legal entities to remove asset values from one's estate, while maintaining 100% control of the assets while one is alive.

The preventive medicine to use to protect one's assets involves using a family limited partnership (FLP) and a family limited liability company (FLLC). These entities allow the physician to share ownership with family members yet maintain control. In this strategy, the physician and his or her spouse would give ownership interests to children as gifts over time using the combined annual \$22,000 per donee gift tax exclusions, thereby removing those interests from the estate for tax purposes. Still, as long as the physician and spouse are the FLP general partners or LLC managers, he

and she will maintain control of the underlying assets.

Protecting Real Estate

Here's a hypothetical case study involving a 63-year-old retired physician whom we'll call Robert Jones, MD. Jones owned almost \$3.1 million in assets and established an FLP to own the real estate, naming himself as the sole general partner. He initially owned 95% of the partnership interests, giving 1% as gifts to each of five grandchildren. Since each 1% was worth approximately \$11,000 (which is below the \$12,000 annual per person limit), the gifts to the grandchildren were tax-exempt. Under a common practice known as discounting, one may give \$15,000 per year as a gift to each child or grandchild (or \$30,000 per year if a physician and spouse give such gifts) without having to pay gift taxes.

Jones can continue to give each grandchild \$11,000 as a gift in FLP interests each year, completely tax-exempt. If Jones lives to age 75, he will give \$660,000 in FLP interests to his grandchildren (or \$1.32 million if he and his wife each contributes) and this amount would be tax-exempt. The \$660,000 would no longer be in his estate and therefore not subject to estate tax.

Jones' other assets put him in a combined state and federal 50% estate tax bracket, meaning his tax savings using the FLP would be \$330,000 (50% of \$660,000). As the FLP's sole general partner, Jones has complete

control of the real estate while alive and can distribute the income to himself or sell some of the properties.

Losing 70% or more of pensions, 401(k) plans, and IRAs to taxes unnecessarily. Most professionals are surprised to learn that most of the assets in pensions, 401(k) plans, and IRAs could end up with state and federal tax agencies. After paying taxes for a lifetime of work, a physician's "tax qualified" plans could still be taxed at rates above 70%. While the details of the techniques needed to minimize the tax implications of pensions and retirement plans are beyond the scope of this article, there are strategies physicians can use to reduce the taxes that could otherwise decimate a qualified plan. These strategies require advance planning, of course, and so we suggest that physicians interested in these plans should meet with their tax professionals and financial advisers for advice on how to minimize the tax implications of these plans. The cost for meeting with a financial adviser should be minimal.

While it is important for each physician to get educated on these potential errors in estate planning, but just as in medicine, there is no substitute for consults with a licensed professional experienced in these matters. In this way, an estate planning "examination" may be the first step a physician should take when seeking to develop any worthwhile estate plan.

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

Tools to Help Avoid Estate Planning Mistakes

Mistake	Tool	Desired Benefit	Cost
Allowing life insurance to be estate taxed	ILIT	Proceeds are estate-tax exempt	\$2,000–\$4,000
Leaving too much value in taxable estate	FLP, FLLC	Remove value from estate while keeping control	\$3,000 and up
Leaving too much value in qualified retirement plans	Advanced planning	Eliminate 80% of the taxes on such plans	No out-of-pocket costs

Recruiter Says Practices Are Changing as Medicine Becomes More Specialized

Phillip Miller is vice president of corporate communications with the recruiting firm of Merritt, Hawkins, & Associates in Irving, Texas, and the co-author of Guide to Physician Recruiting—First Edition (Practice Support Resources, Inc., 2007). He also is the co-author of an earlier book, Will the Last Physician in America Please Turn Off Lights: A Look at America's Looming Doctor Shortage. Miller has more than 19 years of experience in the physician recruitment business. He spoke with Editor-in-Chief Richard L. Reece, MD, about the changing nature of physician practices.

Q: Why did you write a book about physician recruiting?

A: We had two primary reasons. First, we are marking 20 years in the physician recruiting industry this year and have conducted more than 25,000 physician search assignments. We wanted to put in one volume what we have learned about physician recruiting over the course of two decades. Second, we wanted to illustrate how recruiting has evolved into a distinct profession. Initially it was something of an offshoot of executive recruiting, or people without experience or training in physician recruiting did it. We wanted to illustrate how physician recruiting has become a strategic endeavor requiring knowledge and professionalism.

We wrote a previous book about the physician shortage so we tried not to belabor that point too much in this book but instead focus on how to recruit doctors. In our first book, *Will the Last Physician in America Please Turn Off Lights: A Look at America's Looming Doctor Shortage*, we wanted to alert health professionals and policy makers to the physician shortage as we see it from the recruiters' view. In this second book, we provide advice about how hospitals and medical groups can address the challenge.

