

# PHYSICIAN PRACTICE OPTIONS™

July 15, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Experts Outline Seven Steps Groups Can Follow to Smooth the Merger Process

Physician practices that merge to form large single-specialty or multispecialty groups do so in the expectation that the merger will increase their chances of success. While the rewards of a merger may be great, physicians pursuing this option would be well advised to embark first on a careful, months-long planning effort to resolve as many contentious issues as possible before the actual merger.

R. Brett Ringler, an expert in merger transactions, says that seven steps need to be followed if a group merger is to be done properly. Ringler is executive director in the San Diego office of Superior Consultant Co. Inc., a health care information management and technology company in Detroit. The seven steps he says should be followed are:

1. Review goals and culture
2. Determine optimal size
3. Determine group structure
4. Perform financial modeling
5. Determine compensation structure
6. Create an operational structure
7. Market the group

**1. Review goals and culture.** Groups should spend a significant amount of time reviewing each physician's interest in merging before moving ahead with merger discussions. "I've talked to physicians who wanted to consolidate their groups," says Ringler. "But interviews with other physicians in the group revealed that some couldn't care less about merging, or that it was one physician 'leader' who was pulling the group toward the merger." Unless all physicians

involved fully support the idea, the merger could fail.

In addition, physicians should be working toward a common goal, such as enhancing the group's managed care negotiating position or pursuing clinical research endeavors. "Lifestyle issues sometimes affect the strategies physicians are willing to pursue," explains Ringler. For example, older physicians may be less likely to pursue or support managed care strategies, since they've enjoyed the benefits of fee-for-service practice for a long time and may be ready to retire.

Merger partners also should assess compatibility. "Physicians must be aware of the real ability to blend cultures and personalities across groups," states Ringler.

Cliff Hale, MD, a founding member of MidMichigan Physicians, a multispecialty group of 25 physicians in Lansing, confirms that compatibility and a common goal were crucial in making the merger of two groups work. "MidMichigan Physicians began as the merger of two internal medicine groups of eight physicians in 1996," Hale says. "The physicians knew each other well, some for 15 years. The merger process went smoothly because of mutual trust, and because we all had the same goal: to maintain ownership of our practices in an environment where many groups were relinquishing ownership to health plans or hospital systems. We felt that if we built a large group, we would maintain a significant

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## Physician Recruiter Says Rural America Offers Advantages

After spending the last 14 years as a physician recruiter, Dalton Boggs, president of Dalton Boggs and Associates, in Oklahoma City, Okla., has seen the roles of administrative and clinical physicians change dramatically, and one of the biggest changes he has seen involves job satisfaction. As a result of extensive changes brought on by managed health care, many physicians no longer find the clinical practice of medicine to be enjoyable, Boggs says.

"Regardless of the medical environment in which they practice—whether it is with a group practice, as part of a hospital staff, or in private practice—the cost restraints physicians now face have made it impossible for some of them to practice as they did in the past," he says. "In some areas, these constraints have created an oversupply of physicians. This oversupply has come about for a number of reasons: a curtailing of specialist referrals, the need to operate within capitated contracts, the retaining of fewer primary care physicians and increasing the work load of those who are retained, and by requiring primary care physicians to perform many of the procedures that specialists have done in the past."

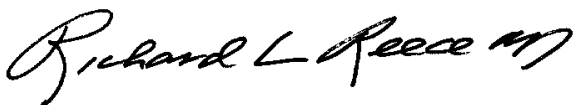
Many administrative physicians also are feeling disillusioned with the direction their careers have taken under managed care. "Competition to keep health care costs as low as possible puts enormous pressure on health plan medical directors," Boggs says. That pressure often leads these physicians to seek alternative career options.

The rural practice opportunity is one career option that both clinical and administrative physicians who are seeking change might want to consider. Since many rural areas have only 10% managed care penetration, the constraints these practitioners may be experiencing in areas with large managed care populations are not prevalent, Boggs says.

Given the pressures on physicians in markets where managed care dominates, it should not be surprising that a large percentage of the physicians who are relocating to rural areas have come from regions in which managed care has a strong foothold, such as California and the Northeast. Many of these physicians have grown tired of having others dictate to them how to practice medicine. They want to practice in areas where managed care enrollment is much lower, like the small rural communities in the southeastern United States. Many physicians attracted to these areas want to practice as far away from managed care as possible, experts say.

Rural practice, however, is not an option all practitioners would find appealing. Many lifestyle issues must be considered along with the career benefits. For example, Boggs says, spouses may not want to live in rural areas. Also, there are not always compatible employment opportunities for nonphysician professionals, although physician recruiters can usually provide assistance to the professional spouse as well as to the physician. "For physicians who want to have more control over their medical practices, and whose families are comfortable with the lifestyle, practicing medicine in a rural environment can be an excellent career option," he says.

Finding the right rural practice opportunity is no different than any other job search, Boggs says. "The same basics apply: working with recruiters and networking," he says. "The Internet is also an excellent search tool. But most of all, in this market, it helps to be flexible and persistent."



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# Health System Governance Evolves

By Thomas M. Gorey, JD

**A**ligning physician and hospital interests, and thereby facilitating the pursuit of common goals, has been a popular strategy in recent years. In some cases, this strategy has involved developing entities like physician hospital organizations (PHOs), management services organizations (MSOs), and hospital-owned primary care practices. Steps to encourage physician-hospital collaboration, however, are also occurring at the board level of hospitals and health systems.

A health care system's success in navigating through the turbulent health care environment requires the involvement and commitment of all components of the system. Yet, physicians have traditionally had a limited role in health system governance. Often, the medical director or chief of staff is the only physician with an official voice in health system policymaking. To form more equitable partnerships with physicians, many health systems are rethinking the role of physicians in governance as part of a broader reexamination of their boards.

A study conducted by Policy Planning Associates for the Milbank Memorial Fund, a philanthropy in New York, and the American Hospital Association's Health Research and Educational Trust (HRET) points to some of the changes affecting the role of physicians in governance, as well as other changes in health system governance.

## An Expanding Role

Simply giving physicians a larger role in health system decisionmaking is not a magic bullet and cannot improve relations overnight. In particular, where a tradition of hostile or adversarial relations between the hospital and its medical staff exists, there may be initial misgivings on

*Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development.*

both sides to overcome. However, expanding the involvement of physicians in a health system's governance structure can, over time, be a key ingredient in enhanced physician-hospital relations and increased physician support for the system's policies and initiatives.

It makes sense for a health system to expand the involvement and role of

ally part of the decision-making process and to be candid with them in order to have a successful system."

- "You need to solidify the various components of your system, and physicians have to be part of the team because they drive cost and quality; if they are not with the administration, you are not going to be successful."

