

PHYSICIAN PRACTICE OPTIONS™

August 15, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Consider Capacity, Group Chemistry When Adding a Partner

How do physicians in a group practice know when to add a partner? And, if adding a partner is deemed to be the answer to a problem the practice faces, how does the group structure the agreement to meet the needs of both the group and the new physician?

By building larger groups in order to be more viable in managed care markets, many physicians today are asking these questions. Given that larger groups have more marketing clout and can more readily afford the information systems needed to compete effectively, many physicians in solo practice and in small groups are considering the implications of adding partners.

"Physicians today say they feel as though they are being paid less while being asked to accept more in terms of administrative burdens and pressure to work faster," says Debi Croes, a partner in the Croes-Oliva Group, practice management consultants in Burlington, Mass. "This feeling of being overwhelmed can lead them to think that more doctors are the answer."

Market Growth

Adding a physician may provide some relief for an overextended physician or a small group. "But you need to ask why you need an associate before you invite someone to come on board," Croes advises.

"If, for example, you plan to retire in 10 years and you want to get the value out of your investment," Croes continues, "adding a partner may be a legitimate

strategy. If, however, you want to build the practice so you can sell it, that's a different strategy. Under this strategy, you would want to add associates, not partners, to build volume and revenue without giving up ownership. Or, perhaps you're not overtaxed, but you want to bring in a partner because you think doing so will help you to win new contracts, or because you anticipate your practice will grow because of housing developments or new factories being built in your community."

Such scenarios are examples of opportunities to capture greater market share, and adding a partner may give a practice the advantage it needs to compete effectively. To know whether adding a physician is the proper strategy, the group must examine information related to group capacity and market demand. Do the numbers of patients seeking care support the decision? To determine this answer, the practice needs to use market data to project reasonable patient volume, and then to compare these data with group capacity. How many patients does the practice currently serve? How many hours do providers spend treating patients, and what revenue is produced as a result? Is the practice staff near the limit of its ability to handle patient volume so that additional labor is an issue? Or could the practice eliminate inefficiencies? Most important, could the practice generate enough additional income to support a new partner?

Numbers tell the story for Nancy Levitt-Rosenthal, vice president of health

(Continued on page 8)

Introducing a Column on Managed Care Theory

In this issue, we are publishing the first in a series of columns on how managed care is evolving. The column, "Managed Care Theory," begins on page 4 and is written by Douglas W. Emery, a consultant in Salt Lake City who specializes in developing systems of care built on the episodes of care model. The president of Zoadigm Health Systems Inc., in Salt Lake City, Emery is also the editor of *Global Fees for Episodes of Care: New Approaches to Healthcare Financing*, published this year by McGraw Hill.

In his first column, Emery explains how managed care is evolving toward a model built on episodes of care. He argues that the concept of episodes of care is attractive to physicians because it offers less burdensome regulatory and capital requirements and because it separates health care from health insurance. In traditional managed care settings, executives say they are managing care, when in fact they are paying for care through an employer-financed reimbursement system. As Emery argues, they are managing the physicians who provide care not the care itself.

In future issues, Emery will write about physicians and health systems that are using episodes of care to build more efficient health care systems. Also, on occasion, Emery will write feature articles for the newsletter.

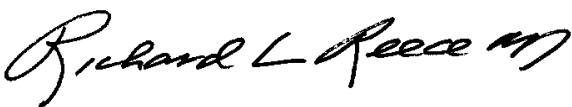
A Funny Thing Happened...

Also in this issue, we have an article that resulted from an interview I did with Patch Adams, MD, who became famous this year when Hollywood made a movie about him. After I saw the movie, *Patch Adams*, the story about an unusual family practitioner in Arlington, Va., who has labored for years to build a free hospital named *Gesundheit* in the mountains of West Virginia, I decided to interview Adams.

In seeking to build his own hospital, Adams chose the ultimate practice option: Take all patients, charge no fees, accept no third-party reimbursement, refuse malpractice insurance, and have fun. He may be eccentric, but Adams is making his dream of building that hospital a reality.

In preparing to write this story, I learned that interviewing Adams doesn't happen easily. When I called his office, his assistant said he was terribly busy and would not consent to be interviewed until I read his book, *Gesundheit!* (Rochester, Vt.: Healing Arts Press, 1993) on which the movie was based. When I called back a week later after having read the book, I was informed that Adams was so busy raising funds for the hospital, he wouldn't be able to do the interview.

Figuring Adams might be a kindred spirit, I asked again. But this time, my request was couched in the form of a 15-line poem in rhyming verse that I composed and sent to him by fax. The following week, the phone rang and I heard a voice say, "This is Patch. Let's do it now!" The resulting article, "Patch Adams Breaks New Ground," is on page 3.



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Patch Adams Breaks New Ground

By Richard L. Reece, editor-in-chief

Managed care is to the nation's health care woes as *El Nino* has been to worldwide weather calamities: Both have been blamed for unwelcome, far-reaching changes. Most recently, the decrease in the amount of charity care being given by doctors and other health care providers is being blamed on managed care's cost-cutting strategies. Earlier this year, the *Washington Post* published an article saying "managed care systematically erodes physicians' willingness to treat people without insurance or money." The *Post* article was reporting on a recently published article in *JAMA* that looked at the sources of physician income and their relationship to charity care.

For Patch Adams, MD, however, charity care is not affected by the turbulence of managed care. The physician behind the movie of the same name, Patch Adams, is a graduate of the Medical College of Virginia (MCV). He began his medical career as a pediatric resident before going into family practice in a communal setting. For the past 28 years, he has been a self-described "social revolutionary" in pursuit of a vision of medical practice that embraces free care and is free of third-party insurance and malpractice cases against physicians.

Well known today as a result of the recent movie *Patch Adams* starring Robin Williams, Adams says the movie is not entirely accurate. "Hollywood never copies biography," he says. "But it isn't me who is important anyway, but rather the ideas that I'm about: being compassionate, generous, and funny in the context of providing joyful service."

The release of the film has helped Adams to get the recognition, and the financial means, to break ground this year for building his hospital, named *Gesundheit*. He plans to open the facility within four years. But breaking ground on the physical building is not the only form of ground breaking in which Adams is involved. Spreading the word about his hospital and his vision for it has resulted in several thousands of doctors and nurses a

year saying that they would come to work at his hospital for free. "That's another kind of breaking ground," Adams says.

"We live in a country where most people cannot get the kind of care that they need," Adams continues. "So there is an overwhelming need to alleviate so much suffering and we are unable to deal with

children of a happy life," he continues.

Playfulness, fun, and clowning will be evident in Adams' hospital. "Gesundheit will have many surprises, places of mystery, and secret passageways," he says. "It'll be a Disneyland, a Monty Python kind of place, and in order to work there full time, a person will have to be funny."

"It isn't me who is important, but rather the ideas that I'm about: being compassionate, generous, and funny in the context of providing joyful service."

