Defining The Elusive 'Medical Practice'

ELIZABETH BROWN, MD; LEONARD GREEN, MPH; JOHN P. FULTON, PhD; MICHAEL FINE, MD

Rhode Island's small size creates unique opportunities for public health. We can easily imagine how the Rhode Island Department of Health (HEALTH) might partner with primary care and specialty physicians to bring effective prevention and treatment to the entire population. We can also imagine how we might use primary care medical assets in non-traditional ways during emergencies when mobility is restricted to care for our population in place.

At present, however, we do not have the means formally to address Rhode Island's physicians above the individual provider level because the medical practices with which they are associated have been heretofore ill-defined. To be sure, we know a medical practice when we see one, but because "medical practices" are not defined by Rhode Island state law, and therefore have no formal relationship with state government, we do not know *how many* medical practices exist, *where* they are located, or *who* works in them. Also, because medical practices come in many shapes and sizes and have many kinds of legal structures, we do not really know how best to use the natural organization of the medical assets they contain. Finally – and vitally important to protecting the public's health – we do not know what people (patients) these heterogeneous medical practices serve.

By partnering with practices, Rhode Island can make use of these collaborations to reduce the incidence and prevalence of disease, but first we need a good definition of a "medical practice."

CONTEXT

Ambulatory care in the United States is provided in a wide variety of settings, ranging from privately owned solo physician offices to large multi-specialty practices organized under a corporate structure. The term "medical practice" has been used to describe the combination of elements that together serve as a mechanism through which physicians provide care, including physical space, support staff, medical record systems, billing processes, formal and informal relationships with other physicians and healthcare professionals, and patient panels. The shapes and sizes of medical practices vary as widely as the physicians and other medical providers who work in them.

Despite this natural heterogeneity, medical practices have been proposed as a unit of analysis for public health and health system initiatives, including quality measurement, workforce planning, and infrastructure improvement. Indeed, in times of emergency, public health departments scramble to define, locate, and communicate with medical practices, using various and sundry *ad hoc* methods. During the H1N1 influenza pandemic, for example, HEALTH created a list of medical practices by cross-referencing address information from individual physician licenses (some of which contained at least one address of a medical practice in which the licensee worked), telephone directories (Yellow Pages listings of medical practices), and internet searches.

Currently, license records maintained by HEALTH provide little data on medical practices in the state, because Rhode Island, like most states, regulates ambulatory medical care (read, "medical practices") primarily through the licensure of individual physicians. Because physicians commonly practice at multiple sites, and because these locations change with some frequency, the state does not require physicians to provide an exhaustive, much less an up-to-date list of practice locations. This critically limits the state's ability to match medical resources to populations in need.

In short, existing information is insufficient to advance coordination of medical care in the state, to expand primary and specialty healthcare, to allow effective medical planning, and to improve overall healthcare quality. We need more information about medical practices in the state – much more information – and we need to begin by defining what we mean by "a medical practice." In fact, we may need more than one definition, as the answer to the question "what is a medical practice?" varies according to why the question is asked, and for what the answer will be used.

COMMON DEFINITIONS OF "MEDICAL PRACTICE"

Medical Subject Headings (MeSH) Definitions

MeSH terms are used to classify information by key topics in the medical literature.[1] The MeSH database includes definitions of three types of "medical practice:" *private*, *partnership*, and *group*. A *private* practice is a practice in which one sole physician works.[2] A *partnership* practice is defined as a "voluntary contract between two or more doctors who may or may not share responsibility for the care of patients, with proportional sharing of profits and losses," which suggests a business alliance.[3] A *group* practice is defined as "three or more full-time physicians organized in a legally recognized entity for the provision of healthcare services,

who share space, equipment, personnel and records for both patient care and business management, and who have a predetermined arrangement for the distribution of income."[4] Although this definition is somewhat more patient-care-oriented, it is still primarily based on business organization.

Definitions Promulgated by Other State Governments

In addition to physician licensure, many states have additional ways to regulate outpatient facilities. Frequently, however, these regulations apply only to certain subsets of medical practices. Rhode Island, for example, regulates "organized ambulatory care facilities" (OACFs), defined as "structurally distinct public or private healthcare establishment(s), institution(s) or facilit(ies), primarily constituted, staffed and equipped to deliver ambulatory and urgent healthcare services," but also *exempts* any facility that is wholly owned by physicians licensed in the state.[5] In practice, the exemption excludes *most* outpatient clinics except federally qualified health centers (FQHCs).