**Expanding the involvement of physicians in health system governance can be a key ingredient in enhanced physician-hospital relations and increased physician support for the system's policies and initiatives.**

physicians in health system governance for several reasons, as follows:

- Doing so can ensure that physicians' vision is adequately represented on the board and that management is responsive to the physicians' needs.
- If physicians are listed as partners, it makes sense that they should have a direct say in how the health system functions.
- Providing physicians with a meaningful role in health system governance can promote a spirit of cooperation.
- Since physicians have a unique understanding of patient care delivery issues, their insight can be helpful to the health system's management and board.
- Involving physicians in health system governance can provide a framework from which to begin aligning incentives and working collaboratively.

In the study, health system representatives made many comments about the role of physicians that illustrate the new commitment of health systems to physician participation in governance:

- "Physicians are partners in our business."
- "An organization cannot be successful without increased physician involvement in governance."
- "You need to keep physicians continu-

- "Any system contemplating change should make sure that physicians are involved."
- "It is really important to have physicians in key positions on the board if the system is going to come together."

## Medical Quality

Physicians who serve on hospital or health system boards often play multiple roles in governance, including serving as community representatives and patient advocates. The reluctance of many hospitals to provide a larger role for physicians in governance may arise from a concern that physicians will simply represent and advocate for their own professional interests. Yet, hospitals that have expanded the role of physicians on their board usually are pleasantly surprised to learn that physician trustees or directors rarely act solely to protect physician interests. Rather, physician board members generally act based on what is best for the health system and its patients, from a medical quality perspective.

In addition to playing a more significant role on hospital and health system boards, physicians are being brought into decisionmaking processes through other administrative and governing bodies.

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Some health systems, for example, have formed joint physician-management executive committees. These committees work with the system's CEO to address various operational issues. Physician participation on executive committees allows physicians to be involved in a level of administrative detail that general board membership does not allow. Other ways that health systems have increased physician involvement include their participation in the governance of foundations and contracting entities and membership on advisory boards.

Although physicians are assuming a more prominent role on many local hospital and health system boards, they are not necessarily doing so in multistate systems. The nature of physician leadership may, at least in part, explain this phenomenon. Physician leaders generally evolve gradually, and physician board members tend to rise out of local physician leadership positions. In a multistate system, it is more difficult for a core of physicians to be perceived as leaders by other physicians in the system.

### Other Governance Changes

Increasingly, boards are relying on strong, visionary CEO leadership. Greater responsibility and authority are being given to health system CEOs to lead their organizations through change. Boards are placing value on strong CEOs who have a vision of where the system should be going, and who can present a range of well-thought-out options and strategies to the board for consideration. Having a CEO who is a consensus-builder and who can work with physicians and other key constituencies is also of considerable importance.

The focus of health system boards is shifting from operations to strategic planning. There has been a definite shift in the focus of board activities from operational issues to strategic planning. Most board members view this shift as a welcome change. By delegating to the CEO responsibility for the day-to-day management of the health system, the board can spend more time on strategic planning and on addressing major policy issues. For this shift in focus to occur, however, the

board must trust in the knowledge and skills of the administrative team.

Health system boards are increasing the technical expertise and diversity of their members and are beginning to more closely resemble corporate boards. Increasingly, in filling board seats, health systems are looking for people with experience in business, law, insurance, and health care, who will be able to address the complex issues their systems face.

Many health systems are instituting term limits—for example, a total of nine years of service—to promote, creative thinking and to keep board members from

when health systems are formed, seats are allocated to representatives of all system partners. As partners are added, additional seats are added to the board. Most health systems that have reduced the size of their board have done so because the additional seats eventually made the board unwieldy. As trust is built up in the board, it is possible to move away from a representational model.

Board committees are performing much of the detailed work of the boards as a means of streamlining decisionmaking. For many health systems, board committees are now at the level at which detailed

**In a multistate system, it is more difficult for a core of physicians to be perceived as leaders by other physicians in the system.**

becoming "institutionalized." Such frequent turnover also is providing an opportunity to create a more diverse board that represents an entire community.

Health systems are consolidating governance authority and moving away from representational boards. Many health systems are reconfiguring their governance to increase allegiance to the system instead of its components. Health systems are putting considerable effort into ensuring that their members do not act as representatives of a segment of the system. Some systems have moved away from the representational culture by ending the practice of allocating system board seats to system components. The consolidation of governance into a system board almost uniformly meets with resistance—and at times hostility. Nevertheless, in most cases, consolidation ultimately proves to be beneficial. The ability to speed up decisionmaking and to respond more quickly to changes in the external environment is a major benefit for most systems.

The size of health system boards is being reduced or stabilized, despite growth in the number of system components. Such smaller boards often result from a movement away from having a representational system board. Typically,

analysis and discussion of issues take place. An active, efficient committee structure can be an effective means of keeping the board from becoming overwhelmed. Board members who serve on committees are already familiar with issues being presented to the board because of their service on the committees. Also, by the time an issue comes to the full board, much of the necessary analysis and debate have taken place.

As health systems continue to evolve, new methods of governance and new types of leadership are required. As a result, health systems are moving away from traditional models of governance and are developing new approaches that allow them to engage in creative problem solving and to respond quickly to changes in their markets. An expanded role in governance can provide physicians an important opportunity for health system decisionmaking and improved relations between health systems and physicians. ■

Copies of the report *Governing Health Systems: Ten Stories* can be obtained from the Milbank Memorial Fund, 645 Madison Avenue, 15th Floor, New York, NY, 10022, 212/355-8400.

# Process Redesign Improves Efficiency

By Neil West, MD

From 1993 to 1997, price wars among health plans competing for purchaser contracts in Tucson, Ariz., caused an average net decrease of \$8 per member per month (PMPM) in capitated rates paid to physicians. At the same time, the cost of practicing medicine—including office rent, supplies, and staff salaries—continued to rise, while the size of patient panels remained relatively stable. For a large group practice with 40,000 patients, that \$8 PMPM decrease represented a drop in revenue of \$3.8 million each year.

It is not surprising, therefore, that many physicians view managed care as a threat to the financial success of their practices and an impediment to providing quality care to patients. Perhaps this view has been fueled in part by the fact that changes in reimbursement methodologies and in the health care delivery process have come more from external sources—health plans and purchasers—than from physicians. Balking at the edicts imposed by others may be human nature, but viewing the new rules of managed care as a stimulus for improving efficiency may be more beneficial. To do so, physicians must be willing to ask if the way they currently practice is the best that they can do.

## Process and Outcomes

In any medical practice, there are clinical and administrative processes that have existed for years without changing. Sometimes, a process hasn't changed because it works well; sometimes, it hasn't changed because no one has ever questioned whether it is the most efficient or effective method.