—Patch Adams, MD

even a tiny fraction of it. The movie has made me a star. And it has sparked an interest in the humanitarian aspects of medicine. For example, MCV, which hadn't done much to recognize me in the past, recently created an annual Patch Adams award for the student who is considered the most compassionate. However, I'm less interested in having my name attached to an award than in having some formal and wonderful recognition of compassion because I'm far from the first—and in fact just one of many—who loves the practice of medicine and loves to serve humanity."

Adams communicates his love of medicine and service to humanity through unconventional behavior; that is, by clowning. "The clown manner is not really different from the bedside manner," Adams explains. "You bring love and tenderness and humor to a person who is suffering with the hope of relieving that suffering. I love my clown character more than I love any of my other selves. And I've done him for years. I've clowned in Bosnia for people at war. I've clowned for men on death row who were later hung. I've even taken people who have no clowning experience, including doctors, to Russia to get a chance to find their playful, fun-loving selves.

"I believe that love and fun are the

Not surprisingly, Adams' unconventional medical demeanor will be reflected in *Gesundheit's* unusual hospital setting: 310 acres in West Virginia, a land of waterfalls, a four-acre lake, and a mountain of hardwood trees.

It took him 14 years to get the first donation for his hospital, Adams says. But now, the publicity that has come following the movie has changed the situation dramatically. Is he afraid the notoriety will contaminate his dream? "Anything having to do with celebrity is anathema to me," Adams says. "People see the movie and they think they know who I am. Yet, the character in the movie isn't who I am or what I'm all about."

So what is Patch Adams all about? "I live the life of a person who believes that things can happen differently and I work all the time at it," he explains. "I can't remember the last time I did something I didn't want to do."

If the future of charity care in this country can be gleaned from the results of the study reported in *JAMA*, Adams and his colleagues at *Gesundheit* will have much (clowning) work to do and many to do it for. The *Post* article says the number of people without medical insurance has grown steadily throughout the 1990s, to a total of 43 million today.

—Edited by Paula Grant, in Lincoln, Va.

The Advantages of Episodes of Care

By Douglas W. Emery, MS

For physicians who seek to gain greater control over how health care is delivered in their communities, experts commonly suggest that they either form their own health plans or organize integrated delivery systems (IDSs). But because of the problems HMOs and IDSs have had over the past three years, physicians may find it unwise to develop their own organizations built on these models. Moreover, because the business logic of insurance and of care differ categorically, physicians might be well served to recognize that this type of organizational format does not necessarily serve their best interests or those of their patients.

A more conservative and sustainable strategy involves organizing around clinically integrated episodes of care (EOCs). Many physicians find this strategy attractive because it is far less burdensome in terms of regulatory and capital requirements, and because building operations around EOCs keeps doctors in the business of health care rather than the business of health insurance. There is another compelling reason as well: As a business plan, organizing to sell care through clinically integrated EOCs conforms more naturally with what is becoming an information-based health care system based on consumer choice.

The Theory Behind EOCs

The theoretical concept behind EOCs was first developed by Jerry A. Solon, PhD, a health care researcher, and his colleagues in 1967. At the time, Solon and other health services researchers were concerned that the traditional indices used to measure care processes did not fully reveal the underlying processes governing medical resource utilization. In

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their seminal paper, "Delineating Episodes of Medical Care," published in the *American Journal of Public Health*, the researchers collected the thinking of the time, observing, "The summary statistical data used to describe the medical care received by a population usually take the form of (1) stating how many in the population have obtained medical services in a given period of time (the volume of users), and/or (2) expressing the volume of services in terms of the number of physician visits made, the days of inpatient care provided, the number of x-rays, lab tests, medications, physical therapy treatments, and so on. These culminations are valuable in so far as they represent, in an overall way, the sheer volume of service. But their very simplicity, their objectivity, and

Episodes of care are integrated units of accountability that can illuminate all activities related to health care.

apparent precision are deceptively reassuring. There is much more to tell of medical care than these superficial counts reveal."

Modern managed care, and particularly capitated managed care, has collected reams of summary statistical health care data. But as Solon noted over 30 years ago, such summary data create the illusion that utilization is genuinely understood when, in fact, health care utilization is not. Therefore, a unit of analysis that more closely matches the natural history of patient care was required that would give full expression to the reality of medical care.

A substantial body of scientific literature has built on Solon's pioneering work. Information systems have greatly advanced since then (producing new EOC-capable technologies), and a growing consensus is emerging that the EOC is not only a superior unit of analysis for understanding care processes, but a superior method of payment and delivery as well.

So what, then, is an episode of care? In my new book *Global Fees for Episodes of Care*, Michael Pine, MD, a health care researcher, and I summarized 30 years of literature on the topic so that an EOC can be defined as: the complete, self-contained sequence of medical interventions between a patient and providers of health care services in pursuit of a defined clinical objective over a specified period of time. This definition holds for both acute and chronic episodes.

Three Views

The EOC was conceived of and developed as a holistic, unifying concept that circumscribes every service, and only services required to diagnose and treat each well-defined health problem. It organizes

medical reality into a social unity of three critically important viewpoints:

1. The episode of illness patients experience
2. The episode of disease that health care providers treat
3. The episode of medical services encountered by the health care financial system

For a patient, an episode of illness begins with the onset of symptoms associated with clinical illness or with the loss of a sense of physical or psychological well-being. The episode of illness continues until its manifestations disappear or stabilize as a result of cure, remission, palliation, control, or death. Episodes of illness can be short and self-limited, such as upper respiratory tract infections, or they can be chronic with potentially serious sequelae, such as diabetes mellitus.

Traditional medical models define clinical outcomes solely from the clinician's perspective. In contrast, episodes of illness

acknowledge the essential role of the experiences and objectives of patients in justifying the existence of organized medicine. Patient satisfaction surveys that focus on EOCs rather than on the general performance of health plans not only make more sense, they also reinforce the fact that the primary product or output of health care is the cessation, palliation, or control of illness from the patient's point of view.

An episode of disease describes a patient's illness from the clinician's point of view. To care for patients effectively, clinicians construct cognitive models of the etiologies and natural histories of illnesses. These constructs incorporate pathophysiological manifestations and probable responses to alternative interventions. They also encompass periods of time when patients are free of symptoms and may consider themselves in excellent health.

When patients present with perceived episodes of illness, clinical care begins by establishing diagnoses that classify illnesses in terms of these cognitive models. Care continues by using these models to guide clinical interventions designed to alleviate patients' symptoms and eradicate or ameliorate their underlying causes. When no episode of illness is perceived—such as when patients have asymptomatic hypertension, ischemic heart disease, or prostate cancer—clinicians still may diagnose and treat an episode of disease based on physical signs and laboratory determinations. The fact that an episode of disease can progress in the absence of an episode of illness both explains and justifies the importance of preventive care and screening.

Episodes of medical service encompass all activities that trigger resource consumption and bundle them into discrete units of analysis. Therefore, an EOC can be described from the perspective of any economic entity (whether patient, provider, or payer) responsible for the financial or clinical management of care.