Q: In your latest book you describe the changing physician market and recruiting business. What are some of the most significant changes you've seen?

A: Like most technical fields, medicine is becoming more specialized. The idea that we should revert the whole system back to general primary care is misguided. It's not realistic because of the rapid evolution of technology, medical treatments, and sub-specialization. In addition to increased specialization, we're facing a continued shortage of doctors in most specialties. Between the complexity of medicine and the growing shortage of doctors, it's become more difficult, time consuming, and resource intensive to recruit physicians.

There are a number of issues affecting the demand for medical services and they are changing the way physi-

cians work. One of the most significant issues is population growth. We have robust population growth in the United States and we have about 70 million Baby Boomers who will soon start turning 65. Older patients use physician services at a dramatically higher rate than younger patients do.

Being a physician is much more challenging than it was in years past in part because of technology, which means there's much more to do for many patients. The old idea of having a patient take two aspirin and call back in the morning is outdated. Now, physicians can use all kinds of tests. Diagnostic imaging, for example, has become much more varied and available. Physicians also have to consider many new medications and have the ability to do many non-invasive procedures as well.

In addition, all patients want the latest and greatest care. And many patients today have a focus on lifestyle, quality of life, and yearn for perpetual youth. These factors generate demand for more surgery, such as knee or hip replacement, or skin procedures.

Q: Are younger physicians also having an influence on medicine by asking for more vacation time and a more balanced lifestyle?

A: Yes, that's another major factor changing how medicine is practiced. The old paradigm of the

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“Being a physician is much more challenging than it was in years past in part because of technology, which means there's much more to do for many patients. The old idea of having a patient take two aspirin and call back in the morning is outdated,” says Phillip Miller of Merritt, Hawkins, & Associates.

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doctor practicing 80 hours a week for 30 to 40 years is gone. The main priority among young doctors is not so much money as quality of life. They want to have set hours just as other professionals have, and they want to attend their children's games and recitals and other activities.

These factors often have more leverage as bargaining chips than money has, though the financial incentives offered to physicians need to be competitive. All things being equal, young doctors tend to gravitate toward employment opportunities and regular hours, as do a growing number of older doctors as well. They want to go to work, work very hard, and then be home at 6 pm and not be on call.

As these trends grow we have seen more physicians work in hospitals as employees. Many doctors today are now hospital-based, while other physicians receive salaries from hospitals to practice outside the hospital in community settings. The hospital is running the practice and paying for malpractice so the doctor doesn't have to worry about reimbursement and the other aspects related to running a business.

Doctors are weary of trying to meet overhead costs and being preoccupied with business matters. Many would prefer to be salaried and leave those problems behind. Physicians aren't trained to run businesses. That's generally not what attracted them to medicine in the first place. So, being an employee simplifies matters considerably. You give up some autonomy but what you gain is more time to focus on medicine. You get to do what you're trained to do. All of these fac-

tors are changing how medicine is practiced and how we recruit.

Q: *In your book, you list 190 recognized medical specialties. Does such a large number symbolize the complexity and specialization of modern medicine?*

A: Yes it does. If you're recruiting a subspecialist in pediatric rheumatology or clinical neurophysiology, you have to know something about what those doctors do. You need to be a well trained, sophisticated salesperson because recruiting is basically sales. And you must be more than a layperson off the street who's suddenly labeled as a physician recruiter.

In general, people don't understand the multiple dimensions of physician recruiting. It is a very challenging process to contact a physician who usually is a complete stranger and convince that doctor to leave his practice, sell his home, take his children out of school, and relocate. Incentives play a role in this process, but in general physicians are not like executives who typically move for a more prestigious title or more money. They want practice settings where they are free to be physicians, where they can be fairly compensated for their skills and hard work. It takes a coordinated effort by a group or hospital including involvement and commitment at the CEO or group administrator level to be successful.

In addition, physician recruiting challenges are not limited to rural areas anymore. We represent clients in some of the most attractive resort areas in the country, as well as major metropolitan areas, many of which

were thought to be "over-doctored" in the past. It's a highly competitive market, and you need to offer a certain minimum salary if you are going to be taken seriously. So we counsel clients that if they're looking for a highly qualified physician, perhaps the average of what is offered may attract only an average candidate. But if you offer a more competitive salary, your chances of getting a better candidate are likely to increase.

Q: *On the issue of physician retention, why are turnover rates high?*

A: One of the basic tenets of physician recruiting is that physicians are not pulled from their practices by flashy recruiting incentives. Rather, they are pushed by conditions in their current practice that they find unacceptable. We refer to this concept as the "primacy of the workplace." For physicians, the workplace is of paramount importance and if there are unsatisfactory aspects of the workplace, physicians will go elsewhere.