Take, for example, the process for ensuring that elderly patients receive flu shots. Rather than asking them if they have had a flu shot when they come in for

an office visit, could the process be improved by sending them a postcard reminder early in the fall and scheduling five-minute office visits one day a week for a month to provide the shots? Studies have shown that such programs can be cost effective. A study published in the March 2 issue of the *Annals of Internal Medicine* showed a 50% reduction in hospitalization rates for seniors who received flu shots as compared with those who were not immunized. Such improvements in quality of care and reductions in costs

others, for example, examining data would quickly reveal answers to the following questions:

- Is there any correlation between how long patients wait and office staffing for a particular day?
- How many same-day appointments were scheduled for days with longer wait times? Shorter wait times?
- Are any times of the day when wait times are shortest? Longest?
- Is there a relationship between patient characteristics—such as age, diagnosis,

**Physician groups that worked more collaboratively than others had a lower percentage of patient visits to the urgent care clinic than groups that did not work this way.**

provide ample reasons to probe for ways to improve processes.

At least one truth about processes is known: Repeating the same process in the same way each time will not produce a better outcome. If the process is stable, so are the outcomes of that process. To illustrate this point, try collecting a week's worth of data on any process in your office. Record, for example, how much time patients spend in the waiting room. How long do they wait on average between 8 a.m. and 9 a.m., and between 9 a.m. and 10 a.m.? If you collect these data for a month, three months, six months, or a year—without making any changes in scheduling or other processes—the data for one week will represent the data for any week during a larger measurement period.

## Data Define the Process

The relationship between stable processes and predictable outcomes means that outcomes data can provide a rich source of information about current practice processes. To discover what causes some patients to be kept waiting longer than

or payer type—that may contribute to longer wait times? Shorter wait times?

If you know the data are reliable, you can assume that improvements will not occur until the process is improved. But to improve the process, you must first identify its shortcomings.

As associate medical director of operations for Group Health Medical Associates (GHMA) Medical Centers, a large multispecialty group practice in Tucson that was affected by the \$8 PMPM decrease in capitated payments, one of my charters was to improve efficiency and reduce costs while improving patient satisfaction. An area that was ripe for all three of these efforts was reducing the use of urgent care services.

With a large volume of patients seeking care in our urgent care clinic, our first reaction was to hire more urgent care physicians. But we quickly realized that by doing so, we would, in effect, be paying twice for services, since the primary care capitation dollars had already been allocated to the individual physician practices. Nonetheless, we needed to find a way to accommodate patients who sought

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Neil West, MD, is associate medical director of operations for Group Health Medical Associates Medical Centers, a large multispecialty group practice in Tucson.

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care in this more expensive setting because they were unable to get same-day appointments with their own physicians.

To determine the relationship between patient visits to the urgent care clinic and demand for same-day appointments, we collected patient encounter data from the urgent care clinic for a week. We discovered in analyzing these data that some physician groups, or "pods," worked more collaboratively than others, providing coverage for each other's patients. These groups had a lower percentage of patient visits to the urgent care clinic than other groups that did not work this way. We also found it was possible to predict how many same-day appointments were needed for each specialty—just as airlines have learned how to forecast accurately how many seats will be sold for various flights.

Our pediatric physicians needed to allocate 40% to 50% of their appointment schedule for same-day appointments in the winter season, family medicine needed 25% to 30%, and internal medicine required 10% to 15%. With this information, we could redesign each doctor's scheduling protocols accordingly.

But unlike the *Field of Dreams* incantation, "If you build it, they will come," patients did not call their physicians for

same-day appointments, even though they were now readily available. Why? When we asked them, patients told us that they had learned through experience that it was a waste of time to call the office because same-day appointments had never been available. Therefore, modifying the process also meant that we needed to market the availability, convenience, and quality of care that same-day appointments with the patient's own physician could offer.

Changing how patients access same-day care may seem like a minor way to reduce health care costs. But for GHMA, this one change saved \$180,000 in extra physician salaries. Most changes yield a more modest \$40,000 to \$50,000 of sustained savings for the organization as a whole. But improving the way we manage the common, everyday processes in our practices has far more potential to achieve desired levels of cost savings than improving the efficiency of bone marrow transplants or other high-cost, infrequently performed procedures.

Physicians cannot expect a handful of improvements or a short-term commitment to redesigning processes to be effective over time. Compensating for multi-million dollar shortfalls requires a con-

centrated dedication to initiating dozens of process improvements each year.

### Goals Guide Improvements

Improving processes will be different in each practice. Although our ultimate goals may be the same—to improve efficiency, increase patient satisfaction, or save money—individual circumstances influence which processes will be most effective in reaching those goals.

From the physician's point of view, reimbursement mechanisms are probably one of the most significant drivers in structuring optimal processes. To illustrate this point, consider the treatment management process for urinary tract infections (UTIs) for women age 18 to 50. Because UTIs are relatively common and tend to recur frequently in affected women, a treatment algorithm designed and approved by physicians could be used to manage patients over the telephone. In a typical case, a woman with a UTI has to leave work, drive to the physician's office, wait to see her doctor, wait for urine culture results, and then drive to the pharmacy to pick up the prescribed medication. But with a change in process, the patient could simply call the physician's nurse and then stop by the pharmacy to pick up the prescription on her way home from work. Changes in this process obviously benefit the woman's employer, since she is not obliged to leave work, and offer convenience for patients with recurring UTIs.

But is this a process improvement for the physician? If the physician is in a highly capitated market, reducing the number of unnecessary patient encounters saves money. But for providers in areas where fee for service is the predominant form of reimbursement, adopting such a process would result in lost revenue because office visits and lab tests—the revenue generators—would be eliminated. Therefore, a critical aspect of process redesign involves assessing whether changes will result in overall improvements.

### Substantial Change

Sometimes true process improvement requires global changes that reach far

## References for Redesign

The following references may be helpful to physicians interested in process redesign for their practices:

- Balestracci, D, and Barlow, JL, *Quality Improvement: Practical Applications for Medical Group Practice*, 2nd ed. (Englewood, NJ: Medical Group Management Association, 1996).
- Berwick, DM, "Eleven Worthy Aims for Clinical Leadership of Health System Reform," *JAMA*, 272(10):797-802, 1994.
- Brook, RH, "Managed Care Is Not the Problem, Quality Is," *JAMA*, 278(19):1612-14, 1997.
- Chassin, MR, "Assessing Strategies for Quality Improvement," *Health Affairs*, 16(3):151-61, 1997.
- Institute of Medicine, National Roundtable on Health Care Quality Improvement, *Collaboration Among Competing Managed Care Organizations for Quality Improvement*, Molla S. Donaldson, ed. (Washington, D.C.: National Academy Press, 1999).
- Nichol KL, Baken L, and Nelson A, "Relation Between Influenza Vaccination and Outpatient Visits, Hospitalization and Mortality in Elderly Persons With Chronic Lung Disease," *Annals of Internal Medicine*, 130(5):397-402, 1999.

**For one group, changing how patients access same-day care saved \$180,000.**

beyond a physician's own practices. While such improvements may have the greatest potential to raise the quality of care and reduce total costs, roadblocks, such as competition in a market, often make implementation a challenge.