From a patient's perspective, an episode of service encompasses specified out-of-pocket costs and certain health care services related to a specific episode of illness. From a provider's perspective, an episode of service encompasses costs, accounting, and outcomes associated

Organizing around episodes of care is attractive to physicians because it has less burdensome regulatory and capital requirements, and it keeps them in the health care business as opposed to the insurance business.

with a collection of clinical processes related to a specific episode of disease. From the payer's perspective, an episode of service encompasses the fees (whether itemized, global, or prepaid) and the attendant outcomes associated with a collection of related health care services.

EOCs encompass not only the care of illness, but also the maintenance of health in the absence of illness. In this context, an episode of preventive care reduces the likelihood that illness will occur, thereby avoiding future, more costly EOCs. If this approach were to succeed and become commonplace, resources would be shifted from the diagnosis and treatment of disease to the prevention of illness. While the health care system is a long way from such a fundamental shift, prevention of illness is of great importance and should be pursued vigorously. One way to accomplish this goal is for insurance plans and physicians to collaborate on creating panels of preventive and health maintenance episodes, such as inoculations, mammograms, and chronic disease care management.

While the EOC generally is accepted as an organizing principle for acute medical and surgical services, some executives are skeptical about applying it when patients have chronic conditions. This skepticism is due, in part, to a tradition that regards episodes as fragments of hospital care and, in part, to a limited view of the full scope and intellectual content of the concept. But as Neal Friedman, MD, medical director for disease management at Lovelace Health Systems, in Albuquerque, N.M., has said, "Because of its comprehensive nature, the EOC approach appears promising as the basis for a disease-specific clinical practice improvement program that uses 'systems thinking' to advance health care reform and minimize the total cost of illness."

Properly construed, EOCs become a conduit to channel both information and money. They are integrated units of accountability that can illuminate all activities related to health care and support systematic market discipline. EOCs bind patients, providers, and payers.

Phases of Care

Individual EOCs can be divided chronologically into three phases: diagnosis, therapeutic intervention, and follow-up. These phases are linked to patient factors, process factors, and outcome factors. During the first phase, diseases are identified, and severity of illness is assessed. During the second phase, care is delivered as a sequential series of interrelated processes that can be standardized and improved, and which depend on the various paths that may come as a result of the diagnostic work-up. In the follow-up phase, outcomes are evaluated in terms of clinical and functional status, resources consumed in care, and patient satisfaction. These phases may proceed simultaneously at times, as when diagnostic and therapeutic phases overlap or when outcomes of chronic diseases are assessed during treatment.

As a model for reforming managed care, the EOC constitutes a powerful leveraging concept for instituting physicians as the managers of care while leaving HMOs and other payers in the business of health insurance. As a natural unit of exchange, episodes mark the way for creating a more efficient means of allocating risk and determining value in terms of processes and outcomes.

Editor's note: This article by Douglas W. Emery, MS, is the first in this new column focusing on how managed care is evolving in the United States.

New Physicians Eschew Managed Care

Newly graduated physicians consider a number of factors when deciding where they want to practice. Research has shown that earning opportunities, quality of life, levels of affluence and education in a community, and prior contact with the area can influence their location choices.

Recent research sheds light on how managed care enrollment levels affect new physicians' career choices and what that could mean for the future of health care. Jose J. Escarce, MD, PhD, and his colleagues, studied the effect of HMO penetration on practice location for new physicians who finished graduate medical education between 1989 and 1994. The research was published in an article, "HMO Penetration and the Practice Location Choices of New Physicians," in the November 1998 issue of *Medical Care*. Escarce is a senior scientist with the RAND Health Program in Santa Monica, Calif.

In 1989, at the beginning of the study, the researchers found that new generalists were more likely than new specialists to seek areas with high levels of enrollment in HMOs. But by the end of the study period, the proportion of both generalists and specialists who selected high HMO penetration areas had decreased, leading the authors to speculate that there were fewer jobs or that growing numbers of physicians simply wanted to avoid managed care altogether.

"Over the last several years, many articles have been written on doctors' attitudes toward managed care," says Escarce. "In many of the studies, physicians expressed a great deal of satisfaction with managed care. On the other hand, an undercurrent of discontent seemed to be surfacing."

Seeking the reasons for the discontent, Escarce's team identified physicians who finished their most recent residency or fellowship between 1989 and 1994, and then narrowed that group to 75,081 physicians who were practicing patient care two and a half years after completing their graduate medical education. They

focused on 98 metropolitan areas in the United States that in 1994 had more than 500,000 residents. HMO penetration in these metropolitan areas averaged 19% in 1989, and ranged from 1% to 46%. By 1994, HMO penetration in the metropolitan areas had grown to 27%, and ranged from 0% to 61%.

Using a statistical model, the researchers analyzed decisionmaking by taking into account not only the characteristics of the area that the physician actually chose, but also the characteris-

tors also seemed to steer clear of the most mature managed care markets.

Escarce's team believes there are two explanations for the decreasing proportion of new physicians who chose areas with high HMO penetration: lack of jobs or dissatisfaction with managed care.

"We can't distinguish between those two explanations because the doctors' behavior would be the same under both circumstances," says Escarce. "We do, however, speculate on other evidence and studies we looked at, such as HMO

"As HMO methods for curbing costs and controlling utilization took hold...specialists went elsewhere."

—Jose J. Escarce, MD, PhD, RAND Health Program

tics of all the other areas that the doctor did not choose. "That is the important feature of the study model we used to analyze decisionmaking," explains Escarce. "If all the cities were the same in terms of size, education, income level of the population, and so on, and the only thing that differed among them was the level of HMO penetration, how would doctors distribute themselves across those cities? That is what we were able to answer with this model."

Love It or Leave It

At the beginning of the study, new generalists were more likely to settle in areas where HMO penetration was higher. As for specialists, the level of HMO penetration seemed to have little if any effect on choice of location. "This finding squares with the notion that HMOs increase the call for generalists' services compared with the demand for specialists' services," notes Escarce.

"But by the end of the study," he says, "all things being equal, specialists were much less likely to locate in cities with high HMO penetration and generalists were slightly less likely to do so." The team also found that by 1994, new doc-

recruiting patterns and physician supply-and-demand figures. We believe that for specialists, the decision to avoid high HMO areas was due to lack of work. As HMO methods for curbing costs and controlling utilization took hold, there was less demand for specialists' services, and they went elsewhere.

"But for generalists, we are less sure," Escarce admits. "It is possible that cities with a lot of HMOs did have jobs for generalists—meaning nice jobs with good pay—but that they preferred to look for jobs with good pay in cities with little HMO penetration. That is speculation on our part, using evidence from other studies."

The team theorized, for example, that since medical school training rarely prepares physicians for HMOs' style of doing business—financial risk-sharing, aggressive contracting, and imposed patient-care guidelines—they shun heavily saturated managed care environments.

Indeed, medical schools may play a highly influential role in the selected practice location. In an article in the March 25 issue of *The New England Journal of Medicine*, Steven R. Simon,

MD, and colleagues found “that negative views of managed care are widespread among medical students, residents, faculty members, and medical school deans.”