The State of Connecticut gives the Commissioner of Public Health broader statutory power to license an outpatient clinic, defined as an organization operated by a municipality or an organization other than a hospital which provides ambulatory medical or dental care for diagnosis, treatment and care of persons with chronic or acute conditions which do not require overnight care, or medical or dental care to well persons including preventive services and maintenance of health."[6] However, Connecticut's licensure requirements do *not* apply to any facility owned and operated exclusively by physicians practicing under their own individual licenses, which has created data-gathering challenges similar to those faced in Rhode Island.[7]

Although most states do not license practices as such, 63 percent of state medical boards use their licensing mechanisms to capture some information on the distribution and supply of healthcare providers.[8] The state of Vermont, for example, incorporates a survey that asks physicians for the town, specialty, and number of hours for each location at which they practice medicine. Survey results are used by the state to analyze physician data at the county level.[9] A similar survey strategy could be used by Rhode Island to gather information about the sites in which physicians practice.

Centers for Medicare and Medicaid Services (CMS)

CMS has multiple definitions of "medical practice," specific to different needs. In the context of anti-kickback legislation, a physician practice is a medical practice comprised of two or more physicians organized to provide patient care services, regardless of its legal form or ownership. For quality incentive programs, CMS has created the Group Practice Reporting Option, which defines a group practice as more than 25 individual physicians who practice under a single tax identification number.[10] Physicians who practice in groups that do not fit these criteria must report data as individuals in order to qualify for incentives. Nonetheless, most CMS outpatient care analyses are still at the individual provider level. For example, although electronic health records (EHR) systems are purchased by "medical practices," EHR incentive programs for adoption of EHR systems are based on individual physicians.[11]

National Committee for Quality Assurance (NCQA)

NCQA's recognition program for "Patient Centered Medical Homes" is based on a definition of "medical practice" as any group of physicians who practice together in a single location. "Practicing together" is further defined as follows:

- The practice care team follows the same procedures and protocols.
- Medical records for all patients treated at the practice site, whether paper or electronic, are available to and shared by all clinicians, as appropriate.
- The same systems—electronic and paper-based—and procedures support both clinical and administrative functions, for example: scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up.[12]

In order to be recognized as Patient Centered Medical Homes, *practices* must apply. Like other definitions of "medical practice," the NCQA definition is need-specific, and thus excludes many practice types.

Rhode Island Quality Institute (RIQI)

Similar to CMS, RIQI uses multiple definitions of "medical practice," depending on the context (personal communication, 2012). For example, the Beacon program uses "*practice*" to refer to a legal entity, "*site*" to refer to a geographic location where care is provided, and "*provider*" to refer to a specific individual. Alternatively, the CurrentCare program allows patients to authorize their "providers" to have access to the patients' healthcare information. A "provider" in this context refers to a combination of:

- one or more healthcare providers who are licensed to prescribe medications and treatment;
- and possibly, one or more healthcare providers who are not licensed to prescribe medications and treatment;
- and possibly, one or more persons who provide clerical support.

This "provider" entity may or may not be a legal corporation or LLC, and may be found at one or more geographical locations. This definition is rather open-ended. One might ask, for example: Should physicians who share after-hours coverage have access to patient records, even if they are not legally or geographically connected? Or: Should access to patient information be available to all doctors in a network that owns multiple clinic sites, even if it is unlikely that the information will be accessed at most of the sites?

DISCUSSION

Considering the limited definitions of medical practice that exist, Rhode Island may be well advised to create its own definition(s). Existing, albeit limited, information on medical practices provides a place to start. Geographic practice locations, for example, may be generated from sources mentioned above. Organized practice entities may also be identified by means of National Provider Identification (NPI) numbers, which designate entities that exchange protected health information with other organizations. Type I NPI numbers apply to *individual* physicians, while Type II NPI numbers apply to *groups*. These data may be used to generate lists of possible medical practices against which a hypothetical definition may be tested.

In the same vein, medical practices might be identified without a very specific definition by asking healthcare professionals to self-designate membership in medical practices at specific geographical locations, and by asking each self-described medical practice to register electronically with HEALTH. Such an approach avoids the complexity of the various definitions fielded to date, which all seem to exclude one type of practice or another, while allowing HEALTH to categorize and address the medical assets of each place, serving each population. This approach has the additional advantage of effectively automating practice personnel change updates, which would occur with health professional re-licensure.