Nearly all primary care physicians provide care to patients with chronic illnesses, such as diabetes, but do so without regard to the type of health benefits coverage the patient has. Until recently, physicians would see their diabetic patients 10 to 12 times each year and would provide the patients with a full range of care services, from nutritional counseling to blood glucose testing. In the last several years, however, some practices have found that using a care team—consisting of a diabetes educator, a nurse, a nutritionist, and perhaps a podiatrist—to provide care to diabetic patients has improved both the quality and efficiency of care. Using a care team also reduces the cost of care because less expensive resources—namely non-physician practitioners—provide care during three-quarters of all office visits. A key component in this model of care is to implement clinical protocols and treatment algorithms so that each member of the care team works in unison to deliver optimal care to the patient.

Despite the benefits of an approach that uses a care team, most managed care organizations are unwilling to provide financial support for such infrastructure at the practice level, preferring instead to offer diabetes educators and other resources only to patients covered by their particular plan. While the intention of offering such resources is good, such a system is impractical to implement within a medical practice. As physicians, we care for patients covered by a variety of health plans, but we do not make a distinction in how we manage them medically. To improve the entire process, physicians may need to look for solutions that are practical and easily integrated into everyday medical practice, as well as benefit all patients.

We also need to look for ways to improve the processes that are within our control and to examine global processes, which will likely involve other organizations, if we are to make significant improvements in terms of lower cost and increased quality. Championing these improvements and crossing the boundaries of competition are not always easy, but fledgling efforts across the country—including collaborative projects among physicians, health plans, employers, and hospitals in Minneapolis, New Hampshire, Oregon, and other states—have shown that such improvements are possible if we work together.

Viewing managed care as a stimulus for managing the processes of care efficiently and effectively—rather than as a restriction of physician and patient choice—is a good place to start.

—Additional reporting and writing by Laura M. Northup, in Mashpee, Mass.

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presence in the market, which would allow us to participate in managed care contracts and finance the necessary information systems to manage those contracts while still owning our business.”

MidMichigan Physicians has since grown to 25 physicians after merging five additional practices (in pulmonology, nephrology, obstetrics-gynecology, oncology, and family practice) with the original two. These practices share the goal of autonomy in the marketplace.

**2. Determine optimal size.** “The size of the region’s population should dictate the size of the group,” says Ringler. Large metropolitan areas can support large groups because of the volume of patients available. But, he cautions, a group should not be so large in any one specialty that it represents an oversupply of physicians.

On the other hand, the larger the market, the larger the group must be to become an important player in the market. “For example, in one fairly large metropolitan area, 12 physicians wanted to merge their practices,” says Thomas M.

Gorey, president of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that advises physicians on organizational strategy development. “After a feasibility study, the physicians realized that a group of only 12 doctors would not be large enough to develop a widely known reputation or gain an incremental benefit in managed care negotiating leverage. They recruited additional physicians and began as a group of 50.”

Determining the appropriate practice size can have legal implications, and this factor must be addressed by a lawyer. For example, in small markets, too many specialists in one group can invite scrutiny from the U.S. Department of Justice because of a perception of market dominance, warns Ringler.

**3. Determine group structure.** There is no optimal structure for merged entities. Some are full-asset mergers; while in some mergers, the groups retain their own practice assets, but share expenses. “Group structure must be based on the personal, financial considerations of the individual physicians and on what’s best

for the group as a whole,” Ringler says.

Determining the new entity’s governance structure is one of the first issues to resolve—even before financial modeling, Ringler says. “If the physicians can’t agree on governance, then the numbers don’t matter.” While governance structure can vary, there are some generalities. Groups usually have a board of directors with representation from each of the original groups. Boards should be small to facilitate decisionmaking and should include a leader respected by all the physicians.

**4. Perform financial modeling.** The next step is to perform financial modeling. “Before physicians dramatically change their practice structure, they have to understand the financial implications of doing so,” Ringler advises. One key factor to consider is compensation. “Compensation is ultimately most important,” says Ringler. “Physicians need to know what will happen to their income if the merger takes place.”

In fact, compensation is the one issue that can make or break every merger, says Gorey. Therefore, it is best to resolve this issue as early as possible. To do so may require a financial analysis that accounts for the assets of the practices and the value of each physician’s ownership stake in the new entity.

Financial analysis is especially important when practices, especially single-specialty groups, have significant capital to bring to the merger.

MidMichigan Physicians hired a consultant to help the original partners to analyze the financial implications of its merger. “During our six-month planning process, we touched on all the important issues: governance, capitalization, compensation, cost allocation and accounting, retirement, banking, insurance issues, personnel policies, billing, and handling of accounts payable,” says Hale. “Issues regarding income were especially important, since all the physicians wanted to know how a merger would affect their compensation.”

**5. Determine compensation structure.** Financial modeling can be used to predict the effect of the merger on com-

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## Large Group Reaps the Benefits

Physicians in small groups struggling to compete in managed care markets, may find that a large group will win more managed care contracts simply because of its size, experts say. “Large groups typically develop protocols and guidelines to provide high-quality, standardized care,” says R. Brett Ringler, an expert in group merger transactions for Superior Consultant Co. Inc., in San Diego. “And payers often prefer large, geographically dispersed groups so that all of their enrollees are covered, rather than negotiate numerous contracts with small groups.”

Since merging eight groups into one, MidMichigan Physicians in Lansing has enjoyed increased strength in negotiating with managed care organizations, says Cliff Hale, MD, a founding member. “For example, in one instance, we were able to improve contract terms by switching from discounted fee-for-service reimbursement to capitation,” explains Hale. “As a large group, we had the data to show that we would meet our financial and clinical objectives under these terms. And we had the payer’s attention because it did not want to lose access to our specialists, who have excellent reputations in the market. In the past, when such contracts came across our desks, we had no alternative but to sign them.”

Other opportunities for large groups exist as well. “Cash flow can be consolidated to offer investment opportunities, such as building an ambulatory surgery center,” says Ringler. Large groups, especially single-specialty groups, are also better positioned to participate in clinical research and pharmaceutical trials.

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## **“Compensation is ultimately most important. Physicians need to know what will happen to their income if the merger takes place.”**

**—R. Brett Ringler, Superior Consultant Co.**

*(Continued from page 8)*

compensation, and it can help physician managers to develop the optimal compensation structure for the group. Compensation structures can vary; for example, splitting the group's net income equally among all physicians in the group, or compensating each physician according to his or her collections, less allocated expenses.

“Many groups enter a merger with a ‘share and share alike’ attitude, and start with an equal split of net revenue,” says Gorey. “Over time, physicians recognize that there are fairly large differences among them in terms of the revenue they generate and the expenses they incur.” On the revenue side, physicians may have a wide range in terms of hours worked, patients seen, and revenue generated. Variation in expenses might stem from staffing differences, such as the number of nurses and support staff in each practice. “As the groups mature, they modify their compensation model to make it more productivity-based,” says Gorey.