Presumptions aside, the message is clear: The practice of medicine may become less attractive over time. “Clearly HMOs are having a major impact on doctors’ opportunities for having a satisfying medical practice and career,” according to Escarce and his colleagues.

“This trend has important implications because much geographic variation in the extent of HMO and other types of managed care still exists,” continues Escarce. “If managed care continues to grow and spreads nationwide, particularly with fairly restrictive arrangements, the opportunity to find practice jobs and set up practices in areas with low HMO penetration will increasingly disappear, a trend that could lead doctors to question the attractiveness of the medical profession as a whole,” he concludes.

Midcareer Changes

In addition, a wave of discontent seems to have washed over “established” physicians, those who began medical careers under fee for service and who are now working in managed care systems. For some, the transition has been rocky, leading growing numbers to make mid-career changes.

“Doctors who I’m talking with these days seem to be influenced by the instability of the business arrangement they find themselves in,” says William W. Fore, MD, senior vice president for medical affairs for FirstHealth of the Carolinas (FHC) in Pinehurst, N.C. When practice management companies acquire practices and then either do a poor job of managing the day-to-day affairs or leave the business altogether, physicians are left to develop their own practice strategies, and in many cases, they are left unemployed.

“The growth of HMOs eventually may affect established physicians’ decisions to relocate their practices, modify their practice scope, or give up patient care,” Escarce says. Yet, such trends do not necessarily mean managed care is bad, he adds.

Physician Moves to a Smaller Group

Making midcareer changes, some physicians have moved away from what they consider the intrusive and unpleasant aspects of managed care in favor of a less complicated situation in an area where HMOs do not dominate. One of these areas is Pinehurst, N.C., which has a mild climate and where managed care has had a minimal effect to date. “In North Carolina, managed care contracting is between 10% and 15%,” says William W. Fore, MD, senior vice president for medical affairs for FirstHealth of the Carolinas (FHC) in Pinehurst, N.C. “But in our area specifically, we’re less than 5%. We don’t have any at-risk contracts in our area at all, just some managed fees.”

A less complicated business arrangement, warm weather, and friendly people attracted Marvin H. Williams Jr., MD, and his family to Pinehurst and FHC. A family physician, Williams was in private practice in Cincinnati when the influx of managed care, and growing concerns about surviving in solo practice, led him to join a group practice of seven family physicians. This practice soon became part of a group of 60 primary care and specialty physicians that merged again—much to Williams’ dismay—to join some 1,200 doctors, assembled and managed by a multihospital corporation looking for an edge in Cincinnati’s competitive managed care market.

“Trying to manage a group of 1,200 became very impersonal,” says Williams. “The physicians on the bottom had little input or influence in the management and decisions regarding the practice and care of their patients. That’s when I decided to leave the area.”

Williams and his family had vacationed in Pinehurst and planned to retire there. “When we decided to make a change, we contacted FirstHealth to see what the medical needs were in the community,” he says. “There was an opportunity to join the group here, and I did.”

Some of Williams’ medical friends and colleagues have made similar moves by leaving large metropolitan areas and the constraints of managed care in search of professional autonomy and job satisfaction. “My sense about the physicians in practice in Cincinnati when I left was that there was growing dissatisfaction with the practice of medicine under that system,” Williams says. “Many people I knew were planning to retire earlier than they had anticipated.” —LGC

“Those who think HMOs are the way to go, and that managed care is great for delivering medicine in the United States because it squeezes out inefficiencies and provides good-quality care at low cost look at our study and say it shows that the system is working exactly as it should,” Escarce says. “We have too many specialists, and HMOs are keeping more from coming in. And the generalists are pretty much in balance.” The physicians who feel forced to change, however, may view managed care negatively.

The chief concern about these trends, Escarce says, is that over time medicine could become a less attractive profession. “It doesn’t necessarily have to go that way,” he says. “We’ve seen ups and downs

before. In the late 1980s there was much hand-wringing about medicine becoming an unattractive profession because the number of applicants declined. Many medical educators were concerned that medical schools would have to accept students who were less qualified.

“Fortunately, that trend turned around quickly,” Escarce says. “A few years later, the number of applicants rose again. These trends are hard to predict and much depends on what is happening in other sectors of the economy. The danger, however, is that medicine could become less attractive to the ‘best and the brightest,’ which would be bad for everyone.”

—Reported and written by Lisa Gilson Clancy, in Hopkinton, N.H.

(Continued from page 1)

system development for Greenwich Hospital in Greenwich, Conn. Levitt-Rosenthal works with physicians who are either employed by a primary care practice affiliated with the hospital or in independent practice. "When we started a practice with one of our physicians, we projected what his revenue and volume were expected to be for every month over many years," she says. "We measured his performance against the projected monthly revenue and volume, and found that he was consistently performing above projections. There was a continued pattern of growth over time, not just an aberration for a month or two. That tells us it's time to bring in a partner."

Area medical societies or hospitals often can help physician practices make reasonably accurate market projections. A practice also can use existing resources, such as accountants, to make financial projections based on past history and projected market growth.

After a practice has captured such data, practice management consultants can help it assess its capacity and review its internal systems to decide if an opportunity exists to do more without adding a partner. Perhaps the group needs to realign tasks to make better use of provider resources and expertise. More efficient patient-visit planning and streamlining operations can result in smoother work flow, enhanced employee morale, an expanded patient panel, and greater patient satisfaction. All of these changes can be made without adding a partner.

If the group decides a new hire is appropriate, it might add a physician extender rather than a full-time physician. "A nurse practitioner or a part-time physician may be the answer," Croes says.

The Right Chemistry

Apart from capacity, the practice's workplace style is another key factor to consider when taking on a partner. "A partnership is like a marriage, and you want to marry the right people," says Croes. Chemistry and cultural fit are essential. Does the new person share the same work ethic and clinical philosophy? Is that person comfortable with how decisions are made in the practice? "Hiring someone

Practice Adds Partner After Three-Year Trial Period

Baystate Ob/Gyn Group Inc., a group practice with offices in Springfield, Mass., believes firmly in the value of a three-year partnership track. Six physicians, four midwives, and two nurse practitioners work out of four offices in Western Massachusetts. When Richard Molenaar joined as practice administrator seven years ago, the group had only one site and four doctors.

"A key element for us is finding individuals who mesh, in terms of their chemistry, with the physicians in our group," says Molenaar. "We're fortunate in that our physicians practice at Baystate Medical Center, a teaching facility in Springfield. So they get to work closely with the residents; in fact, we've recruited partners from that group. Still, we start them out on a three-year partnership track to be sure working together is a viable option, and that the chemistry is there."

Shortly after Molenaar arrived, the group brought in a partner to help build the practice in an underserved area near South Hadley, Mass. "We had reached the saturation point in our Springfield office and we wanted to expand," Molenaar explains. "The Medical Center was willing to sublease office space to us there, and so we added a physician and a site at the same time."

The new recruit was hired with a three-year guaranteed salary that increased by \$10,000 each year. She was treated as a partner, sitting in on all financial meetings and being privy to all practice information. At the end of three years, the senior physicians voted to accept her as a partner, and she agreed.