Problems may include inadequate reimbursement, not enough time off, high malpractice rates, a low ratio of nurses to patients, inefficient hospitals that can't turn around studies or lab tests or admit patients or discharge them in a timely manner, or administrators who are confrontational or simply non-responsive. Whatever the reason, when physicians reach a breaking point, they will leave undesirable environments. Physicians today have many options and, because many are employees, they may be less attached to the practices than they were in the past when most doctors were essentially small business owners.

"We often say that the primary care giver of tomorrow will be a woman. This trend is already happening in pediatrics and ob-gyn. It's a positive development for medicine, but it exacerbates the doctor shortage. Women at certain stages in their lives work considerably fewer hours per week than male physicians work," Miller says.

Q: You mention that the market for locum tenens is exploding. Why is that?

A: In the past, locum tenens doctors were primarily used when permanent doctors were absent from a group or a hospital due to continuing medical education or for vacation or illness. Now it's the doctor shortage driving the use of locums. Hospitals and groups are using locums to hold a place until they can find a permanent physician. It's similar to hospitals using traveling nurses to keep beds open until they can find permanent nurses to join the staff.

There's been tremendous growth in the locum tenens industry so that it's a much larger part of the recruiting business than permanent physician recruiting. We have an affiliated company called Staff Care that provides locum tenens staffing services. In terms of personnel and revenue, Staff Care is a larger company than Merritt, Hawkins, & Associates.

Q: Why is there so much of a focus on specialty hospitals that physicians develop?

A: Specialty hospitals attempt to appeal to physicians by focusing on the primacy of the workplace. What doctors hope to gain from specialty hospitals is efficiency, clinical control, and return on investment. These are key pieces to the puzzle when it comes to appealing to physicians. If traditional acute care hospitals can maintain an appealing environment from the doctor's point of view, they can stave off competition from physician-owned facilities while increasing physician retention rates. Adding hospitalist programs, paying physicians to be on call for the emergency department, increasing general efficiency, employing doctors,

joint venturing with them, and focusing on communication are ways in which acute care hospitals can vie for physician loyalty and cooperation.

Q: You point out that physicians are much like everyone else in that so many of them want to live in a city of 100,000 or more, and shun cities of 25,000 or fewer.

A: Rural recruiting has always been a challenge because many of the amenities that physicians and other professionals seek may not be available in rural areas. The doctor shortage is causing more communities throughout the country to compete for physicians, which adds to the challenge for rural communities. We are concerned that we may soon reach a tipping point where some rural hospitals simply will not have the physicians they need to stay open. If current trends continue, advanced practice allied professionals, such as physician assistants and nurse practitioners will deliver an increasing amount of care in rural areas. Often the physicians in rural areas are in solo practice, which is difficult to sustain from a lifestyle point of view. Professionally, many younger doctors are not comfortable being on an island and prefer specialty support and a regular schedule.

Q: Why is there such a high percentage of women in various specialties?

A: We often say that the primary care giver of tomorrow will be a woman. This trend is already happening in pediatrics and ob-gyn. It's a positive development for medicine, but it exacerbates the doctor shortage. Women at certain stages in their lives work considerably fewer hours per week than male physicians work.

The gender shift affects the total number of physician work hours avail-

able and so has a significant effect on physician availability in the United States. Many women coming out of residency are in peak childbearing years, and so many female residents will be out on maternity leave within a year or two after residency. And then while they are raising their children, they may need flexible hours.

Q: What would we do without the 25% of physicians in the United States who are international medical graduates who tend to go into specialties?

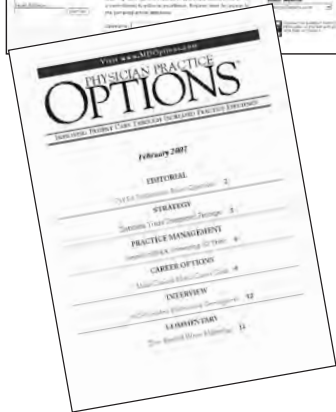
A: We'd be hard pressed to function without them. They're filling health care gaps in America, and alleviating physician shortages. They've gone from the periphery of the medical workforce to serving as heads of local physician societies. Often they're chief residents, medical directors, or hold other leadership positions. We've seen them innovate medical technology, and the quality and communication skills of international medical graduates have improved greatly over the years.

We counsel our clients to keep an open mind when they're developing their candidate parameters. The ideal candidate is one who has the training and skills you're seeking and who wants to be in your community. This candidate may be an international graduate or an American-trained doctor.

Surprisingly, some facilities still hesitate to consider international medical graduates. But we tell our clients that the two fastest ways they can improve their chances are, first, focus on quality, not country of origin, and, second, consider experienced physicians in their 50s or older. —More information on physician practice strategies is available on our Web site (see page 16).

“We’d be hard pressed to function without international medical graduates. They’re filling health care gaps in America, and alleviating physician shortages,” Miller says.

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