The compensation for MidMichigan Physicians is based on production, says Hale, and expenses are divided according to individual use of resources. “For example, our billing costs are allocated to each practice by the number of billing staff hours used,” he explains. “Disability insurance and workers’ compensation costs are allocated by full-time equivalent staff in each practice. Salary costs of the executive director are split equally.”

**6. Create an operational structure.** Creating an operational structure for the new entity can be difficult, especially given the need to streamline staff. “It is inefficient to employ multiple nurse managers, front office managers, lab managers, and other key staff positions,” says Ringler. “Physicians who merge their groups must steel themselves for difficult staffing decisions, and choose the ‘best of

the best’ for the new entity’s staff.” In addition, says Gorey, a top-notch practice administrator with a deep understanding of medical group operations should be hired, since the complexity of operations is much greater for a large practice than it is for small groups.

The most significant operational issue can be the development of an information system. “A large group must develop a solid information system to network the physicians, handle billing and collections, maintain electronic medical records, and track managed care contract activity,” says Ringler.

Hale’s group is currently installing an expanded information system. “Our original system included only billing and scheduling functions,” he says. “As we grew, we needed something more complex. Our new system has a clinical component; we will have terminals in the examination rooms and will enter clinical data so that we can do analyses based on data from actual clinical activity rather than data pulled off claims. These data will be extremely powerful when we want to demonstrate patient outcomes during contract negotiations.”

Often, physicians expect to streamline operational expenses by merging and are disappointed or even surprised that expenses increase instead. Gorey and Ringler point out that administrative staffing costs can increase, since individuals with high-level business skills must be hired. In addition, the sophisticated information systems required by merged practices are almost always extremely costly. Finally, in some cases a group may need to upgrade physician offices, since some physicians may not have office facilities that are consistent with the image the group wants to create.

Hale reports that his group’s overhead may have risen after the merger, but only slightly. “Most large groups have a capital partner, so they tend to spend money a

little more freely and their overhead rises,” he says. “We funded the merger ourselves, so we are very careful about how we spend our money. As a result, our overhead has stayed relatively lean.”

**7. Market the group.** Ultimately, the real measure of the group’s success will be its ability to generate new business for its physicians. One benefit of a large group is the potential to cultivate name recognition within the community. Creating a “brand” means patients associate certain traits, such as high quality, low cost, or easy access, with the group’s name.

One of the best ways to create a positive brand is through public service work, says Ringler. “Patient education, screening, and participation in health fairs can highlight the group while providing important services to the community,” he adds. Practices also can promote subspecialty expertise and use of cutting-edge technology. “The message is, ‘If you live here, you don’t need to travel to receive care at a university. We can provide it.’”

Hale confirms that his group is trying to build name recognition in the community. “For example, we built a Web site that includes physician biographies, and advertised the site on billboards,” he says. “And we were able to connect this marketing effort with a service because the Web site is a medical information service with links to disease-specific sites.”

Moreover, large groups can appeal to MCOs by providing “one-stop shopping” in contract negotiation, and can verify cost effectiveness and high quality by tracking comparative pricing information and patient outcomes. Gorey suggests that large groups also should prove that they include high-quality physicians by sharing physician credentials, number of years in practice, statistics on patient loads, and other such data with MCOs.

—Reported and written by Deborah Neveleff, in North Potomac, Md.

# Physicians, Hospitals Can Beat HMOs at Their Own Game, Author Says



*J.D. Kleinke is chairman of Health Strategies Network, a consulting company in Denver. He is a noted health care executive, medical economist, and author of the recently published book *Bleeding Edge: The Business of Health Care in the New Century* (Aspen Publishers, Gaithersburg, Md., 1998). This interview was conducted by Richard L. Reece, editor-in-chief.*

**Q.** Let's begin by discussing your book *Bleeding Edge*. What happened in your career that led you to write it?

**A.** In my first job, back in the late 1980s, I worked for Sheppard Pratt Health System, in Baltimore, the largest private psychiatric hospital in the world. In sorting through the business challenges the system faced because of the sudden onslaught of managed mental health care, I suggested that rather than shy away from managed care, we embrace the enemy, neutralize it, and restore our strength as an organization that way. Because the inpatient census was crashing, and nobody else had a better survival strategy, we, in effect, created what has since come to be known as the first physician-hospital organization in the country. In 18 months, we carved out the full mental health benefit for 150,000 covered lives and turned the system around.

This was long before PHOs became trendy, a trendiness that has since faded a bit. Back then, our strategy was simply an attempt to formalize a working organization among our various care sites and caregivers. In 1992, I joined HCIA, a data company in Baltimore that grew quickly into a developer of databases and information tools for hospital systems, HMOs, and pharmaceutical companies. Between 1992 and 1996, HCIA grew into the largest publicly traded health

care informatics company in the world. In fact, the business grew from about \$3 million to \$90 million in annual revenue from 1992 to 1997, and about half of the increase in revenue came through acquisitions and half through raw growth.

For most of the time that I was working at HCIA, I was involved in corporate development and product development, and in getting our pharmaceutical research business off the ground. Also during that time, I was writing my book, which had started out as a thesis for my graduate degree in finance at Johns Hopkins University. Basically, I was seeking to write a classic business textbook about the health care industry, since no other books like it existed. I left HCIA about two years ago to finish it, get it

us the role of physicians in all of this turmoil.

**A.** The conflicted and lately undervalued role of physicians is the central and probably most heavily debated theme of my book. Unlike many technocratic approaches to reforming health care, which view physicians as a peripheral element in the health care system, I believe that physicians are the hub of the entire system. I believe that no technocratic approach to fixing health care in the United States—whether it is private market or government-based—is going to work if it is not grounded in this basic assumption. At the end of the day, the element in the health care system that consumers trust, rely on, and hold accountable for the progress of their personal health status is their personal

**“At the end of the day, the element in the health care system that consumers trust, rely on, and hold accountable for the progress of their personal health status is their personal physician. The whole theory behind HMOs flies in the face of this fact.”**

published, and promote its messages.

**Q.** What does Health Strategies Network, your current company, do?

**A.** It's a consulting firm I started as an outlet for the strategic frameworks and business opportunities I discuss in *Bleeding Edge*. It's my attempt to help physicians in hospital organizations realize the vision of the book.

**Q.** In *Bleeding Edge*, you describe five interrelated forces: risk assumption, consumerism, consolidation, integration, and industrialization. In reading your description of these forces, the image that came to my mind was of tectonic plates grinding together and causing massive restructurings and earthquakes. Describe for

physician. The whole theory behind HMOs flies in the face of this fact.

**Q.** Can you talk about the five forces mentioned above and the effect they have on physicians? Let's start with risk assumption. How do physicians prepare to assume risk?