To become a partner, the new doctor had to purchase a certain amount of stock from each existing partner, plus buy into a share of the group's real estate obligation with graduated payments over time. She no longer collects an automatic salary, but, like a full partner, shares equally in the draw for each pay period.

—LGC

cold and bringing that person in as a partner is like marrying a stranger," she says.

No group should add a partner without having worked with the physician over time, Croes says. "The practice needs to employ that person for at least three years," she says. "At the end of that period, the owning entity votes up or down, and if it's thumbs up, the would-be partner can say yea or nay."

In three years, the group will get to know the physician thoroughly. Such a trial period is particularly important if the physician is a recent graduate. "It takes time for new graduates to build their competency in terms of productivity," Croes says. "What's more, all new physicians should have to prove themselves to be a good fit."

Often, after having worked together for some time, the new physician and the group decide that they do not fit well together. "The success of bringing on a

partner has less to do with structuring the right deal from a financial perspective," says Croes. "It has more to do with fit in terms of practice culture and values, which are the major reasons why partnerships fail."

During the trial period, some practices offer associates compensation packages with bonuses for exceeding productivity goals. "If you really want to motivate this person to be on a partnership track, you could even set aside part of the bonus and apply it toward practice purchase," Croes advises. If the senior partners decide not to offer partnership at the end of three years, any bonus that has been set aside can be returned to the associate.

The number of scenarios groups use to add new partners is endless. "Let's say you're ready to add an associate because you're doing 150% of the work you used to do," explains Croes. "On the day your associate starts, there isn't 200% work yet, but you now have 200% capacity. You

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could actually wind up spending time and money to subsidize that person for 18 months, and it could take you the entire three-year trial period before that person is productive, making money and paying you back for the investment you made. And now your associate is going to become your partner." To cover their initial investment in training, some physicians may ask the new associate for a buy-in fee to join the partnership.

Also, the converse may occur. "Let's say the person began making money for you after only 12 months," Croes says. "By the end of three years, you might have made \$200,000 on your associate's hard work. Then, you might be willing to say, 'You earned your way. You're a partner.'"

Buy-in Formulas

When the group is ready to add a partner, it needs to address the buy-in arrangement, which includes setting a valuation of the practice. Again, a wide variety of scenarios is possible.

Some practices use formal buy-in arrangements that include a combination of cash and stock. Other groups simply make the newly hired physicians work harder, such as by having them work more weekend or evening hours, before making them a partner.

In all cases, there is room to be creative. The group should explain what it is willing to pay in salary and might ask the new hire to meet certain productivity goals. If the new physician can generate a certain amount of revenue in the predetermined time, the group might consider that revenue to be equal to what it would cost to buy into a practice. If the physician cannot generate this amount, the practice might ask for a cash payment.

Regardless of the formula used, Croes advises groups to complete a practice valuation before taking on a new associate. Practices should understand their value in terms of tangible assets—such as equipment and real estate—and intangible assets, which financial professionals sometimes call goodwill. Setting a value just before an associate starts means that if the practice has a valuation done years later, it will have a baseline figure to use for comparison, allowing the practice to

Flexibility Helps Make Part-Timers Effective Staff Members

For many physician groups seeking new hires, it may be easier to find someone who wants a part-time rather than a full-time commitment of 40 or more hours per week. Yet scheduling part-timers can be difficult, says Nancy Levitt-Rosenthal, vice president of health system development for Greenwich Hospital in Greenwich, Conn. "When patients call, they want their doctor there because they want continuity," she says. "There are also on-call issues. These are dilemmas that don't go away, even if two part-timers share a job."

Physician practices may need to be flexible to accommodate new hires who want part-time work. Today, both women and men are seeking workplace flexibility so they can have time for young children or other interests. "I know of one practice that cannot recruit and keep young female physicians because it has no cultural acceptance of anything less than full time," says Debi Croes, a partner in the Croes-Oliva Group, practice management consultants in Burlington, Mass. "These female physicians are women who are balancing careers and families. Yet, there is no alternative track in this practice. And the members of the group wonder why they can't retain their women physicians who they feel are clinically excellent."

To attract and retain part-time professionals who can add tremendous value to an organization, Croes suggests practices define "part-time" in specific terms. The practice should state how many patient-care hours a part-time provider must work each week, and set on-call and vacation policies.

Giving the choice vacation weeks to the more senior, full-time people, for example, isn't necessarily a negative policy because "people are free to accept or decline," Croes says. "But assuming that you can take school vacation weeks off only to learn that you can't could create a lot of ill will. Whereas, if policies are articulated up front, such as policies for maternity leave, people are able to make good, informed decisions."

Since lifestyle issues have become important, many young physicians seeking to balance family and career commitments are choosing to be employed in hospitals and other settings where the work hours are more predictable than they are in a group practice. "The perspective of being in private practice has changed," Levitt-Rosenthal argues. "Years ago people graduated from medical school and expected to hang up their shingle, work hard, and be busy and successful. Expectations for new graduates are different and varied now."

—LGC

measure a new associate's contribution over time. In this way, both sides can reach equitable buy-in terms.

A valuation done early also is in the best interests of would-be partners. "If I were buying in as a partner, I would want the practice valued on the day I started my three-year track," Croes says. "If the practice is worth more at the end of my three years, I've already paid for that in part. I helped build that equity. So why should I have to pay for it again?"

Finally, Croes advises that not all med-

ical school graduates want to practice on their own. "I see more young people who want to be good physicians, but they want a job, not a partnership," she says. "If you decide to expand your practice, you may find you have plenty of recruits but none who wants to be a partner. It's a new phenomenon. The idea of partnership and ownership is an historical one. I'm not saying that it's one that's dead, but rather that it isn't necessarily a given."

—Reported and written by Lisa Gilson Clancy, in Hopkinton, N.H.

What to Consider If Courting a Partner

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

The dynamic and evolving health care industry is presenting strategic and financial challenges to physician groups nationwide. The imperative for groups to broaden their market positions and enhance negotiating leverage is becoming ever more significant. Unless your group decides simply to retrench and hope for the best, it is likely it will need to find a partner at some point to provide capital, or management infrastructure, or both.

Before entering a partnership, physician groups should prepare themselves for the courtship process by taking as many steps as time and resources allow. The following recommendations for such preparation are divided into two categories: The first seven address issues related to management; the next six address issues related to the partnering process.

Develop a business plan. Such a plan helps to show potential partners that the group is committed to the enterprise going forward. The plan should include a description of the group's market, strategy, financial results, and strengths. It should also explain how the group is addressing its weaknesses.

Develop a track record and potential for growth. Showing a history of being able to expand market share and having a plan to continue such expansion help keep potential partners interested.

Be willing to make changes to improve operations. Potential partners look for groups they can work with. When evaluating a group, capital or management partners tend to examine trends in billing and administrative costs and expenditures for information technology.

Nurture strong physician leadership. Strong physician leaders can help to guide a group to make the right decision regarding a partner and help to ensure that the clinic will continue to be successful.