Other organizations are exploring definitions of medical practice, as well. *Our* efforts to do so can be informed by *their* work, and *vice versa*. The Federation of State Medical Boards has proposed a minimum data set on practice patterns and workforce that can be tied to licensing in each jurisdiction, then compiled to create a national workforce database.[8] If Rhode Island decides to require practice registration for health professionals, the Federation's data can serve as a rich source of information about what data to collect and how it is collected by other states. Knowing how Rhode Island's medical providers sort themselves into organized entities will be immediately helpful in organizing information from Rhode Island's Health Information Exchange (HIE), and in future, for many and diverse purposes.

As HEALTH moves forward with any initiative to define "medical practice," it should consider which projects it wishes to prioritize, because such considerations will shape how data gathering and designations should proceed. Starting from a virtual *tabula rasa*, HEALTH has the opportunity to create a definition (or *definitions*, tailored to current and future needs) that helps shape the public health collaborations of the future.

References

1. U.S. National Library of Medicine. Medical Subject Headings (MeSH) in MEDLINE/PubMed: A Tutorial. http://www.nlm.nih.gov/bsd/disted/meshtutorial/introduction/02.html. Published Oct 12, 2012. Accessed Mar 17, 2013.
2. National Center for Biotechnology Information (NCBI). Private Practice. http://www.ncbi.nlm.nih.gov/mesh/68011331 Accessed Mar 17, 2013
3. NCBI. Partnership practice. http://www.ncbi.nlm.nih.gov/mesh/68010317. Accessed Mar 17, 2013.
4. NCBI. Group practice. http://www.ncbi.nlm.nih.gov/mesh/68006123. Accessed Mar 17, 2013.
5. Rhode Island Department of Health. Rules and Regulations for the Licensing of Organized Ambulatory Care Facilities [R23-17-OACF]. http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/4837.pdf. Sept 2007. Accessed May 5, 2013.
6. Connecticut Department of Public Health. *Licensing Outpatient Clinics Operated by Corporations or Municipalities*. Sept 1, 2009. Accessed May 5, 2013.
7. Primary Care. In: Connecticut Department of Public Health Office of Health Care Access. *Statewide Healthcare Facilities and Services Plan.* Oct 2012. http://www.ct.gov/dph/lib/dph/ohca/hc_facilities_advisory_body/ohcastatewide_facilities_and_services_chapter_9primary_health_care.pdf Accessed May 5, 2013.
8. Federation of State Medical Boards, Workgroup to Define a Minimum Data Set. *Report on a Recommended Framework on a Minimal Physician Data Set.* April 2012. http://www.fsmb.org/pdf/grpol-min-phy-dataset.pdf. Accessed May 7, 2013.
9. Vermont Department of Health. *2010 Physician Survey Statistical Report.* Aug 2011. http://healthvermont.gov/research/HlthCarePrvSrvys/documents/phys10bk.PDF. Accessed May 5, 2013.
10. Group Practice Reporting Option (GPRO) Requirements for Submission of 2012 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program Data. Jan 3, 2012. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2012_GPRO_Requirements_01032012.pdf. Accessed May 5, 2013.
11. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare and Medicaid Programs, Electronic Health Record Incentive Program; Final Rule. *Federal Register* Vol 75(144). July 28, 2010.
12. NCQA. *Standards and Guidelines for NCQA's Patient-Centered Medical Home (PCMH) 2011.* Washington, DC: NCQA; 2011.

Authors

Elizabeth Brown, MD, is a Family Medicine Resident, Brown University / Memorial Hospital of Rhode Island.

Leonard Green, MPH, is Deputy Director of the Rhode Island Department of Health.

John P. Fulton, PhD, is Associate Director of the Rhode Island Department of Health, and Clinical Associate Professor of Behavioral and Social Sciences, the Warren Alpert Medical School of Brown University.

Michael Fine, MD, is Director of Health of the State of Rhode Island.

Disclosure of Financial Interests

The authors and/or their spouses/significant others have no financial interests to disclose.

Correspondence

Elizabeth Brown, MD
Memorial Hospital of RI
Department of Family Medicine
111 Brewster Street
Pawtucket RI 02860
lizbrown95@gmail.com