**A.** Physicians prepare themselves to assume risk by joining larger groups of physicians. The law of insurance is the law of large numbers, and solo practitioners and very small groups don't have the capacity to absorb a lot of the medical losses associated with the few seriously sick people who turn up in every population. Therefore, physicians need to be in a large group—and by

**“Physicians need to recognize that consumerism in health care is a force to be reckoned with, and they have to start adopting some of the practices of other businesses, including strategic market planning.”**

large, I don't mean the national PPMC monsters created by Wall Street, but rather large enough within a local market to have real negotiating power and operating mass. This usually translates into groups of at least 25 doctors, which is still large compared to the old model of three to six. A PCP group of 25 doctors or more will care for enough healthy people in its collective practice to, in effect, subsidize or absorb the losses associated with the few patients who have costly conditions.

**Q.** *What about the next force, consumerism? How do physicians organize to leverage themselves in the eyes of the consumers?*

**A.** Increasingly, physicians are recognizing that they are in the customer service business, which is quite a cultural shift from the tradition in which they could, quite frankly, take patients for granted. It sounds crass, but the more realistic physicians I work with are starting to recognize that they are competing for market share. Many physicians may find this fact distasteful, but it is an emerging reality as consumers become more discerning about health care. Consumers' ability to access health care information on the Internet has contributed to making them even more aggressive in their expectations.

Physicians need to recognize that consumerism in health care is a force to be reckoned with, and they have to start adopting some of the practices of other businesses, including strategic market planning. In essence, this means that they need to understand where their practice fits within the community. How do you make your practice appeal to an existing or targeted consumer market segment? That question should drive their decisions about which hospital system to align with, whether to go after consumers directly, how to deal with HMOs, whether to try to contract directly with large local employers, and so on.

This self-examination requires rigorous analysis of the market and a medical practice's business conditions within it.

**Q.** *A vivid example of what you're talking about involves an obstetrician in Florida who has made serving women who are pregnant and on Medicaid his biggest source of revenue.*

**A.** That's a great example. And it underscores the point that by understanding who you are, what your real patient market is, and how you should adapt your practice to it, you can turn any patient population into a good business opportunity.

**Q.** *Let's talk about the third force, consolidation.*

**A.** In talking about consolidation, I'm referring to the consolidation in a local medical community. Typically, almost every market in the United States has been completely out of whack with the medical resources people really need. Traditionally, the focus has been on inpatient care, with hospitals clustered in central cities. But that's not how communities are organized. We are a suburban society, and a society that increasingly demands other types of facilities for our care, including subacute, outpatient surgery, and rehab. Unfortunately, we have developed tremendous excess capacity in the wrong care categories because of some distortions in the marketplace caused by the federal government. This problem is exacerbated by the way Medicare reimbursement has always worked, which was—and in effect still is—to reimburse in kind for the expansion of inpatient capacity.

As for physicians historically, the logical way for them to practice—because they are so fiercely independent—has been in solo practices or in small team-based practice settings. Traditionally, that scenario has worked in a fee-for-service environment where every doctor got paid for every individual service that he or she delivered. It does not work well

in the brave new world of health care—which is all about getting paid for the covered life, not the covered service. That shift requires such watershed changes in physicians' attitudes and behavior, as well as in economic incentives, as to suggest a corresponding change in the way that physicians have always been organized.

To appeal directly to consumers and to assume the financial risk for their medical care means the law of big numbers becomes important. For example, a physician group that wants to appeal directly to a large employer for what are called “direct contracts” needs to have every kind of specialist in its group, or close links with every kind of specialist, or the employer won't bite. If a group cuts the HMO out of the picture, it will have to do the HMO's work of organizing a provider network.

What I am describing is a local or maybe regional phenomenon. The need for capital, for large numbers, and for contracting expertise, has been falsely blown up to a national scale by the good financial engineering folks on Wall Street. But the nation does not have a health care system that you can simply duplicate from community to community. If you've seen one local health care market, you've seen one local health care market. They all are different and have historic precedents for why they evolved the way they did.

The reality is that local health care markets were always on a collision course with the theory behind the physician practice management companies, which is a one-size-fits-all idea of organizing doctors and handing them a boilerplate contract for a national health care insurer that is supposed to be as workable in Albuquerque as it is in Baltimore or Seattle. That strategy simply doesn't work. Health care economics vary from market to market.

The whole PPMC debacle that got us

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so far off track with this wrongheaded thinking is a classic example of Wall Street's attention deficit disorder. Managed care contracting is not a national phenomenon. Cigna is based in Connecticut; United HealthGroup is in Minneapolis, and PacificCare in Southern California, but their actual provider contracting occurs in individual cities and markets across the county at the state level. So the idea that a deal that PhyCor, operating out of Nashville, cuts with Cigna, operating out of Connecticut, would affect physician care for people nationwide is pure fantasy. As a result, the single most potent promise of the PPMCs—big collectivized contracting—never materialized.

**Q.** *What would you say, then, about Columbia/HCA's abortive attempt to consolidate and create nationwide brand-name recognition? Was it on the right track?*

**A.** That's a tough question to answer because a hospital and a group of physicians are very different entities: One is a facility, a shell of activities; the other, a highly differentiated set of individual people. Physician practices are local service businesses. Hospitals, unlike physicians, can benefit to some degree from the standardization of practices that comes from meaningful national consolidation. For example, a national hospital chain that purchases billions of dollars of equipment, medical devices, and supplies represents a compelling economic argument for national consolidation. At the same time, the idea of branding health care around a recurring national hospital name may have more limited chances of success because local hospitals—where members of the community were born, deliver their babies, and so on—have some obvious personal connection with patients, if not to the degree that a long-term relationship with a doctor has.

**Q.** *Let's talk about integration. The buzzword, "vertical integration," has been flying around for years now but it seems that many of the big vertically integrated organizations have been spectacular flops. What does the term portend for physicians?*

**A.** Vertical integration describes an attempt to piece together all the

different types of facilities and the different levels of care—inpatient and outpatient surgery, home health care, rehab, and so on—and to tie them together with the physician. Historically, the health care system has been crying out for vertical integration. But the vertical integration attempts that we have seen so far—and will continue to see until we come up with a successful way of making it work in the clinic and not just on paper—represent less of a big innovation for our health care system than a historic correction of the ongoing disintegration of the system at its inception.

The fact that our hospitals and physi-

**"The nation does not have a health care system that you can simply duplicate from community to community. If you've seen one local health care market, you've seen one local health care market."**

cians are separate economic agents is an accident of history. The development of outpatient surgery centers and home health agencies as corporations separated from inpatient facilities is an accident of the nonprofit status of most hospitals and the for-profit opportunities that were spotted by Wall Street in the 1970s and 1980s.