Institute a governance structure that promotes quick decisionmaking. Having processes in place for quick decisionmaking

shows potential partners that the group can respond quickly to a crisis or opportunity.

Foster a group mentality. A physician group that functions cohesively as a unit—as evidenced by low physician turnover and a shared information system, for example—is more attractive to potential partners than a group of physicians who try to practice as individuals.

Reinvest capital. When a group invests its own capital in operations, partners gain confidence in the group's prospects for growth and in the physicians' commitment to success. Partners are attracted to groups that have shown a willingness to

Approach several potential partners. Competition among different potential partners yields better terms and conditions in a transaction. Furthermore, having options gives groups leverage and confidence throughout the process.

Run an honest, fair bidding process. Making sure that all potential partners have access to the same information at the same time helps ensure that potential partners will not drop out of the process.

Focus on both quantitative and qualitative issues. Expressing concern for how the two organizations will fit and work together after the purchase price is paid

Having processes in place for quick decision-making shows that the group can respond quickly to a crisis or opportunity.

invest their own funds to make important capital expenditures and operational improvements.

After completing the seven steps described above to help ensure that the group runs smoothly, the physicians need to ensure that the partnering process is also efficient and effective. They can do so by following these steps:

Create an effective marketing document. A document that contains information about the group, its market, and its historical and projected financial results helps potential partners understand the practice. When potential partners understand the group and its market, they are likely to be more aggressive and thus more willing to continue the discussions beyond the preliminary talks.

Provide accurate information. Distributing accurate financial statements and credible projections and giving the potential partners access to information relevant to group performance help potential partners bid with confidence.

shows potential partners that the group is committed to the partnership. Focusing solely on the financial implications of a deal is shortsighted.

Engage experienced advisers. A partnering transaction is an event that usually happens only once for most groups. It is important for the group to negotiate a deal that is fair and that will help it prosper in the future. Furthermore, advisers can help the deal run more smoothly and free up physicians to focus on the practice of medicine. Experienced and qualified legal and financial advisers will bring the physician group value far beyond any fee paid to them.

Finally, continuing to focus on group operations during the partnering process is important because most partnering transactions take several months to complete. Significant swings in operating results or failure to hit budgets can lower potential partners' assessment of the group's value. On the other hand, exceeding budget during negotiations can increase the value of the group. ■

W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in health care transactions. Also, he is a member of the editorial Advisory Board of Practice Options. Jill S. Frew is managing director of Townsend Frew & Co.

Author-Consultant Shows Physicians How Medical Care Continues to Evolve



Peter R. Kongstvedt, MD, is a partner at Ernst & Young in Washington, D.C. He received his medical degree and internal medicine training at the

University of Wisconsin. Prior to joining Ernst & Young in 1994, he spent 16 years in senior-level management positions in managed health care. A fellow in the American College of Physicians, Kongstvedt is co-editor of *Best Practices in Medical Management* (Gaithersburg, Md.: Aspen Publishers, 1999). He is also a member of the editorial Advisory Board of *Practice Options*. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. Let's begin by discussing your book, *Best Practices in Medical Management*, which you co-edited with David Plocher, MD, a partner in Ernst & Young's Minneapolis office. The 675-page book has 59 contributors and discusses the best practices in medical management in a managed care environment. How did this book come to be?

A. Our book resulted from a combination of factors. The first involved another book I edit, the *Managed Health Care Handbook* (Aspen) which is now in its third edition. The handbook contains a section on medical management, but it doesn't cover the entire topic. Also, as we were working with clients, it became clear to us that everyone involved in medical management seems to have his or her own particular focus on the topic, whether it's disease management, profiling, or whatever. And although there are many books that focus on specific aspects of medical management, none touched on all of them.

To become best in class, we believe it is necessary to look at everything in medical management. That doesn't mean you have to do it all, but you need to know it all—or at least all that is necessary to make good decisions and not be lulled

into thinking one or two techniques are enough to carry you. Basically, the book came about because we saw that no single resource covering a full range of medical management topics was available, and we wanted to fill that gap.

Q. Our readers will be interested in hearing how you went from being a board-certified internist to being a partner at Ernst & Young. Can you describe for us how you made that transition?

A. In the early 1980s, I was in private practice and fee-for-service medicine in Illinois. Back then, the term "HMO" was seen as a new service and regarded as some sort of socialist threat to life as we know it. At first, I had no reason to believe otherwise. But as I began to question the way medicine was structured in terms of the relationships between doctors and doctors and between doctors and patients, I saw that, in fact, there was little overall coordination of patient care. Rather, the focus was on one diagnosis and one form of treatment at a time.

fashioned HMO that needed to hire a medical director because it wasn't doing very well. I had enjoyed being the medical director of a small private practice group in Illinois just before that time, and when the opportunity came along to be a medical director of a larger group in Lincoln, Neb., in a very different type of a setting that required the coordination of all aspects of patient care, I found the offer attractive. That's how I became involved with HMOs. From there, I assumed larger responsibilities in progressively larger organizations, and spent most of my career at the CEO or COO level. When Ernst & Young approached me about making a change, I was ready, and have enjoyed the high level of intellectual stimulation that accompanied that change.

Q. Of the 59 contributors to your book, 14 of them are Ernst & Young consultants. Why does Ernst & Young seem to have such a huge stake in the managed care industry?

A. Ernst & Young has a tremendous stake in health care, not simply the

"Research has shown that nurse-advice lines are likely to pay off by increasing patient satisfaction and decreasing hassles for physicians. They also are likely to lead to better medical care at a lower cost."

Since I've always been an advocate of group practice, I was intrigued when I learned more about HMOs and that they involve group practices. Basically, medical groups are good structures. They provide the capability for coordinating services and for physicians to assess the quality of care they are delivering simply by interacting with their peers.

Since my early involvement in HMOs was as a medical director in a 12-physician medical group in a prepaid setting, charging fees and billing insurers weren't big issues then. In fact, it was a rather old-

managed care sector of it. In fact, a large proportion of our health care consulting practice has nothing to do with managed care. For example, besides audits, we work with large medical groups, hospital systems, academic health centers, pharmaceutical companies, and long-term care providers, among others. We're involved in all aspects of strategic planning, operations improvement, clinical pathway development, financial management, and a large range of other services.

Q. I also noticed that 11 of the book's contributors are from Minnesota and

(Continued on page 12)

“Health plans that earn the respect of physicians are far more likely to succeed than those that do not. This does not mean, however, that a health plan can or even should do whatever any physician says. Rather it has an obligation to be fair, honest, and consistent.”

(Continued from page 11)

most of them are from HealthPartners, a 750,000-member HMO in Minneapolis. Do you regard HealthPartners as a model for best practices in the industry?

A. Our book is not meant to endorse HealthPartners, Ernst & Young, or anyone else. What we aimed to do was convey the knowledge of individuals who are experts on the topics we wanted to cover. HealthPartners is certainly a fine organization, but that was not our reason for approaching those authors. In other words, our concern in the book was with having authors who have the ability to articulate what the topic is about.