These historic system-formation accidents have resulted in a system that is hopelessly inefficient. For example, in my book I cite a survey revealing that the number one complaint of 30% of those who have been hospital inpatients is the continuity of their care after they leave the hospital. In other words, after people are discharged from the hospital, they don't know what to do about their care. That type of sloppy "aftercare" situation would be completely intolerable in other industries and yet we accept it in our health care system. But how can it be otherwise in a system that forces physicians into the manual management of medical care, relying on their memory and paper charts? As a result, many people fall through the cracks.

Many are holding out hope that the electronic medical record will fix all this,

but I have been in the health information systems business, and it makes the health care delivery business look simple and workable by comparison. These days you hear more about why EMRs can't work, than why they can.

**Q.** *Two companies that you cite in your book as examples of having successful integrated continuums of care are Integrated Health Services, in Owings Mills, Md., and HealthSouth, in Birmingham, Ala. Could you say more about them here?*

**A.** Yes. But I would revise your remark by saying that both of these companies have captured only sections of the continuum. Both combine

subacute care with home health care and rehab services, but they have not integrated further back in the continuum of care in terms of some of the inpatient facilities. Columbia/HCA was the best hope for combining inpatient care with out-patient facilities, nursing care, and home health care. And look where that strategy got it. It ran into regulatory trouble precisely because it was trying to build a system that allowed a patient to move smoothly from one care site to the next; in the old fee-for-service world, doing this smacks of self-referral.

The issue of self-referral brings up another big hurdle for true vertical integration of health care: Providers that try to build a better, seamless, integrated system of care simply can't because doing so looks self-serving. Such efforts expose them to the real danger of running afoul of the ridiculously antiquated legislative rules designed to safeguard against self-referral in a fee-for-service world.

**Q.** *Let's turn our discussion to industrialization. Do you see that as inevitable?*

**A.** Absolutely. When anything starts to cost too much, people start to

measure the value of those costs. In the old days, many health care decisions were driven purely by clinical studies or by intuitive thinking based on the notion that in a technology-driven society, more is better. But beginning in the 1980s, the cost explosion in health care caused us to start looking at the value of what we are getting for so many exploding health care dollars. For example, what are we getting for all the additional technologies like the MRIs, the new chemotherapies, the additional lab tests? Are they worth it? How do we get optimal outcomes for restricted dollars? How do we balance quality and cost? These are the types of questions that other industries asked and answered decades ago.

One of the hard messages of managed care is that the quest for unlimited quality will result in diminishing returns for the effort, while generating ever higher, ever more unmanageable costs. That is not a tolerable situation for a society that has come to outspend the rest of the industrialized world on a per capita basis for health care by 50% to 100%.

**Q.** *Speaking of costs, you say in your book that managed care and industrialization have resulted in an unexpected bonanza for the pharmaceutical industry. Could you elaborate on that observation?*

**A.** Yes. Drug companies are extremely well positioned since everybody on the management side of health care works furiously to “rationalize” the delivery of medical care, or to find the optimization point that I just described. Traditionally, we haven’t had a health care system, but rather an illness care system. The clearest message of managed care—in theory, if not in practice—is that it makes more sense to invest in preventing illness and to treat a condition aggressively and early, before it has galloped out of control with the patient in an ER or an ICU, or requiring expensive surgery.

This theory has resulted in systems and efforts that reward the promotion of aggressive early intervention, which translates into more drugs—whether they are prescribed to lower patients’ cholesterol, manage their hypertension, or keep them out of the hospital. For managed care companies, this theory is

sound in principle and has worked well over a long period of time. This is why HMOs have always offered a more liberal prescription benefit, and it is one reason the elderly have been attracted to them as opposed to more traditional indemnity plans that have no drug coverage or higher drug copays. Many people who flock to HMOs have taken full advantage of this prescription benefit.

But the problems this causes for HMOs involve the precise nature of what we call the “economic offsets” associated with more aggressive medical intervention. Yes, more expensive drugs are really cheaper in that they lower total health care costs by keeping patients out of the hospital or lowering length of stay if hospitalization is required. But there are too many confounding variables involved, and HMOs don’t have the data resources or the intellectual capacity to measure

of that kind of economic window. Wall Street is breathing down its neck to make money now. As a result, it becomes difficult for HMOs to swallow the economic argument about investing to improve the health of plan members, many of whom will be in another company’s plan in five years anyway.

**Q.** *Health care is a fast-moving game, and the rules and players are constantly changing. Since you wrote your book, what has pleased you about your predictions in it and what has surprised you?*

**A.** I’m obviously most pleased that a few of my predictions have come true. I predicted with some relish but a lot of trepidation in the first draft of the book more than two years ago that PPMCs would dry up and blow away. I also predicted that pharmacy benefit management companies would prove to be a big waste of time, money, and ener-

**“The whole PPMC debacle that got us so far off track with this wrongheaded thinking is a classic example of Wall Street’s attention deficit disorder.”**

them, so they can’t relate increases in prescription cost to decreases in other kinds of costs. This puts HMOs in the problematic situation of paying some people in the organization to keep pharmacy costs low at the expense of increasing other health care costs.

The other problem is that the actual economic offset, or what I refer to as the pharmaco-economic benefit, tends not to show up in the short term. For example, getting a patient on an SSRI as opposed to a tricyclic antidepressant is much more expensive at managing depression on the front end, but downstream it results in better compliance, fewer hospitalizations for depression, and lower incidents of other primary care because the tricyclics aren’t as effective, aren’t tolerated as well, and so forth. But those economic benefits often won’t show up for two, three, or four years. A typical HMO does not have the luxury

gy for the pharmaceutical companies that acquired them, and that they would eventually divest them. I’m delighted to see that a lot of what I said in *Bleeding Edge* did in fact make strategic sense and that certain events that my analysis foresaw have come true.

What’s distressing to me is that much of the book’s greatest hope and call to arms—that is, the combination of physicians and facilities into entities able and willing to cut out HMOs and do direct contracting with employers and the government—is not gelling as quickly as I’d like it to. A number of setbacks have occurred in the last year or so that have caused these contractual integrations to occur more slowly than I would like. Even so, I believe that, by working together, physicians and their hospital colleagues will ultimately beat managed care at its own game.

—Edited by Paula Grant, in Lincoln, Va.

# Two Readers Seek Funding to Go Solo

By W.L. Douglas Townsend Jr. and Jill S. Frew

As the market for physician services continues to change, it is not surprising that so many physicians have questions about where to get capital to develop new operations. Recently, two readers in different markets wrote to say that they were leaving large organizations and wanted to know how to get capital to get started in solo practice.

The first question is from a 37-year-old internist in a 160-person multispecialty group just outside of Los Angeles. The group was breaking up due to some negative experiences it had with a large national physician practice management company.

## Leaving in Frustration

"After five years with this group, I'm leaving because my income is dropping, I'm frustrated by the organizational politics, I feel I have no voice, and I see no future," the physician wrote. Seeking to establish a solo practice in a medium-sized city in Southern California, the physician wanted to know where he could get a loan and what he would need to apply for one.