Q. You describe your book as a handbook, and you emphasize that it is about clinical management, not operational or financial management. Who is your targeted audience?

A. The book is targeted at medical directors in managed care, although it is applicable in nonmanaged care settings as well. It doesn't talk about capitation, network contracting, or credentialing; it deals strictly with clinical topics of interest to medical directors, practicing physicians, and department chairs who want to look at the techniques they can use in a clinical managed care setting. Nurse managers will also find the book useful, as will those who teach in medical schools and want to help the new generation of physicians understand the current health care environment.

Q. One chapter I found particularly compelling discusses nurse-advice services. The chapter's author, Barry Wolcott, points out that one reason this topic hasn't received more attention may be that physicians have never charged for phone calls and have never thought of the telephone as an effective instrument for managing care.

A. His argument is compelling. In fact, research that we've done at E&Y has shown that nurse-advice lines are likely to pay off in a variety of ways by increas-

ing patient satisfaction and decreasing hassles for physicians. They also are likely to lead to better medical care at a lower cost.

Q. Another chapter I found compelling in the book was Plocher's discussion of the differences among medical management, hospital management, and disease management. He argues that physicians are no longer the eminent disease management system or the center of care giving, but rather that nonphysicians are delivering most care. He also argues that fee-for-service physicians in hospitals are not being rewarded for disease management.

A. Some people might argue with that last point. It is statistically true that physicians would not be rewarded in a purely fee-for-service system. On the other hand, in systems in which the risk of the cost of medical care for the overall organizational structure is combined among the physicians, the hospital, and so forth, then the physicians are being rewarded. But certainly in a purely fee-for-service environment, he's absolutely right.

Q. Another chapter in your book that readers might find compelling was written by Gordon Moser, MD, a board-certified internist who's executive director of the Institute for Clinical Systems Integration in Minneapolis. In his closing paragraph, he talks about the importance of establishing trust between physicians and the health plan. Is winning the trust of physicians a big issue for health plans?

A. Yes. Without it, nothing in the system will work, at least not for long. Health plans that earn the respect of physicians are far more likely to succeed than those that do not. This does not mean, however, that a health plan can or even should do whatever any physician says. Rather it has an obligation to be fair, honest, and consistent.

Q. You tackle some tough issues yourself in the book, such as the handling of

utilization review in hospitals. Would you comment on that topic here?

A. That chapter is a modification of the discussion in the *Managed Health Care Handbook*. Some readers might say the topic of utilization review is outdated, but actually most successful medical groups and IPAs in the managed care environment still do utilization review, although they now make it as friendly and hassle-free as possible.

Q. You also take on the authorization issue in the book, and argue that no managed care system can succeed without effective authorization. Isn't that a rather strong statement?

A. Yes, it is, and time may prove me wrong. I can, however, say with complete certainty that at least up until now, that observation holds true. Whether it will remain true, I don't know. The health care environment is different now, and some of the so-called open access plans may succeed by blending some managed care techniques with more traditional economic barriers, such as copayments and coinsurance. But in many cases, that's playing with financial fire for whoever is bearing the risk for medical costs.

Q. A number of recent books, such as J.D. Kleinke's *The Bleeding Edge* and Douglas Emery's book, *Global Fees for Episodes of Care*, predict doom and gloom for the conventional HMO industry. Are HMOs in trouble?

A. Everything evolves, including HMOs. One thing to keep in mind, though, is that all pundits end up being wrong. Take, for example, Paul Starr's 1982 book, *The Social Transformation of American Medicine*, which is one of the best books ever written about the U.S. health care industry. In it, Starr predicts that all health care will be provided by vertically integrated megacorps. That hasn't happened. In the

“Profiling provides a wonderful opportunity for physicians to see how their overall behavior looks in comparison to their peers, and to see that change is possible.”

early to mid-1980s, the pundits were saying that before the millennium, we would all be in staff-model HMOs. That hasn't happened. Then, it was predicted that we would all be under capitated systems. That hasn't happened. More recently, Harvard Business Professor Regina Herzlinger made predictions about focused factories, which haven't happened either. So, none of the pundits have been right. In reality, the industry is hugely more complex than anyone wants to give it credit for.

Q. *What about consumers? Are they showing some muscle in terms of what's happening in the current health care environment?*

A. Definitely. At one time, the group- and staff-model HMOs were hugely effective and convenient when compared with the previous unmanaged and expensive health care non-systems. But now that the rest of the health care world is becoming more organized, is being more efficiently managed, and is offering broader choices, competitive pressures exist that weren't there before. And that is likely to keep happening.

Q. *You wrote in your book about one of the big catalytic agents of this transformation: the use of information. You also discuss the use of information and provider profiling. Could you say more about those topics?*

A. Yes. The activities of providers—primarily physicians, but not only physicians—drive a lot of the outcomes, whether it's cost outcomes, clinical outcomes, or whatever. It's hard for people to change for the better if they don't have the information to see how they could be doing better. There are many possible uses for profiling, some of which make physicians uncomfortable, just as there are many ways of adjusting profiles to account for illness burden. The fact is, the days when physicians could do whatever they wanted with no one ever knowing are fading into history. But profiling also provides a wonderful opportunity for physicians to see how their overall behavior looks in comparison to their peers, and to see that change is possible.

Q. *Doesn't that argument relate back to the chapter you wrote on changing behavior and managed care, in which you point out that physicians are creatures of habit and that it is hard for them to change their habits?*

A. Absolutely. That's a major force, even on the issue of measurement alone. W. Edwards Deming always said that you cannot manage what you cannot measure. To a large degree, that's true. I don't want to pound this point too hard because the art of medicine is involved here as well, and art is not easily measured. But there is also science in medicine, and even within the art of medicine there are patterns of behavior one can observe.

—Edited by Paula D. Grant, in Lincoln, Va.

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Internist Seeks Advice on Going Solo

Question: I'm an internist in my early 30s, in a 400-physician group on the West Coast. Our group was bought out by MedPartners, a physician practice management company in Birmingham, Ala. As you know, MedPartners decided to shed the clinics and the physicians it acquired. I see no future in such a large group, and would like to go into solo practice. What are the prospects for a future as a solo practitioner?

Answer: There are several benefits to being a solo practitioner, according to Nathan Kaufman, president of the Kaufman Group, a division of Superior Consultant Co. in San Diego. "The most important benefit is that the solo practitioner is the sole decisionmaker," Kaufman says. "Many solo practitioners enjoy complete control over their practices."

Another benefit could be lower overhead. "Sometimes, the overhead of a solo practitioner is lower as a percentage of income compared to that of a group practice," says Kaufman. "A solo practitioner can hire one person to be responsible for all office functions: billing, collections, and general office management. It can be a less complicated, and therefore less costly, practice to run."

Also, Kaufman points out, a strong solo practitioner would not need to worry about being dragged down by less successful partners. "In a solo practice, a physician who is a strong practitioner is not surrounded by weak practitioners or difficult practitioners, as could be the case in a group setting," Kaufman explains.