Getting start-up loans is not as easy as it used to be. Five to seven years ago, when reimbursement was much more generous than it is today, physicians could get loans for equipment and office systems simply on their signature. Banks were certain that future cash income would provide enough revenue to repay the loan and provide funds for other operations as well.

Today, however, reimbursement methods are being scrutinized and banks are

skeptical that the cash flow of physician practices will be sufficient to service the debt. As a result, banks are beginning to consider a physician's personal assets as a secondary means of repayment. The more concerned the bank is about the ability of your practice to survive in its market, the more it will insist that you pledge hard, marketable assets to secure your debt.

The best way to avoid pledging such assets is to have a well-developed business plan that, first and foremost, demonstrates that your market is underserved in your particular specialty. If you

operations in which physicians are employed. One reason for this failure to generate profit involves physician productivity issues when there is no longer the "eat what you catch" incentive that so many physicians operated under in solo and small-group practices.

Another reason for this failure is that institutional owners have not recognized the income value "money-losing physician networks" can bring in the form of stabilizing other parts of their business. Most organizations that have employed physicians would likely find that the losses sustained by employing

**Physicians should be aware that the current health care market makes starting a solo practice a risky venture, and banks, like physicians, are not risk takers.**

can convince the bank of such a market need, the argument that practice cash flow can service the debt will be plausible. Be aware, however, that the current health care market makes starting a solo practice a risky venture, and banks, like physicians, are not risk takers.

## Group Cut Loose

A similar question came from a 41-year-old female internist in Tucson, Ariz., whose group had been owned by a hospital but was being cut loose and the group members were splitting apart. "Some of us are moving away, and others are setting up our own solo or small group practices," the internist wrote. "How do you find capital to form a group in a market like this one that is heavily infiltrated by large HMOs and dominated by global capitation? It seems that no organizations—HMOs, hospitals, or PPMCs—can make money on physicians as employees."

It is true that many organizations are finding it difficult to make a profit by

productive physicians are less than the potential losses other portions of their business would suffer because of the lack of a cohesive physician network strategy.

Tucson appears to be a competitive urban market where there is pricing pressure on the managed care payers and on the local hospitals. The hard reality may be that the market is going through a dislocation as it tries to find a balance between premium income and provider costs.

In competitive markets, the weak are cast aside and the strong survive. If the hospital is cutting the physicians loose, it must have sufficient stability in the physician market and loyalty from other physician sources to allow the group to fall apart. You may need to move to a more rural or small-city market in which managed care does not have a significant presence. From what you describe, Tucson does not sound like a market well suited for an internist to open a solo practice. ■

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## NCQA to Collect Cholesterol Data From Health Plans

The National Committee for Quality Assurance is beginning to collect data on how well health plans manage patients with hyperlipidemia, according to executive vice president Cary Sennett, MD.

The nonprofit NCQA in Washington, D.C., which accredits managed care organizations, will include the cholesterol information in its Health Plan Employer Data and Information Set database, he said. Employers and consumers can access HEDIS data to determine how health plans measure up in terms of patient care and customer service. Some employer purchasing coalitions and some states have used the data to compile reports on health plan performance.

Starting this year, health plans that submit to the voluntary NCQA accreditation process will be asked to report on whether low-density lipoprotein (LDL) cholesterol was measured for cardiac patients within 60 days to one year of hospital discharge. Patients, 18 to 75 years of age, would have had to be continuously enrolled in the plan for at least two years and have a history of myocardial infarction, bypass operation, or angioplasty within the past year.

Next year, the plans will have to show improvement in patient outcomes as a result of more focused cholesterol management. The plans will be asked to document that LDL among

these same cardiac patients was reduced to less than 130 mg/dl within 60 to 365 days of discharge.

The LDL measure was chosen because there is strong evidence that curbing LDL reduces adverse events and death, and because there is wide variation in how health plans manage patients with high cholesterol and other cardiac risk factors, Sennett said.

One NCQA study of 1997 data from 250 health plans found that two of every five patients who had a heart attack were not being given beta blockers. In some plans, 80% of patients were given these life-enhancing drugs, while in others, only 20% to 30% received beta blocker therapy, Sennett explained.

So far, Sennett said, he knew of only one health plan—Group Health Cooperative of Puget Sound—that was actively profiling its members' cholesterol levels and using the data to manage care. But, other plans could be doing so as well, he said.

The effort to get cholesterol management and other patient care data out to the public is faltering, Sennett noted. In 1998, 450 health plans gave data to the NCQA, but one-third barred the organization from making that information available to the public. There had been an increase in 1998 in the number of plans wanting to keep data out of the public eye, Sennett said. (Source: Reuters Health)

## Pap Tests Cut Invasive Cervical Cancer Rates

The ratio of invasive to *in situ* cervical cancer has decreased by about one-third in Medicare-eligible women since Medicare began to cover Pap smear testing, Frederick Montz, MD, told the 35th annual meeting of the American Society of Clinical Oncology in Atlanta in May.

Montz and colleagues from Johns Hopkins University examined the California Cancer Registry for cervical cancer incidence between 1988 and 1990 and between 1991 and 1995. The study periods included the three years prior to and the five years after Medicare began paying for Pap smears.

The statistics show that during the three years prior to Medicare funding for Pap tests, 21 out of every 100,000 women over the age of 65 had invasive and 14 had noninvasive cervical cancer. In the five years following Medicare funding for Pap tests, 18 women in 100,000 developed invasive cervical cancer while 17 in 100,000 developed *in situ* cervical cancer. (Source: Reuters Health)

## MedPartners to Pay \$12 Million Under Agreement With CMA

The California Medical Association reached an agreement with MedPartners in May to ensure payment to physicians who treat patients enrolled in MedPartners' bankrupt California unit, MedPartners Provider Network. The agreement called for MedPartners to place \$12 million in a California account that would be used to pay fully adjudicated claims made by physicians who have contracts with medical groups affiliated with MedPartners or provide services to such groups. The physicians were to be paid within two days of when the medical groups received the funds. The medical association said that an additional \$12 million was to become available on June 4, provided that the medical groups receive their capitation payments from MedPartners on time.

Jack Lewin, MD, executive vice president of the association, in San Francisco, said the agreement was important for those interested in preserving continuity of patient care. The CMA had heard from many physician specialists who had not been paid since well before the March 10 bankruptcy.

Lewin noted that the current agreement is a short-term solution. A long-term solution is being addressed in the association's current negotiations with MedPartners regarding existing unpaid claims and future claims.

In May, MedPartners announced that the California Superior Court approved an agreement between the state and MedPartners that allows MedPartners to proceed with its plans for the disposition of the operations of MedPartners Provider Network. A state-appointed monitor will oversee the bankrupt network and maintain certain operational controls, pending approval by the U.S. Bankruptcy Court of a definitive settlement agreement. (Source: Reuters Health)



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July 15, 1999



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