But solo practice has drawbacks, too. "The lifestyle can be tough," says

Editor's note: Readers of *Practice Options* are invited to call our toll-free line to speak with Richard L. Reece, MD, editor-in-chief. Often, Reece poses questions from readers to members of the newsletter's editorial Advisory Board. In this column, Advisory Board member Nathan Kaufman responds to a reader's questions.

Kaufman. "A solo practitioner who is not on a call panel is on call every night."

More important, the disadvantages can be significant in a market dominated by managed care. "In certain markets, it is much harder to gain access to contracts as a solo practitioner than it is by being part of a group," Kaufman explains. "When putting together a panel in markets where groups are common, managed care organizations are more likely to seek the one-stop-shopping that a group offers than to try to negotiate numerous contracts with solo practitioners."

Furthermore, solo practitioners simply cannot reap certain benefits available to practitioners in single-specialty group set-

in sclerotherapy for varicose veins. "This internist left a large group practice and has developed quite a following not only in San Diego, but throughout the southern part of North America," he says.

Kaufman has observed some internists, mostly in small groups of two or three physicians, who "specialize" in an extremely high level of patient service, such as easy access to physicians. Since this level of service may be unusual in certain markets, patients may be willing to pay extra for it.

"Small groups can excel in providing exceptional patient service, and can gain quite a bit of patient volume and referrals as a result of word of mouth," says

"Physicians who can find a lucrative niche do exceptionally well. Their offices are packed."

—Nathan Kaufman, Superior Consultant Co.

tings. "A large single-specialty group is much more likely to have the capital and the patient volume necessary to provide its own ancillary services," says Kaufman. "And because of higher patient volume, groups can attract pharmaceutical trials, which can be very lucrative."

Finding a Niche

These disadvantages notwithstanding, solo practitioners can achieve some measure of success in most markets, Kaufman adds. "On the West Coast, even in markets with heavy managed care enrollment, there are internists who are not in large group practices and are still successful," he reports.

Many solo practitioners or physicians practicing in small group settings have developed successful practices for one of two reasons, Kaufman says. "Some physicians have subspecialized in a niche area in which people are willing to pay out of pocket for care," Kaufman explains. "Physicians who can find a lucrative niche do exceptionally well. Their offices are packed." He offers the example of an internist in San Diego who subspecializes

Kaufman. "Patients will be attracted to certain physician practices that offer pleasant offices, 24-hour-a-day access, same-day appointments, and excellent bedside manner."

The strategy of providing exceptional service, particularly access, is one solo practitioners who seek to make their practice attractive to patients and managed care organizations should adopt. "Accessibility to the physician is often the key factor in patient service," continues Kaufman. "When people are sick, they want to see a doctor immediately. If their own doctor is not accessible, they will simply find another one. Doctors will not engender a lot of positive feelings if their patients cannot get to see them."

The solo practitioner's most likely strategy is to join some form of alliance that will bolster the practice's patient flow but still allow the physician to retain his or her independence. "The physician will likely have to join an IPA or other alliance," says Kaufman. "In this way, the physician can be part of a 'group' just for contracting purposes." ■

Texas Physicians to Negotiate Fees Collectively

Beginning Sept. 1, Texas physicians will be able to negotiate collectively with health care plans without threat of federal antitrust penalties. Negotiation rights were included in legislation signed by Texas Governor George W. Bush on June 20. Similar proposals are pending in legislatures in Florida, Maryland, Michigan, New Jersey, Pennsylvania, and the District of Columbia.

"We hope this new law will put an end to the 'take-it-or-leave-it' attitude that some health plans have exhibited toward patients and physicians," said Randolph D. Smoak, MD, chairman of the AMA, which supported the legislation.

The law requires the Texas attorney general to approve all requests from physicians to negotiate or propose a contract collectively. Competing physicians within a health plan's service area may meet to discuss a wide range of issues, such as patient referral policies, reimbursement methods that affect care, quality assurance programs, and health service utilization review procedures.

The law will limit physicians to negotiating fees and discounts with health plans that have "substantial market power" as determined by the attorney general, and to cases in which the fees and discount terms already have negatively affected or threaten to affect access to care and quality of care. The state has yet to define "substantial market power."

The Texas Association of Health Plans strongly opposes the law. A spokesman from the group told Reuters Health that the law "has weak state supervision and is unlikely to satisfy the state action doctrine needed to achieve protection from federal antitrust enforcement."

Karen Ignani, president and CEO of the American Association of Health Plans, in Washington, D.C., argued in an association press release that the "Texas legislation has gone too far...This action gives physicians collective bargaining rights without any of the obligations or oversight of the National Labor Relations Act."

Source: Reuters Health

Compliance Guidelines Will Raise Costs

Physicians contracting with Medicare managed care plans can expect to incur higher costs and find their relations with health plans more acrimonious as a result of new federal guidelines aimed at eliminating fraud and abuse in federal health programs.

The federal Health and Human Services Office of the Inspector General released guidance for Medicare health plans designing internal compliance programs at a Washington, D.C., conference in June hosted by the Health Care Compliance Association.

Although voluntary, the guidelines are being taken seriously in the managed care industry because the government has made it a priority to fight fraud and abuse in health programs. The federal Health Care Financing Administration is expected to use the guidelines as its blueprint to monitor HMOs' internal compliance efforts. As a result, Medicare managed care plans will use the detailed model to design their own compliance programs, which are mandated by the Medicare program beginning in January.

The guidelines offer guidance on policies, procedures, standards of conduct, designation of a compliance officer, development of training and education programs, creation of hot-lines for complaints, the performance of internal audits, and enforcement by disciplinary directives.

Physician practices contracting with multiple health plans will have to restructure their internal computer systems to supply each HMO's requested data differently.

Source: Reuters Health

Health Plans to Report Hypertension Data

Members of the American Society of Hypertension have praised managed care plans for including hypertension treatment among the quality control measures recently added to the Health Plan Employer Data and Information Set (HEDIS).

HEDIS is a standardized set of some 60 performance measures used by an estimated 90% of the nation's managed care plans. The newest version, HEDIS 2000, is the sixth iteration of the standards developed under the direction of the National Committee on Quality Assurance (NCQA), in Washington, D.C., and scheduled to take effect Jan. 1. It states that patients who have been in a managed care plan for 18 months or longer and are age 45 or older should have hypertension controlled to a level of less than 140/90 mmHg.

Clarence Grimm, MD, a hypertension expert from Wayne State University School of Medicine in Detroit, said that the new measure may do more to bring hypertension treatment to the forefront of medical care than any guideline issued by government or professional organizations.

Earl Steinberg, MD, from Covance Health Economics and Outcomes Services Inc., in Washington, D.C., reported that Covance worked with NCQA's hypertension measurement committee to test the measure in a pilot program. "The prevalence of hypertension was 39% of all 2,000 patients," Steinberg reported. "But among Medicare patients, prevalence was 50%. It was 38% among Medicaid patients and more than 60% among diabetics."

Source: Reuters Health



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